Issued: May 24, 1994

Donna R. Koehnke

Secretary.

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Corrections

Federal Register
Vol. 59, No. 102
Friday, May 27, 1994

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 94N-0171]

Discovery Experimental and and Development, Inc.; Deprenyl Gelatin Capsules and Liquid (Deprenyl Citrate); Proposal to Refuse to Approve a New Drug Application; Opportunity for a Hearing

Correction

In notice document 94-12196 beginning on page 26239 in the issue of Thursday, May 19, 1994, make the following correction:

On page 26239, in the second column, under **DATES**, in the second line, "June 30, 1994" should read "June 20, 1994".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 94N-0118]

Preamendments Class III Devices; Strategy Document; Availability

Correction

In notice document 94-10998 beginning on page 23731 in the issue of Friday, May 6, 1994, make the following correction:

On page 23732, in the first column, in the last paragraph, in the second line, "July 9, 1994" should read "August 4, 1994".

BILLING CODE 1505-01-D

SECURITIES AND EXCHANGE COMMISSION

17 CFR Parts 275 and 279

[Release No. IA-1411; S7-2-94]

RIN 3235-AG02

Disclosure by Investment Advisers Regarding Wrap Fee Programs

Correction

In rule document 94-9890 beginning on page 21657 in the issue of Tuesday, April 26, 1994, make the following correction:

On page 21663, in the third column, in Appendix 1, paragraph 7(i), in the last line, "managers" should read "manager".

BILLING CODE 1505-01-D

federal register

Friday
May 27, 1994

Part II

Department of Defense

48 CFR Parts 202, 204, 207, etc.
Defense Federal Acquisition Regulation Supplement; Miscellaneous Amendments; Interim Rule

DEPARTMENT OF DEFENSE

48 CFR Parts 202, 204, 207, 209, 210, 214, 215, 219, 222, 223, 225, 226, 231, 232, 233, 235, 237, 242, 243, 245, 247, 248, 249, 250, 251, 252, 253, Appendices B, F, G, H, and I to Chapter 2

[Defense Acquisition Circular (DAC) 91–6]

Defense Federal Acquisition Regulation Supplement; Miscellaneous Amendments

AGENCY: Department of Defense (DoD).

ACTION: Interim rule with request for comment and final rules.

SUMMARY: Defense Acquisition Circular (DAC) 91–6 amends the defense FAR Supplement (DFARS) to revise, finalize, or add language on distribution of contracts, suspension and debarment, made in America labels, ozone-depleting substances, bills of material, price competition, prenegotiation objectives, set-asides, certificates of competency, small business subcontracting plan, surety bond waiver reporting, Small Business Competitiveness Demonstration Program, Pilot Mentor-Protege Program, ammunition and explosives, storage and disposal of toxic and hazardous materials, Angolan petroleum, hand or measuring tools, four ton dolly jacks, coal and petroleum pitch carbon fiber, antifriction bearings, supplemental cost principles, penalties for unallowable costs, overseas severance costs, legislative lobbying costs, GAO bid protest procedures, certification of contract claims, fixed price development contacts, basic agreements, designation of paying office, reports of Government property, precious metals, notification of proposed program termination or reduction, title to contractor acquired property, Small Business Innovation Research Program, coordinated acquisition, and activity address numbers.

DATES: Effective date May 27, 1994.

Comment Date: Comments on the interim rule, Item XXXVIII, sections 249.7003 and 252.249–7002, should be submitted in writing on or before July 26, 1994 to the address shown below.

ADDRESSES: Comments on the interim rule should be submitted to Mr. Eric Mens, Defense Acquisition Regulations Directorate, PDUSD(A&T)DP(DAR), 3062 Defense Pentagon, Washington, DC 20301–3062. Please cite DFARS Case 93–D321 in all correspondence concerning the interim rule.

FOR FURTHER INFORMATION CONTACT: Ms. Lucile Martin, or for Item XXXVIII, Mr. Eric Mens, (703) 604–5930.

SUPPLEMENTARY INFORMATION:

A. Background

This Defense Acquisition Circular (DAC) 91–6 includes 48 rules and miscellaneous editorial amendments. Twelve of the rules in the DAC (Items IX, XVIII, XXVII, XXX, XL, and XLIII–XLIX) were published previously in the **Federal Register** and thus are not included as part of this rulemaking notice. These 12 rules are being published in the DAC to revise the looseleaf edition of DFARS to conform to the previously published revisions.

B. Determination to Issue An Interim Rule

A determination has been made under authority of the Secretary of Defense to issue the rule in Item XXXVIII as an interim rule. Compelling reasons exist to promulgate this rule without prior opportunity for public comment. However, comments received in response to publication of this rule will be considered in formulating the final rule.

C. Regulatory Flexibility Act

DAC 91–6, Items I, V, VI, VIII, X, XIII, XVI, XIX, XXII, XXV, XXXI, XXXIII, XXXIV, XXXV, XXXVI, XXXVII, XXXIX, XLI, XLII, L

The Regulatory Flexibility Act does not apply because these rules are not significant revisions within the meaning of Public Law 98–577. However, comments from small entities will be considered in accordance with section 610 of the Act. Such comments must be submitted separately. Please cite DFARS Case 94–610 in correspondence.

DAC 91–6, Items II, III, IV, VII, XI, XII, XIV, XV, XVII, XX, XXI, XXIII, XXVI, XXVIII, XXIX, XXXII

DoD certifies that these rules will not have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act because:

Item II—The rule merely standardizes debarment procedures. Contractors who avail themselves of the opportunity to present matters in opposition to debarment proceedings need not engage legal representation or present written material.

Item III—The rule only applies to those convicted of fraudulently affixing "Made in America" labels.

Item IV—Any additional expenses to contractors as a result of this rule will be reimbursable.

Item VII—The rule merely clarifies existing guidance.

Item XI—The rule is based on a statutory provision which expressly directs these procedural revisions.

Item XII—The rule provides additional guidance on evaluating the contractor's use of small and small disadvantaged businesses as subcontractors.

Item XIV—The rule extends a test program directed by statute.

Item XV—The rule does not diminish any preferences accorded small businesses, but instead increases incentives for mentor firms to provide assistance to small businesses.

Item XVII—The rule merely prohibits storage or disposal of hazardous material on Government property.

Item XX—The rule prohibits acquisition of hand or measuring tools of foreign manufacture.

Item XXI—The rule prohibits acquisition of dolly jacks of foreign manufacture.

Item XXIII—The rule prohibits acquisition of antifriction bearings of foreign manufacture.

Item XXVI—Most contracts awarded small entities are awarded on a competitive, fixed-price basis and the cost principles do not apply.

Item XXVIII—Most contracts awarded small entities are awarded on a competitive, fixed-price basis and the cost principles do not apply.

Item XXIX—Most contracts awarded small entities are awarded on a competitive, fixed-price basis and the cost principles do not apply.

Item XXXII—The rule is based directly on a statutory provision which expressly establishes criteria for certification.

DAC 91–6, Item XXXVIII

The Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, applies but the magnitude of the expected impact on small entities as a result of the rule is unknown and impossible to estimate. An Initial Regulatory Flexibility Analysis (IRFA) was performed and a copy submitted to the Chief Counsel for Advocacy of the Small Business Administration for the initially published interim DFARS rule. An amended IRFA will be submitted to reflect the latest changes in guidance as a result of the statutorily-imposed changes.

D. Paperwork Reduction Act

DAC 91–6, Items I, VIII, X–XIV, XVI, XVII, XIX–XXIII, XXV, XXVI, XXVIII, XXIX, XXXI–XXXV, XXXVII, XXXIX, XLI, XLII, L

The Paperwork Reduction Act does not apply because the revisions in this rulemaking notice do not contain and/or affect information collection requirements which require the approval of OMB under 44 U.S.C. 3501 *et seq.*

DAC 91–6, Item XV

The Paperwork Reduction Act applies. OMB approved the paperwork collection requirement in section 219.71, Pilot Mentor-Protege Program, under clearance number 0704–0332, through January 31, 1995. OMB also approved the paperwork collection requirement in appendix I, Policy and Procedures for the DoD Pilot Mentor-Protege Program, under clearance number 0704–0338, through February 28, 1995.

DAC 91–6, Item XXXVI

The Paperwork Reduction Act applies. OMB has approved the information collection request for Item XXXVI under clearance 0704–0246, through December 13, 1996.

Claudia L. Naugle,

Deputy Director, Defense Acquisition Regulations Council.

Defense Acquisition Circular (DAC) 91–6 amends the Defense FAR Supplement (DFARS) 1991 edition, prescribes procedures to be followed, and provides informational interest items. The amendments, procedures, and information are summarized as follows:

Item I—Distribution of Contracts

This final rule amends DFARS section 204.201 to ensure that contract distribution is consistent with security regulations.

Item II—Uniform Suspension and Debarment Procedures

DFARS section 209.402 and appendix H are added to provide uniform suspension and debarment procedures that are to be followed by all DoD debarring and suspending officials.

Item III—Made in America Labels

This item revises and converts the interim rule published as Item VIII of DAC 91–5 to a final rule. The interim rule added DFARS sections 209.406–2 and 209.406–4 to require debarment consideration for anyone convicted of fraudulently affixing "Made in America" labels and to specify the period of debarment. This final rule deletes section 209.406–4, which specified the period of debarment because the statutory mandate to specify the period of debarment was not continued in the Fiscal Year 1994 Defense Appropriations Act.

Item IV—Elimination of Ozone-Depleting Substances.

This finalizes the interim rule issued by Departmental Letter 93–005 on May 21, 1993. The interim rule added DFARS sections 207.105(b)(15) and 210.002–71 to implement section 326 of the Fiscal Year 1993 Defense Authorization Act. Section 326 places restrictions on the award and modification of contracts that require the use of ozone-depleting substances. The interim rule is converted to a final rule without change.

Item V—Bills of Materials

DFARS sections 210.001 and 210.011–70 are revised, and sections 210.070 and 252.210–7005 are deleted to remove unnecessary direction on contracting for bills of materials. In addition, DD Forms 346 and 347 are removed from part 253. Guidance on bills of materials can be found in DoDI section 4210.8, Department of Defense Bills of Materials, and MIL–STD–295, Preparation of Bills of Materials.

Item VI—SBIR Rights in Data

Alternate II of the clause at section 252.227–7013, Rights in Technical Data and Computer Software, is revised at paragraphs (b) and (c) to clarify the allocation of rights in technical data and computer software acquired under the Small Business Innovation Research Program.

Item VII—Adequate Price Competition

DFARS section 215.804–3 is revised to clarify guidance on adequate price competition in dual source acquisitions.

Item VIII—Documentation of Prenegotiation Objectives

DFARS section 215.807(b) is added to emphasize the requirement for documentation of the disposition of audit findings and recommendations in prenegotiation objectives.

Item IX—Industrial Modernization Incentives Program (IMIP)

DFARS section 215.870 and the clause at section 252.215–7003 were deleted effective January 14, 1993, by Departmental Letter 93–001, to reflect cancellation of the DoD industrial modernization incentive program. The program was cancelled September 18, 1992 by the Deputy Secretary of Defense.

Item X—Extension of Set-Aside Authority

DFARS sections 219.000, 226.7000, and the clause at 252.219–7003 are revised to implement section 801 of the Fiscal Year 1993 Defense Authorization Act. Section 801 of Public Law 102–484 codified and extended authorities provided under section 1207 of Public Law 99–661 through Fiscal Year 2000. A new paragraph (c) is added to section 219.502–2–70 to implement section 801(g) by establishing a process for determining whether use of small disadvantaged business (SDB) set-asides has caused a particular industry to bear a disproportionate share of contracts awarded by a particular contracting activity to achieve its SDB goal.

Item XI—Certificate of Competency

This converts the interim rule, published as Item X of DAC 91–5 to a final rule with no revision. The interim rule implemented section 804 of the Fiscal Year 1993 Defense Authorization Act. DFARS section 219.602–1 was amended and a provision at section 252.219–7009 was added to require contracting officers to notify a small business concern, in writing, of a determination of nonresponsibility and of the concern's right to request the Small Business Administration to make a determination of the concern's responsibility.

Item XII—Small Business Subcontracting Plan

This revises and finalizes the interim rule published as Item XIII of DAC 91–5. DFARS sections 215.605 and 236.602–1 are revised to elaborate on the requirement to evaluate the extent of participation of small and small disadvantaged businesses in performance of a contract. DFARS section 219.705–2(d) is revised to cross reference section 215.605.

Item XIII—Surety Bond Waiver Reporting

DFARS section 219.808–1(b)(iv) is added to require contracting officers to prepare quarterly reports on contract awards where Miller Act requirements for performance and payments bonds are waived under 8(a) construction contracts. Report Control Symbol DD–ACQ(AR)1930 is assigned to this requirement.

Item XIV—Small Business Competitiveness Demonstration Program

This item converts the interim rule published as Item XV of DAC 91–5 to a final rule with no change. This rule extended the Small Business Competitiveness Demonstration Program through September 30, 1996. It also revised part 219 to (1) state A–E services in support of military construction projects or military family housing are exempt from the program; and (2) address responsibility for reinstatement of small business set-asides.

Item XV–Pilot Mentor-Protege Program

DFARS is amended to incorporate the DoD policy for the Pilot Mentor-Protege Program as a new appendix I. Conforming changes have been made to subpart 219.71 to correctly reference the new appendix and to delete redundant material. This implements section 813 of the Fiscal Year 1994 Defense Authorization Act.

Item XVI—Ammunition and Explosives

DFARS section 223.370–4(b)(1)(ii) and the clause at section 252.223–7002 are revised to clarify policy regarding safety precautions for ammunition and explosives.

Item XVII—Storage and Disposal of Toxic and Hazardous Materials

The interim rule published as Item XX of DAC 91–5 is converted to a final rule. The interim rule added DFARS subpart 223.71 and the clause at section 252.223–7006 to incorporate the requirements of 10 U.S.C. 2692, as amended by section 2852 of the Fiscal Year 1993 Defense Authorization Act. An editorial correction is made at section 252.223–7006.

Item XVIII—North American Free Trade Agreement

This is an interim DFARS rule that was effective January 1, 1994. The rule was issued December 23, 1993 by Departmental Letter 93–010. Chapter Ten of the North American Free Trade Agreement (NAFTA) Implementation Act of 1993 (Pub. L. 103–182) requires the three parties to the agreement, (the United States, Canada, and Mexico) to eliminate "buy national" restrictions on nondefense-related purchases by the federal governments. The Federal Acquisition Regulation (FAR) was amended, effective January 1, 1994, but implementation of NAFTA also required revision of the Defense Federal Acquisition Regulation Supplement (DFARS) to integrate Buy American Act and Balance of Payment Program waivers necessitated by NAFTA with similar existing Department of Defense waivers for countries with memoranda of understanding or other international agreements.

Item XIX—Angolan Petroleum

DFARS sections 225.702(2), 225.703, 225.704, and 252.225–7011 are deleted to remove the restriction on acquisition of petroleum products originating in Angola. Pursuant to section 842 of the Fiscal Year 1993 Defense Authorization Act, Presidential Determination No. 93–32 certified that free, fair, and democratic elections had taken place in Angola. This action ended the DoD prohibition on purchasing of petroleum products originating in Angola.

Item XX—Restrictions on Hand or Measuring Tools

DFARS sections 225.7002, 252.225–7012, and 252.225–7015 are revised and 225.7003 is eliminated to combine the restriction on hand or measuring tools with the restriction on food, clothing, fabrics, and specialty metals. These items are subject to the same restrictions as a result of section 9009 of Public law 101–165 and similar restrictions in subsequent Defense Appropriations Acts.

Item XXI—Four Ton Dolly Jacks

This revises and converts the interim rule, published as Item XXVII in DAC 91–5, to a final rule. The interim rule implemented section 9108 of the Fiscal Year 1993 Defense Appropriations Act. DFARS section 225.7018 and the clause at section 252.225–7033 were added to restrict purchases of four ton dolly jacks to U.S. manufacturers. DFARS section 225.7018 is revised to limit this restriction to Fiscal Year 1993 funds. This restriction does not appear in the Fiscal Year 1994 Defense Appropriations Act.

Item XXII—Coal and Petroleum Pitch Carbon Fiber

DFARS section 225.7020 and the clause at section 252.225–7034 are added to restrict purchases of coal and petroleum pitch carbon fiber. This implements section 8040A of Public Law 102–172 and section 9040A of Public Law 102–396.

Item XXIII—Antifriction Bearings

This item converts the interim rule published as Item XXVII of DAC 91–5 to a final rule with no revisions. The interim rule moved the restriction on antifriction bearings from DFARS subpart 225.71 to DFARS subpart 225.70 because it is now a statutory restriction based on section 832 of the Fiscal Year 1993 Defense Authorization Act. Section 832 restricts acquisition of antifriction bearings through FY 1995.

Item XXIV—Subcontractor Payment Complaints

On September 27, 1993 the Director of Defense Procurement issued to the Military Departments and Defense Agencies, a memorandum discussing the actions to be taken to address complaints by subcontractors of nonpayment by a DoD prime contractor. Recent General Accounting Office and DoD Inspector General reviews have caused concern that this matter is not fully understood in all locations. Copies of the memorandum should be obtained through normal management channels.

Item XXV—Supplemental Cost Principles

DFARS section 231.100–70 is revised to narrow the prescription for use of the clause at section 252.231–7000, Supplemental Cost Principles. The cost principles in DFARS do not apply to contracts with educational institutions.

Item XXVI—Penalties for Unallowable Costs

This revises and finalizes the interim rule issued as Item XXXIV of DAC 91–5. The interim rule revised DFARS section 231.70 and the clause at sections 252.231–7001, Penalties for Unallowable Costs, to implement section 818 of the Fiscal Year 1993 Defense Authorization Act (Pub. L. 102–484). Changes between the interim and final rule include:

—Sections 231.7000(a) and 252.231–7001(b)—Insertion of the word "indirect" between the words "unallowable" and "costs" to clarify that the penalties apply to unallowable "indirect" and not "direct" costs.

—Section 231.7002–1(b)—Added "administrative" to the types of penalties which may be imposed.

—Section 231.7002–5(c)(1)—In the parenthetical, inserted the words "the types of controls required for" to make the waiver available to contractors which do not formally participate in a DoD sponsored self-governance program.

—Section 252.231–7001(e)—Inserted the words "allocated to this contract" to make it clear that the penalty is not based on the total amount of unallowable costs in the indirect costs proposal.

Item XXVII—Reduction in Progress Payment Rates

This is an interim rule issued by Departmental Letter 93–009 on

November 18, 1993 to implement Section 8155 of the Fiscal Year 1994 Defense Appropriations Act (Pub. L. 103–139). Section 8155 requires the Department of Defense to reduce the customary progress payment rate for large businesses from 85 percent to 75 percent for solicitations issued on or after November 11, 1993. This includes awards to large businesses under foreign military sales contracts. The rule revised language in DFARS section 232.501–1 and the clause at section 252.232–7004. It also revised Table 32–1 at section 232.502–1–71 to preclude the use of flexible progress payments in contracts resulting from solicitations issued on or after November 11, 1993.

Item XXVIII—Overseas Severance Costs

This item converts the interim rule published as Item XXXII of DAC 91–5 to a final rule without change. The interim rule added DFARS section 237.171 to establish the criteria and conditions for agency waiver of the cost limitations at section 231.205–6 and it added clauses at sections 252.237–7020 and 252.237–7021.

Item XXIX—Legislative Lobbying Costs

This item converts the interim rule published as Item XXXIII of DAC 91–5 to a final rule without change. The interim rule added DFARS section 231.205–22(a) to make unallowable the costs of preparing any material, report, list, or analysis on the actual or projected economic or employment impact in a particular State or congressional district of an acquisition program for which all research, development, testing and evaluation has not been completed.

Item XXX—Incremental Funding of Fixed-Price Contracts

This interim rule was issued by Departmental Letter 93–008, effective August 23, 1993. The rule added a new subpart at DFARS section 232.7 to establish specific situations where incremental funding of fixed-price contracts would be appropriate. The clause at section 252.232–7007, Limitation of Government's Obligation, identifies procedures for incrementally funding the contract and requires the contractor to provide the Government with written notice when the work will reach the point at which the amount payable by the Government, including any termination costs, approximates 85 percent of the funds currently allotted to the contract.

Item XXXI—GAO Bid Protest Procedures

This final rule removes the detailed GAO protest procedures at section 233.104 from the DFARS. Comparable language was added to the FAR as Item XVII of FAC 90–16.

Item XXXII—Certification of Contract Claims

This revises and finalizes the interim rule issued as Item XXXVI of DAC 91–5. The interim rule revised DFARS subpart 233.70 and the clause at section 252.233–7000, Certification of Claims and Requests for Adjustment or Relief, to implement section 813 of the National Defense Authorization Act for Fiscal Year 1993 (Pub. L. 102–484). Changes between the interim and final rule include:

—Section 233.7000(a)—Insertion of the words "or request" after the word "claim" in section 233.7000(a)(1); insertion of the words "who is authorized to bind the contractor and" after the word "individual" in section 233.7000(a)(2); and an editorial at section 233.7000(a)(2)(ii).

—Section 252.233–7000—In the certification language, deletion of the word "and" after the words "knowledge and belief"; and revising the last portion of the certification to read "duly authorized to certify the claim on behalf of the contractor." Also, in paragraph (d) of the clause, insertion of the words "who is authorized to bind the contractor and" after the words "signed by an individual."

Item XXXIII—Fixed Price Development Contracts

DFARS section 235.006(b)(ii) is revised to clarify the requirement for USD(A&T) approval of the Government's prenegotiation position before negotiations begin and of the negotiated agreement with the contractor before it is executed.

Item XXXIV—Basic Agreements

DFARS section 235.015(b) is amended to delete the reference to the Office of Naval Research as the central DoD activity for negotiating basic agreements. This reflects the fact that DoD no longer requires a single DoD activity to perform this function.

Item XXXV—Designation of Paying Office

DFARS section 242.205(1) is revised to allow a department or agency payment office to serve as paying office for a contract assigned to the Defense Contract Management Command if authorized by defense financial management regulations. The revision also deletes the Air Force payment office for missile propellants as these contracts are now paid by Defense Financial and Accounting Service (DFAS).

Item XXXVI—Reports of Government Property

DFARS section 245.505–14 is revised to transfer requirements for contractor reporting on Government property to a new clause at section 252.245–7001, Reports of Government Property. In addition, the DD Form 1662, DoD Property in the Custody of Contractors, has been revised to delete the certification requirement and to clarify reporting instructions.

Item XXXVII—Precious Metals

DFARS section 245.607–2(b) is revised to reflect the procedure initiated to streamline the process associated with the recovery of precious metals The Defense Reutilization and Marketing Service is prepositioning annual disposition instructions for certain categories of precious metals with DoD contract administration offices.

Item XXXVIII—Notification of Proposed Program Termination or Reduction

This interim rule replaces the interim rule which was issued as Departmental Letter 93–007 on August 9, 1993. It incorporates revisions necessitated by section 1372 of the National Defense Authorization Act for Fiscal Year 1994 (Pub. L. 103–160).

Item XXXIX—Title to Contractor Acquired Property

DFARS section 251.106(b) is deleted because the inconsistency in FAR, that section 251.106(b) was designed to correct, has been remedied. FAR section 51.106(b) was amended by FAC 90–16 to raise the threshold under which title to contractor acquired property in contracts with educational institutions vests in the contractor. The $1,000 threshold in FAR section 51.106(b) was increased to $5,000 to be consistent with the $5,000 threshold in Alternate II of the clause at FAR section 52.245–2 and Alternate I of the clause at FAR section 52.245–5.

Item XL—Carbonyl Iron Powders

DFARS sections 225.7014 through 225.7014–3 and the clause at section 252.225–7023 were removed by departmental letter 94–001, effective February 14, 1994, to delete the restriction on acquisition of carbonyl iron powders. Language restricting

acquisition to powders manufactured in the United States or Canada was in the FY 93 Defense Appropriations Act but was not in the FY 94 Defense Appropriations Act.

Item XLI—Coordinated Acquisition Assignments

DFARS appendix B is amended to show that the Defense Logistics Agency has only a partial assignment for certain classes of items within Federal Supply Group 36.

Item XLII—Appendix G Update

DFARS Appendix G is amended to update activity address codes.

Item XLIII—Reflagging or Repair Work

DFARS sections 247.571 and 247.573 were revised and section 252.247–7025 was added as an interim rule by departmental letter 94–002, effective February 25, 1994, to implement section 315 of the Fiscal Year 1994 Defense Authorization Act (Pub. L. 103–160). Section 315 places restrictions on performance of reflagging or repair work on any vessel used under a time charter contract.

Item XLIV—Aircraft Fuel Cells

DFARS sections 225.7021, 225.7021–1, 225.7021–2, 225.7021–3, and 252.225–7038 were added as an interim rule by departmental letter 94–003, effective March 7, 1994, to implement section 8090 of the Fiscal Year 1994 Defense Appropriations Act (Pub. L. 103–139). Section 8090 prohibits using fiscal year 1994 appropriated funds to procure aircraft fuel cells unless such cells are produced or manufactured in the United States by a domestic-operated entity. The clause in section 252.225–7038 is to be included in all solicitations and contracts involving fiscal year 1994 funds, unless a waiver has been granted in accordance with section 225.7021.2.

Item XLV—Preference for Local and Small Business

DFARS section 219.504 was revised and subpart 226.71 was added as an interim rule by departmental letter 94–004, effective March 8, 1994, to implement section 2912 of the Fiscal Year 1994 Defense Authorization Act (Pub. L. 103–160). Section 2912 requires DoD, when entering into contracts as part of the closure or realignment of a military installation under a base closure law, to give preference, to the greatest extent practicable, to qualified businesses located in the vicinity of the installation and to small business and small disadvantaged business concerns. This includes contracts awarded to carry out activities for the environmental restoration and mitigation at military installations to be closed or realigned. The guidance in subpart 226.71 is to be used when entering into contracts as part of the closure or realignment of a military installation. If there is a reasonable expectation that offers will be received from responsible business concerns located in the vicinity of the military installation that is being closed or realigned, do not set aside the acquisition for small or small disadvantaged businesses unless an offer can be expected from a small or small disadvantage business located in the vicinity of the installation.

Item XLVI—Lifeboat Survival Systems

DFARS Sections 225.7022, 225.7022–1, 225.70222–2, and 252,225–7039 were added as an interim rule by departmental letter 94–005, effective April 13, 1994, to implement section 8124 of the Fiscal Year 1994 Defense Appropriations Act, Public Law 103–139. Section 8124 prohibits the purchase of totally enclosed lifeboat survival systems, which consist of the lifeboat and associated davits and winches, if less than 50 percent of the entire system's components are manufactured in the United States, and if less than 50 percent of the labor in the manufacture and assembly of the entire system is performed in the United States.

Item XLVII—Small Disadvantaged Business, Historically Black Colleges and Universities, and Minority Institutions

DFARS sections 219.301, 226,7005, 252,219–7000, 252,219–7003, 252.219–7006, 252.226–7000, and 252.226–7001 were revised by departmental letter 94–006, effective April 21, 1994, to implement subsections 811(a), (b), and (c) of the Fiscal Year 1994 Defense Authorization Act (Pub. L. 103–160). Subsections 811 (a) and (b) revise the definitions for historically black colleges and universities (HBCU) and minority institutions (MI). Subsection 811(c) deletes the requirement for an offeror, that represents itself on a DoD solicitation as small disadvantaged business, HBCU, or MI, to maintain its status as such at the time of award. Under this interim rule, the offeror must qualify as an ADB, HBCU, or MI only at time of submission of the offer.

Item XLVIII—Economy Act

By memorandum of February 8, 1994, the Secretary of Defense established requirements for approval of a written determination before an Economy Act order may be released outside of DoD for contracting action. DFARS subpart 217.5 was revised by departmental letter 94–007, effective April 25, 1994, to define the role of the contracting officer in the approval process for Economy Act orders. Contracting officers should provide advice, if requested, to assist requirements personnel in the preparation of written determinations to support Economy Act orders.

Item XLXIX—Petroleum Products

DFARS sections 225.401, 225.403, and 225.403–70 were revised by departmental letter 94–008, effective April 26, 1994, to implement section 8094 of the Fiscal Year 1994 Defense Appropriations Act (Pub. L. 103–139). Section 8094 requires the Department of Defense to treat offers of petroleum products from eligible countries under the Caribbean Basin Economic Recovery Act the same as offers from designated countries under the Trade Agreements Act.

Under the Trade Agreements Act, designated country end products and Caribbean Basin country end products are evaluated without regard to the Buy American Act or Balance of Payments Program. However, petroleum products were previously excluded from the definition of Caribbean Basin country end products. The revisions of DFARS sections 225.401, 225.403, and 225.403–70 remove the exclusion of petroleum products from the definition of "Caribbean Basin country end product." This will result in treating offers of petroleum from Caribbean Basin countries as if they were offers from designated countries under the Trade Agreements Act.

Item L—Editorial Revisions

(Note: The asterisked items are revisions being made only in the looseleaf edition of DFARS.)

(a) The name of the Defense Advanced Research Projects Agency has been changed to the Advanced Research Projects Agency. DFARS has been amended to reflect the name change.

(b) The name of the Strategic Defense Initiative Organization has been changed to the Ballistic Missile Defense Organization. DFARS has been amended to reflect the name change.

(c) The definition of "contracting activity" at DFARS Section 202.101 is amended to update the contracting activity names that appear under the headings: Department of Defense, Army, Air Force, and On-Site Inspection Agency.

(d) DFARS section 204.670–6(b)(2) is amended to revise "Military Airlift

Command" to read "Air Mobility Command."

(e) DFARS section 209.202(a)(1) is amended to update the addressee within AMC.

(f) DFARS section 209.403(1) is amended to update the designation of the Air Force debarring official.

(g) DFARS section 214.406–3 is amended to add the General Counsel, Ballistic Missile Defense Organization as BMDO's delegated authority for mistake in bid determinations.

(h) DFARS section 215.804–6 is amended to revise the Air Force Contractor Cost Data Reporting (CCDR) System acronym.

(i) DFARS section 215.871–3(c) is amended to revise the reference statement "(see Section 250.871–4)" to read "(see Section 215.871–4)".

(j) DFARS section 215.971–3(d)(2) is amended to revise the reference statement "(see also section 217.7406–6(a))" to read "(see also section 217.7404–6(a))."

(k) DFARS section 215.975(b) is amended to revise the addresses of the Army and Air Force designated offices.

(l and m) DFARS section 219.1005(a) is amended for clarification.

(n) DFARS section 222.101–3(3) is amended to revise the reference "RCS DD P&L (AR) 1153" to read "Report Control Symbol DD–ACQ (AR) 1153."

(o) DFARS section 225.302(b)(i) is amended to revise the Air Force authority list.

(p) DFARS sections 225.7004, 225.7007, 225.7010, and 225.7016–1 are revised to update the statutory citations.

(q) DFARS section 231.205–18(c)(2) is amended to revise section "255.7303–2" to read Section "225.7303–2."

(r) DFARS section 235.015–71(i)(3) is revised to update references to FAR cost accounting standard clauses, which were revised by FAC 90–12.

*(s) DFARS section 237.171–1 is amended by removing the letter "a" after the title "Waiver of cost allowability limitations."

(t) DFARS section 242.1203(b)(1) is amended to revise the Air Force address.

(u) DFARS section 243.205–70 is amended to revise the reference "MIL–STD–480 or 481" to read "MIL–STD–973"; and to remove the parenthetical statement "(The contracting officer must consult technical personnel before determining which MIL–STD to use.)"

(v) DFARS section 245.310–(c)(ii)(A) is amended to revise the word "Contract" to read "Contact."

(w) DFARS section 247.105(a)(iii)(A) and (D) are amended to update the Air Force names and addresses.

(x) DFARS section 248.270 is amended by revising the reference "MIL–STD–480 or 481" to read "MIL–STD–973."

(y) DFARS section 249.105–1 is amended by revising in the introductory statement the reference "RCS:DD(I&L)(Q&AR)1411" to read "Report Control Symbol DD–ACQ (AR) 1411."

(z) DFARS section 249.7001(b)(1) is amended by revising paragraph (b)(1) to read "Army—Chief, Legislative Liaison (SALL–SPA)" in lieu of "Army—OSA, OCLL, (SACLL), ASA (I&L)."

(aa) DFARS section 250.201(b) is amended by revising the reference "FAR subpart 50.4" to read "FAR subpart 50.2."

(bb) DFARS section 252.203–7001 is amended by removing in paragraph (h) the extra word "the" between the word "contracting" and the word "The."

(cc) DFARS section 252.217–7026 is amended by revising at the end of the clause the words "(End of clause)" to read "(End of provision)".

(dd) DFARS section 252.223–7006 is amended to revise introductory sentence reference section "233.7013" to reaad section "223.7103."

(ee) DFARS section 252.225–7025 is amended by revising in paragraph (f) the reference "paragraph (g)" to read "paragraph (f)."

(ff) DFARS section 252.225–7031 is amended in the introductory prescription statement by revising the reference section "225.770–4" to read section "225.770–5."

(gg) DFARS section 252.234–7000(a)(4) is amended by revising the acronym "AFSCP" to read "AFMCP."

(hh) DFARS section 252.234–7000(b)(1)(i) is amended by revising the acronym "AFSCP" to read "AFMCP."

(ii) DFARS section 252.243–7000 is amended to update MIL–STD references.

(jj) DFARS section 252.248–7000 is amended to update MIL–STD references.

(kk) DFARS section 252.249–7001(a)(1) is amended to add a beginning quotation mark between the paragraph number "(1)" and the word "Major."

(ll) DFARS part 253 is amended to include updated DD Form 250, DD Form 250C, DD Form 250–1, DD Form 375, DD Form 375C, DD Form 882, DD Form 1149, DD Form 1149C, DD Form 1155, DD Form 1155C–1, DD Form 1342, DD Form 1419, DD Form 1637, DD Form 1639, DD Form 1640, DD Form 1659, DD Form 1662, DD Form 1861, DD Form 2222, DD Form 2222–2 and DD Form 2604.

(mm) DFARS appendix F, parts 3 and 4 are amended to reflect name and address updates for the Air Force.

Interim Rules Adopted as Final Without Changes

PARTS 207 AND 210—[AMENDED]

The interim rule adding sections 207.105(b)(15) and 210.002–71 that was published at 58 FR 32061 on June 8, 1993, is adopted as final without change.

PART 219—[AMENDED]

The interim rule amending sections 219.502–1, 219.502–2, and 219.1006 that was published as Item XV of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final without change.

PARTS 219 AND 252—[AMENDED]

The interim rule amending section 219.602–1 and adding section 252.219–7009 that was published as Item X of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final without change.

PART 225—[AMENDED]

The interim rule adding 225.7019 and 252.225–7016 that was published as Item XXVIII of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final without change.

PART 231—[AMENDED]

The interim rule adding section 231.205–22(a) that was published as Item XXXIII of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final without change.

PARTS 237 AND 252—[AMENDED]

The interim rule adding sections 237.171, 237.171–1, 237.171–2, 252.237–7020, and 252.237–7021 that was published as Item XXXII of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final without change.

Interim Rules Adopted as Final With Changes

PART 209—[AMENDED]

The interim rule adding sections 209.406–2 and 209.406–4 that was published as Item VIII of DAC 91–5 at 58 FR 28458 on May 13, 1993, is amended and adopted as final. Section 209.406–4 is removed.

PARTS 209, 215, AND 219—[AMENDED]

The finalizes the interim rule published as Item XIII of DAC 91–5 at 58 FR 28458 on May 13, 1993. Section 209.106–2 is adopted without change and sections 215.605(b) and 219.705–2(d) are amended.

PARTS 223 AND 252—[AMENDED]

The interim rule adding subpart 223.71 and section 252.223–7006 that was published as Item XX of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final with a minor editorial correction at section 252.223–7006.

PARTS 225 AND 252—[AMENDED]

The interim rule adding section 225.7018 and section 252.225–7033 that was published as Item XXVII of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final with an amendment to section 225.7018.

PARTS 231 AND 252—[AMENDED]

The interim rule revising subpart 231.70 and section 252.231–7001 that was published as Item XXXIV of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final with amendments at sections 231.7000 and 252.231–7001.

PARTS 233 AND 252—[AMENDED]

The interim rule revising section 233.7000 and section 252.233–7000 that was published as Item XXXVI of DAC 91–5 at 58 FR 28458 on May 13, 1993, is adopted as final with amendments to sections 233.7000 and 252.233–7000.

List of Subjects in 48 CFR Parts 202, 204, 207, 209, 210, 214, 215, 219, 222, 223, 225, 226, 231, 232, 233, 235, 237, 242, 243, 245, 247, 248, 249, 250, 251, 252, 253, Appendices B, F, G, H, and I to Chapter 2

Government procurement.

Amendments to 48 CFR Chapter 2 (Defense FAR Supplement)

48 CFR Chapter 2 (the Defense FAR Supplement) is amended as set forth below.

1. The authority for 48 CFR parts 202, 204, 207, 209, 210, 214, 215, 219, 222, 223, 225, 226, 231, 232, 233, 235, 237, 242, 243, 245, 247, 248, 249, 250, 251, 252, 253, and Appendixes B, F, G, H, and I to chapter 2 continues to read as follows:

Authority: 41 U.S.C. 421 and 48 CFR Part 1.

PART 202—DEFINITIONS OF WORDS AND TERMS

202.101 [Amended].

2. Section 202.101 is amended by adding three activities in the definition entitled *Contracting activity* under the heading Department of Defense, to read "Defense Evaluation Support Activity, Department of Defense Office of Dependents Schools and Office of Civilian Health and Medical Program of the Uniformed Services"; by revising under the definition entitled *Contracting activity* under the heading Army, the entry "Laboratory Command" to read "Research Laboratory"; by removing under the definition entitled *Contracting activity* under the heading Air Force, the entries "Air Force Logistics Command" and "Air Force Systems Command" and inserting in their place "Air Force Materiel Command"; by removing under the definition entitled *Contracting activity* under the heading Air Force, the entry "Air Force Communications Command"; by revising under the definition entitled *Contracting activity* under the heading Air Force the entry "Air Training Command" to read "Air Education and Training Command"; by revising under the definition entitled *Contracting activity* under the heading Air Force the entry "Space Command" to read "Air Force Space Command"; by removing under the definition entitled *Contracting activity* under the heading Air Force, the entry "Electronic Security Command"; by revising the heading "Defense Advanced Research Projects Agency" to read "Advanced Research Projects Agency"; by revising the heading and subheading "Strategic Defense Initiative Organization, Headquarters, Strategic Defense Initiative Organization" to read "Ballistic Missile Defense Organization, Headquarters, Ballistic Missile Defense Organization"; by revising in the definition entitled *Departments and agencies* the words "Defense Advanced Research Projects Agency" to read "Advanced Research Projects Agency"; by revising in the definition entitled *Departments and agencies* the words "Strategic Defense Initiative Organization" to read "Ballistic Missile Defense Organization"; and by revising under the definition entitled *Contracting activity* under the heading On-Site Inspection Agency, the entry "Headquarters, On-site Inspection Agency" to read "Acquisition Management Office."

PART 204—ADMINISTRATIVE MATTERS

3. Section 204.201 is amended by removing the introductory paragraph and inserting in its place two new paragraphs reading as follows:

204.201 Procedures.

(1) The procuring contracting officer (PCO) retains the original signed contract for the official contract file. Administrative contracting officers and terminations contracting officers provide the original of each modification to the PCO for retention in the official contract file. Unless otherwise directed by department/agency procedures, the office issuing the orders maintains the original of orders under basic ordering agreements and the original of provisioning orders.

(2) Ensure that distribution of contracts and modifications is consistent with security directives.

* * * * *

204.670–6 [Amended].

4. Section 204.670–6 is amended by revising in paragraph (b)(2) the words "Military Airlift Command" to read "Air Mobility Command."

204.7003 [Amended].

5. Section 204.7003 is amended by revising, in paragraph (a)(1)(i)(J), the phrase "Strategic Defense Initiative Office—SDIO" to read "Ballistic Missile Defense Organization—BMD".

PART 209—CONTRACTOR QUALIFICATIONS

209.202 [Amended].

6. Section 209.202 is amended by revising in paragraph (a)(1) the entry "Army—Headquarters, U.S. Army Materiel Command, AMCCE–PSE" to read "Army—Headquarters, U.S. Army Materiel Command, AMCRD–IC"; by revising in paragraph (a)(1) the entry "Defense Advanced Research Projects Agency—Director, Contracts Management Office" to read "Advanced Research Projects Agency—Director, Contracts Management Office;" and by revising in paragraph (a)(1) the entry "Strategic Defense Initiative Organization—Director" to read "Ballistic Missile Defense Organization—Director."

7. Section 209.402 is added to read as follows:

209.402 Policy.

(d) The uniform suspension and debarment procedures to be followed by all debarring and suspending officials are set out in appendix H to this chapter.

(e) The department or agency shall provide a copy of the Debarment and Suspension Procedures at DFARS appendix H to this chapter to contractors at the time of their suspension or when they are proposed for debarment, and upon request to other interested parties.

209.403 [Amended].

8. Section 209.403 is amended by revising under the definition entitled *Debarring official* the entry "Air Force The Deputy Assistant Secretary (Acquisition)" to read "Air Force—The

Assistant General Counsel for Contractor Responsibility (SAF/GCR)"; by revising under the definition entitled *Debarring official* the entry "Defense Advanced Research Projects Agency—The Director" to read "Advanced Research Projects Agency—The Director"; and by revising the entry "Strategic Defense Initiative Organization—The General Counsel" to read "Ballistic Missile Defense Organization—The General Counsel."

209.406–4 [Removed].

9. Section 209.406–4 is removed.

PART 210—SPECIFICATIONS, STANDARDS, AND OTHER PURCHASE DESCRIPTIONS

210.001 [Amended].

10. Section 210.001 is amended by removing the definition of *Bill of Materials.*

210.011–70 [Amended].

11. Section 210.011–70 is amended by removing paragraph (d).

210.070 [Removed].

12. Section 210.070 is removed.

PART 214—SEALED BIDDING

214.406–3 [Amended].

13. Section 214.406–3 is amended by revising paragraph (e)(i) and adding paragraph (e)(ix), reading as follows:

214.406–3 Other mistakes disclosed before award.

(e) * * *

(i) Advanced Research Projects Agency: General Counsel, ARPA.

* * * * *

(ix) Ballistic Missile Defense Organization: General Counsel, BMDO.

* * * * *

PART 215—CONTRACTING BY NEGOTIATION

14. Section 215.605 is amended by removing paragraph (a) and revising paragraph (b) to read as follows:

215.605 Evaluation factors.

(b) In acquisitions which require use of the clause at FAR section 52.219–9, Small Business and Small Disadvantaged Business Subcontracting Plan, the extent of participation of small and small disadvantaged businesses in performance of the contract shall be addressed in source selection.

(i) For acquisitions other than those based only on cost or price competition, the contracting officer shall evaluate the extent to which offerors identify and commit to small business and to small disadvantaged business, historically black college and university or minority institution performance of the contract, whether as a joint venture, teaming arrangement, or subcontractor.

(ii) Criteria for evaluation may include—

(A) The extent which such firms are specifically identified in proposals;

(B) The extent of commitment to use such firms;

(C) The complexity and variety of the work small firms are to perform;

(D) The realism of the proposal;

(E) Prior performance of offerors in complying with requirements of the clauses at FAR section 52.219–8, Utilization of Small Business Concerns and Small Disadvantaged Business Concerns, and section 52.219–9, Small Business and Small Disadvantaged Business Subcontracting Plan; and

(F) The extent of participation of such firms in terms of the value of the total acquisition.

(iii) Proposals addressing the extent of small and small disadvantaged business performance may be separate from subcontracting plans submitted pursuant to the clause at FAR section 52.219–9, Small Business and Small Disadvantaged Business Subcontracting Plan, and should be structured to allow for consideration of offers from small businesses.

* * * * *

15. Section 215.804–3 is amended by revising paragraph (b)(3)(B)(*2*) and adding paragraph (b)(3)(B)(*3*) to read as follows:

§ 215.804–3 Exemption from or waiver of submission of certified cost or pricing data.

* * * * *

(b) * * *

(3) * * *

(B) * * *

(*2*) Adequate price competition normally exists when—

(*i*) Prices are solicited across a full range of step quantities, normally including a 0–100 percent split, from at least two offerors who are individually capable of producing the full quantity; and

(*ii*) The price reasonableness of all prices awarded is clearly established on the basis of price analysis (see FAR section 15.805–2).

(*3*) If price reasonableness cannot be determined on the basis of price analysis, including the results of negotiations, the exemption at FAR section 15.804–3(a)(1) from submission of certified cost of pricing data shall not apply.

* * * * *

§ 215.804–6 [Amended].

16. Section 215.804–6 is amended by revising in paragraph (b)(2)(A) the words "Air Force—AFLCP/AFSCP 800–15" to read "Air Force—AFMCP 800–15."

17. Section 215.807 is amended by adding a new paragraph (b) to read as follows:

§ 215.807 Prenegotiation objectives.

* * * * *

(b) Prenegotiation objectives, including objectives related to disposition of findings and recommendations contained in preaward and postaward contract audit and other advisory reports, shall be documented and reviewed in accordance with Departmental procedures.

§ 215.871–3 [Amended].

18. Section 215.871–3(c) is amended by revising the reference statement "(see section 250.871–4)" to read "(see section 215.871–4)".

215.971–3 [Amended].

19. Section 215.971–3 is amended by revising in paragraph (d)(2) the reverence "(see also section 217.7406–6(a))" to read "(see also section 217.7404–6(a))."

20. Section 215.975 is amended by revising the entries in paragraph (b) under the headings ARMY and AIR FORCE to read as follows:

215.975 Reporting profit and fee statistics.

* * * * *

(b) * * *

Contracting office	Designated office
Army:	
All	Army Procurement Research and Analysis Office, ATTN: SFRD–KPR(WGL), Bldg 12500, C Wing, Ft. Lee, VA 23801–6045.
* * * * *	
Air Force:	
Air Force Materiel Command (all field offices).	Air Force Materiel Command, 645 CCSG/SCOS, ATTN: J010 Clerk, 2721 Sacramento Street, Wright-Patterson Air Force Base, Ohio 45433.
* * * * *	

PART 219—SMALL BUSINESS AND SMALL DISADVANTAGED BUSINESS CONCERNS

21. Section 219.000 is amended by revising the introductory text to read as follows:

219.000 Scope of part.

This part also implements 10 U.S.C. 2323, which sets a goal for DoD for each of fiscal years 1987 through 2000 to—

* * * * *

22. Section 219.502–2–70 is amended by revising paragraph (a) introductory text and by revising paragraph (c) and adding paragraph (d) to read as follows:

219.502–2–70 Total set-asides for small disadvantaged business concerns.

(a) Except as provided in paragraphs (b) and (c), the contracting officer shall set aside an acquisition for small disadvantaged businesses when there is a reasonable expectation that—

* * * * *

(c) Pursuant to 10 U.S.C. 2323(g), the Office of Small and Disadvantaged Business Utilization, Office of the Under Secretary of Defense (Acquisition & Technology), is responsible for determining whether use of small disadvantaged business (SDB) set-asides has caused a particular industry category to bear a disproportionate share of the contracts awarded by a particular contracting activity to achieve its SDB goal. Upon making a determination that a particular industry is bearing a disproportionate share, the OUSD(A&T) SADBU shall limit the use of total SDB set-asides in the affected industry category, at the contracting activity. This limitation shall not apply to solicitations that already had been synopsized as SDB set-asides. Forward requests for a determination through agency channels to OUSD(A&T) SADBU and include—

(1) The standard industrial (SIC) code(s) affected;

(2) Supporting information to justify the request, including dollars and percentages by the contracting activity, under the affected SIC code(s) for the previous two fiscal years and current fiscal year to date for—

(i) Total awards;

(ii) Total awards to small businesses;

(iii) Total awards to SDBs; and

(iv) Awards to SDBs under the SDB set-aside program.

(d) See 205.207(d) for information on Commerce Business Daily synopsis.

23. Section 219.705–2 is revised to read as follows:

219.705–2 Determining the need for a subcontracting plan.

(d) See 215.605 for unique DoD requirements.

24. Section 219.808–1 is amended by adding a paragraph (b)(iv) to read as follows:

219.808–1 Sole source

(b) * * *

(iv) Upon award of a contract using these procedures, the contracting officer shall prepare a report to include the following information (RCS DD–ACQ(AR)1930). Accumulate reports at each buying activity and forward, at the end of each fiscal quarter, through agency channels to the Director, Office of Small and Disadvantaged Business Utilization, Office of the Under Secretary of Defense for Acquisition and Technology.

(A) Title/Description of construction project.

(B) Estimated dollar amount of the contract.

(C) Name of contracting activity and contracting officer.

(D) Name and address of contractor.

(E) Contract number and award date.

25. Section 219.1005(a) is revised to read as follows:

219.1005 Applicability.

(a) Dredging (SIC 1629, FPDS Y216 and Z216) applies only to the Army Corps of Engineers.

* * * * *

26. Subpart 219.71 is revised to read as follows:

Sec.

219.7100 Scope.
219.7101 Policy.
219.7102 General.
219.7103 Procedures.
219.7103–1 General.
219.7103–2 Contracting officer responsibilities.
219.7104 Developmental assistance costs eligible for reimbursement or credit.
219.7105 Reporting.

Subpart 219.71—Pilot Mentor-Protege Program

§ 219.7100 Scope.

This subpart implements the Pilot Mentor-Protege Program established under section 831 of the National Defense Authorization Act for Fiscal Year 1991, Public Law 101–510, as amended. The purpose of the Program is to provide incentives for DoD contractors to assist small disadvantaged businesses in enhancing their capabilities and to increase participation of such firms in Government and commercial contracts. Qualified organizations employing the severely disabled, as defined in section 8064A of Public Law 102–172, are also eligible to participate as protege firms.

§ 219.7101 Policy.

DoD policy and procedures for implementation of the Program are contained in Appendix I to chapter 2, Policy and Procedures for the DoD Pilot Mentor-Protege Program.

§ 219.7102 General.

The Program includes—

(a) Mentor firms, which are prime contractors with at least one active subcontracting plan negotiated under FAR subpart 19.7.

(b) Protege firms, which are small disadvantaged business (SDB) concerns or qualified organizations employing the severely disabled, eligible for receipt of Federal contracts and selected by the mentor firm.

(c) Mentor-protege agreements, which establish a developmental assistance program for a protege firm.

(d) Incentives, which may be provided to mentor firms by the DoD including:

(1) Reimbursement for developmental assistance costs through—

(i) A separate contract;

(ii) A separately priced contract line item on a DoD contract; or

(iii) Inclusion of program cost in indirect expense pools.

(2) Credit toward SDB subcontracting goals, established under a subcontracting plan negotiated under FAR subpart 19.7, for developmental assistance costs which are either reimbursed through indirect expense pools or are not reimbursed; or

(3) A combination of reimbursement and credit.

§ 219.7103 Procedures.

§ 219.7103–1 General.

The procedures for application, acceptance, and participation in the program are in appendix I to chapter 2, Policy and Procedures for the DoD Pilot Mentor-Protege Program. The Director of Small and Disadvantaged Business Utilization, Office of the Under Secretary of Defense (Acquisition and Technology) approves contractors as mentor firms, approves mentor-protege agreements, and forwards approved mentor-protege agreements to the contracting officer when program funding is available through a DoD Program Manager.

§ 219.7103–2 Contracting officer responsibilities.

Contracting officers shall—

(a) Negotiate an advance agreement on the treatment of developmental assistance costs for credit, reimbursement, or both, if the mentor firm proposes such an agreement, or delegate authority to negotiate to the administrative contracting officer (see FAR section 31.109).

(b) Modify (without consideration) applicable contract(s) to incorporate the clause at section 2523.232–7005, Reimbursement of Subcontractor

Advance Payments-DoD Pilot Mentor-Protege Program, when advance payments are provided by a mentor firm to a protege firm under the Program and the mentor firm requests reimbursement of advance payments.

(c) Modify (without consideration) applicable contract(s) to incorporate other than customary progress payments for small disadvantaged businesses in accordance with FAR section 32.504(c) if such payments are provided by a mentor firm to a protege firm and the mentor firm requests reimbursement.

(d) Modify applicable contract(s) to establish a contract line item for reimbursement of developmental assistance costs—

(1) When funds have been made available for that purpose by a DoD program manager; and

(2) The contractor has an approved mentor-protege agreement.

(e) Advise contractors of reporting requirements in appendix I to chapter 2.

§ 219.7104 Developmental assistance costs eligible for reimbursement or credit.

(a) Developmental assistance provided under an approved mentor-protege agreement is distinct from, and shall not duplicate, any effort that is the normal and expected product of the award and administration of the mentor firm's subcontracts. Costs associated with the latter shall be accumulated and charged in accordance with the contractor's approved accounting practices. Mentor firm costs which are eligible for reimbursement are set forth in appendix I to chapter 2.

(b) Before incurring any costs under the Program, mentor firms need to establish the accounting treatment of developmental assistance costs eligible for reimbursement or credit. Advance agreements are encouraged. To be eligible for reimbursement under the Program, costs must be incurred before October 1, 1996.

(c) If the mentor firm is suspended or debarred while performing under an approved mentor-protege agreement, the mentor firm may not be reimbursed or credited for developmental assistance costs incurred more than 30 days after the imposition of the suspension or debarment.

(d) Developmental assistance costs, incurred by a mentor firm before October 1, 1999, that are eligible for crediting under the Program may be credited towards subcontracting plan goals as set forth in appendix I to chapter 2.

§ 219.7105 Reporting.

Mentor firms shall report on the progress made under active mentor-protege agreements semi-annually as indicated in section I–111 of appendix I to chapter 2.

PART 222—APPLICATION OF LABOR LAWS TO GOVERNMENT ACQUISITIONS

§ 222.101–3 [Amended]

27. and 28. Section 222.101–3 is amended by revising in paragraph (3) the reference "RCS DD P&L (AR) 1153" to read "Report Control Symbol DD–ACQ (AR) 1153."

PART 223—ENVIRONMENT, CONSERVATION, OCCUPATIONAL SAFETY, AND DRUG-FREE WORKPLACE

§ 223.370–4 [Amended]

29. Section 223.370–4 is amended in paragraph (b)(1)(ii) by revising the last sentence in the introductory text to read "The contracting officer shall make a decision after considering recommendations of the ACO and safety personnel responsible for ammunition and explosive safety."

PART 225—FOREIGN ACQUISITION

§ 225.302 [Amended]

30. Section 225.302 is amended by revising in paragraph (b)(i) the entries under the heading Air Force to read "Commander, U.S. Air Forces in Europe, Commander, Pacific Air Force, Commander, Air Mobility Command, Commander, Air Force Materiel Command, Commander, Air Combat Command, Commander, Air Force Space Command"; and by revising the entry "Defense Advanced Research Projects Agency, Director, Contracts Management Office" to read "Advanced Research Projects Agency, Director, Contracts Management Office."

31. Section 225.702 is revised to read as follows:

§ 225.702 Restrictions.

See Section 209.104–1(g)(i) for restrictions on contracting with firms owned or controlled by foreign governments that support terrorism. See Section 209.104–1(g)(ii) for prohibition on award of a DoD contract under a national security program to a company owned by an entity controlled by a foreign government when access to proscribed information is required to perform the contract.

§ 225.703 [Removed]

32. Section 225.703 is removed.

§ 225.704 [Removed]

33. Section 225.704 is removed.

§ 225.704–70 [Removed]

34. Section 225.704–70 is removed.

35. Section 225.7002 is revised to read as follows:

§ 225.7002 Restrictions on food, clothing, fabrics, specialty metals and hand or measuring tools.

36. Section 225.7702–1 is amended by adding paragraph (c) to read as follows:

§ 225.7002–1 Restrictions.

* * * * *

(C) Do not acquire hand or measuring tools that were not produced in the United States or its possessions.

37. Section 225.7002–2 is amended by revising paragraph (a); by revising paragraph (d); and by revising paragraph (i) to read as follows:

§ 225.7002–2 Exceptions.

* * * * *

(a) Any of the items in 225.7002–1(a) or (b), if the Secretary concerned, or designee, determines that they cannot be acquired when needed in a satisfactory quality and sufficient quantity grown or produced in the United States or its possessions at U.S. market prices.

* * * * *

(d) Acquisitions of those supplies listed in FAR Section 25.108(d)(1), unless the supplies are hand or measuring tools.

* * * * *

(i) Purchases of specialty metals and chemical warfare protective clothing when the acquisition furthers an agreement with a qualifying country (see Section 225.872).

38. Section 225.7002–4 is amended by adding introductory text; and by adding paragraph (d) to read as follows:

§ 225.7002–4 Contract clauses.

Unless an exception is known to apply—

* * * * *

(d) Use the clause at 252.225–7015, Preference for Domestic Hand or Measuring Tools, in all solicitations and contracts over the threshold in FAR Section 13.000 calling for delivery of hand or measuring tools.

§ 225.7003 [Removed and Reserved]

39. Section 225.7003 is removed and reserved.

§ 225.7003–1 [Removed]

40. Section 225.7003–1 is removed.

§ 225.7003–2 [Removed]

41. Section 225.7003–2 is removed.

§ 225.7004 [Amended]

42. Section 225.7004 is amended by revising in paragraph (a) the reference

"10 U.S.C. 2507(d)" to read "10 U.S.C. 2534(c)."

§ 225.7007 [Amended]

43. Section 225.7007 is amended by revising in paragraph (a) the reference "(10 U.S.C. 2507a(a))" to read "(10 U.S.C. 2534(a))."

§ 225.7010 [Amended]

44. Section 225.7010 is amended by revising in the introductory paragraph the reference "10 U.S.C. 2507(b)" to read "10 U.S.C. 2534(b)."

45. Section 225.7011 is revised to read as follows:

§ 225.7011 Restriction on Ballistic Missile Defense research, development, test, and evaluation.

§ 225.7011–1 [Amended]

46. Section 225.7011–1 is amended by revising the words "Strategic Defense Initiative" to read "Ballistic Missile Defense."

§ 225.7011–2 [Amended]

47. Section 225.7011–2 is amended by revising in paragraph (a) the words "Strategic Defense Initiative (SDI)" to read "Ballistic Missile Defense (MDB); and by revising in paragraph (c) the acronym "SDI" to read "BMD."

§ 225.7011–4 [Amended]

48. Section 225.7011–4 is amended by revising in paragraph (b) introductory text the words "SDI Organization, Attn: SDIO/IPM" to read "Ballistic Missile Defense Organization, Attn: BMDO/DRI."

§ 225.7011–5 [Amended]

49. Section 225.7011–5 is amended by revising the words "Strategic Defense Initiative" to read "Ballistic Missile Defense"; and by revising the acronym "SDI" to read "BDM."

§ 225.7014 [Removed and Reserved]

50. Section 225.7014 is removed and reserved.

§ 225.7014–1 [Removed]

51. Section 225.7014–1 is removed.

§ 225.7014–2 [Removed]

52. Section 225.7014–2 is removed.

§ 225.7014–3 [Removed]

53. Section 225.7014–3 is removed.

§ 225.7016–1 [Amended]

54. Section 225.7016–1 is amended by revising in the introductory paragraph the reference "10 U.S.C. 2507(f)" to read "10 U.S.C. 2534(e)."

55. Section 225.7018–1 is revised to read as follows:

§ 225.7018–1 Restriction.

In accordance with section 9108 of Public Law, 102–396, no fiscal year 1993 funds shall be used to procure four ton dolly jacks manufactured outside the United States.

56. Section 225.7018–3 is revised to read as follows:

§ 225.7018–3 Contract clause.

Use the clause at section 252.225–7033, Restriction on Acquisition of Four Ton Dolly Jacks, in solicitations and contracts that use fiscal year 1993 funds for the acquisition of four tone dolly jacks.

57. Sections 225.7020, 225.7020–1, and 225.7020–2 are added to read as follows:

§ 225.7020 Restriction on coal and petroleum pitch carbon fiber.

§ 225.7020–1 Restriction.

(a) Section 8040A of Public Law 102–172, and section 9040A of Public Law 102–396, require the Secretary of Defense to take such action as necessary to ensure by fiscal year 1994 that a minimum of 75 percent of the annual DoD requirements for coal and petroleum pitch carbon fibers is acquired from domestic sources.

(b) To meet this goal, all new major systems must use U.S. or Canadian manufacturers or producers for all coal and petroleum pitch carbon fiber requirements.

§ 225.7020–2 Contract clause.

(a) Use the clause of section 252.224–7034, Restriction on Acquisition of Coal and Petroleum Pitch Carbon Fiber, in all acquisitions for major systems (as defined in FAR part 34) that are not yet in production (milestone III as defined in DoDI section 5000.2, Defense Acquisition Program Procedures.)

(b) Contracting officers may, with the approval of the head of the contracting activity, waive, in whole or in part, the manufacturing/production requirement in paragraph (b) of the clause at section 252.225–7034. For example, a waiver is justified if a qualified U.S. or Canadian source cannot meet scheduling requirements.

PART 226—OTHER SOCIOECONOMIC PROGRAMS

58. Section 226.7000 is revised to read as follows:

§ 226.7000 Scope of subpart.

This subpart implements the historically black college and university (HBCU) and minority institution (MI) provisions of 10 U.S.C. 2323, which—

(a) Set a goal for DoD for each of fiscal years 1987 through 2000 to award five percent of contract and subcontract dollars to small disadvantaged business concerns and HBCU/MIs; and

(b) Require a separate goal, for each of fiscal years 1991 through 2000, as a subset of the five percent goal, for the participation of HBCUs and MIs.

PART 231—CONTRACT COST PRINCIPLES AND PROCEDURES

59. Section 231.100–70 is revised to read as follows:

§ 231.100–70 Contract clause.

Use the clause at 252.231–7000, Supplemental Cost Principles, in all solicitations and contracts which are subject to the principles and procedures described in FAR subparts 31.1, 31.2, 31.6, or 31.7.

§ 231.205–18 [Amended]

60. Section 231.205–18 is amended to revise in paragraph (c)(2) introductory text the reference section "255.7303–2" to read section "225.7303–2."

61. Section 231.7000 is revised to read as follows:

§ 231.7000 Scope of subpart.

(a) This subpart implements 10 U.S.C. 2324(a) through (d). It covers the assessment of penalties against contractors which include unallowable indirect costs in—

(1) Final indirect cost rate proposals, or

(2) The final statement of costs incurred or estimated to be incurred under a fixed-price incentive contract.

(b) This subpart applies to all DoD contracts awarded after February 26, 1987, in excess of $100,000, except fixed-price contracts without cost incentives.

(c) The status of the Government's audit of the final indirect cost proposal will determine whether penalties should be assessed under sections 231.7001 or 231.7002. An audit will be deemed to be formally initiated when the Government provides the contractor with written notice that audit work on a specific final indirect cost proposal has begun or the Government holds an audit entrance conference with the contractor.

§ 231.7001 [Amended]

62. Section 231.7001 is amended by revising the word "initiates" to read "initiated."

63. Section 231.7002–1 is amended by revising paragraphs (a)(1)(i) and (b) to read as follows:

§ 231.7002–1 General.

(a) * * *

(1) * * *

(i) The amount of the disallowed costs allocated to contracts that are subject to this subpart for which an indirect cost proposal has been submitted, plus

* * * * *

(b) These penalties are in addition to other administrative, civil, and criminal penalties provided by law.

* * * * *

§ 231.7002–2 [Amended]

64. Section 231.7002–2 is amended by redesignating paragraph (c) as paragraph (b) and removing in redesignated paragraph (b) introductory text the word "rate" between the word "cost" and the word "proposals."

§ 231.7002–3 [Amended]

65. Section 231.7002–3 is amended by revising the parenthetical statement in paragraph (b)(1) "(see FAR section 42.705–2)" to read "(see section 242.705–2)."

§ 231.7002–4 [Amended]

66. Section 231.7002–4 is amended by inserting in paragraph (b) between the word "of" and the word "Treasury" the word "the."

§ 231.7002–5 [Amended]

67. Section 231.7002–5 is amended by inserting in the parenthetical statement in paragraph (c)(1) between the word "include" and the word "satisfactory" the words "the types of controls required for."

PART 233—PROTESTS, DISPUTES, AND APPEALS

§ 233.1 [Removed]

68. Subpart 233.1 is removed.

69. Section 233.7000 is amended by revising paragraph (a) to read as follows:

§ 233.7000 Policy.

(a) Before payment can be made on a claim (see definition in FAR 33.201), a request for equitable adjustment to contract terms, a request for relief under Public Law 85–804 (see FAR part 50), or another similar request that exceeds $100,000, 10 U.S.C. 2410e requires that—

(1) The contractor certify the claim or request as required by FAR section 33.207; and

(2) The person certifying the claim or request be an individual who is authorized to bind the contractor and who has knowledge of—

(i) The basis of the claim or request;

(ii) The accuracy and completeness of the supporting data; and

(iii) The claim or request.

* * * * *

PART 235—RESEARCH AND DEVELOPMENT CONTRACTING

70. Section 235.006 is amended by revising paragraphs (b)(i)(C)(*1*) introductory text, (b)(ii) and (b)(iii) to read as follows:

§ 235.006 Contracting methods and contract type.

* * * * *

(b)(i) * * *

(C) * * *

(*1*) By the Under Secretary of Defense (Acquisition and Technology) (USD(A&T)) for—

* * * * *

(ii) The contracting officer must obtain USD(A&T) approval of the Government's prenegotiation position before negotiations begin and must obtain USD(A&T) approval of the negotiated agreement with the contractor before the agreement is executed for any action that is—

(A) An increase of more than $250 million in the price or ceiling price of a fixed-price type development contract, or a fixed-price type contract for the lead ship of a class;

(B) A reduction in the amount of work under a fixed-price type development contract or a fixed-price type contract for the lead ship of a class, when the value of the work deleted is $100 million or more; or

(C) A repricing of fixed-price type production options to a development contract, or a contract for the lead ship of a class, which increases the price or ceiling price by more than $250 million for equivalent quantities.

(iii) Notify the USD(A&T) of an intent not to exercise a fixed-price production option on a development contract for a major weapon system reasonably in advance of the expiration of the option exercise period.

71. Section 235.015 is revised to read as follows:

§ 235.015 Contracts for research with educational institutions and nonprofit organizations.

(b) *Basic agreements.*

(3) When using a basic agreement—

(i) Incorporate it by reference in section I of the contract; and

(ii) Incorporate any special clause requirements in section H.

71(a). Section 235.015–71 is amended by revising paragraph (i)(3) to read as follows:

§ 235.015–71 Short form research contract (SFRC).

* * * * *

(i) * * *

(3) The following clauses should be incorporated by reference in all SFRC contracts of $100,000 or more. Clauses with a double asterisk (**) apply to nonprofit organizations only.

FAR 52.203–12 Limitation on Payments to Influence Certain Federal Transactions.

252.203–7000 Statutory Prohibitions on Compensation to Former Department of Defense Employees

FAR 52.222–2 Payment for Overtime Premiums (The word "zero" is inserted in the blank space indicated by an asterisk.)

FAR 52.223–2 Clean Air and Water Act (Applies if contract amount exceeds the dollar amount set forth in the preamble to the clause.)

**FAR 52.230–2 Cost Accounting Standards (If contract is not exempt under 48 CFR chapter 99 (appendix B, FAR looseleaf edition), subpart 9903.201.)

**FAR 52.230–3 Disclosure and Consistency of Cost Accounting Practices (If contract is not exempt under 48 CFR chapter 99 (appendix B, FAR looseleaf edition), subpart 9903.201.)

**FAR 52.230–5 Administration of Cost Accounting Standards (If contract is not exempt under 48 CFR chapter 99 (appendix B, FAR looseleaf edition), subpart 9903.201.)

252.231–7001 Penalties for Unallowable Costs.

252.233–7000 Certification of Claims and Requests for Adjustment or Relief.

* * * * *

PART 236—CONSTRUCTION AND ARCHITECT–ENGINEER CONTRACTS

72. Section 236.602–1 is amended by adding a new paragraph (a)(i)(6)(C) to read as follows:

§ 236.602–1 Selection criteria.

(a)(i) * * *

(6) * * *

(C) Consider the extent to which potential contractors identify and commit to small business and to small disadvantaged business, historically black college and university, or minority institution performance of the contract, whether as a joint venture, teaming arrangement, or subcontractor.

PART 242—CONTRACT ADMINISTRATION

73. Section 242.205(1) is revised to read as follows:

§ 242.205 Designation of the paying office.

(1) For contracts assigned to the Defense Contract Management Command (DCMC), designate as the paying office—

(i) The cognizant Defense Finance and Accounting Service (DFAS) payment office as specified in the DoD Directory of Contract Administration Services Components (DLAH section 4105.4), for contracts funded with DoD funds;

(ii) The department or agency payment office if authorized by defense financial management regulations or if the contract is funded with non-DoD funds; or

(iii) Multiple paying offices under paragraphs (1)(i) and (ii) of this section—if the contract is funded with both DoD and non-DoD funds.

* * * * *

§ 242.1203 [Amended]

74. Section 242.1203 is amended to revise in paragraph (b)(1) the Air Force address "HQ, U.S. Air Force Systems Command, Attn: PKCP, Andrews AFB, DC 20334–5000" to read "HQ Air Force Materiel Command, Attn: AFMC/PKM, 4375 Chidlaw Road, suite 6, Wright Patterson AFB, OH 45433–5006."

PART 243—CONTRACT MODIFICATIONS

75. Section 243.405–70 is revised to read as follows:

§ 243.205–07 Engineering change proposals.

Engineering changes can originate with either the contractor or the Government. In either case, the Government will need detailed information from the contractor for evaluation of the technical, cost, and schedule effects of implementing the change. When the contracting officer wants this information submitted in the format prescribed by MIL–STD–973, use the clause at 252.243–7000, Engineering Change Proposals. Use the clause with its Alternate I, when appropriate, to discourage submission of a large number of small dollar, contractor originated engineering change proposals.

PART 245—GOVERNMENT PROPERTY

§ 245.310 [Amended]

76. Section 245.310 is amended to revise in paragraph (c)(ii)(A) the word "Contract" to read "Contact."

77. Section 245.505–14 is revised to read as follows:

§ 245.505–14 Reports of Government property.

(a) Use the clause at 252.245–7001, Reports of Government Property, in all solicitations and contracts containing one of the following clauses—

(1) FAR Section 52.245–2, Government Property (Fixed-Price Contracts);

(2) FAR Section 52.245–5, Government Property (Cost Reimbursement, Time-and-Material, or Labor-Hour Contracts;

(3) FAR Section 52.245–7, Government Property (Consolidated Facilities);

(4) FAR Section 52.245–10, Government Property (Facilities Acquisition); or

(5) FAR Section 52.245–11, Government Property (Facilities Use).

78. Section 245.607–2 is revised to read as follows:

§ 245.607–2 Recovering precious metals.

(b) Precious metals are silver, gold, platinum, palladium, rhodium, iridium, osmium, and ruthenium.

(i) At the beginning of every fiscal year, the Defense Reutilization and Marketing Service (DRMS) will provide each contract administration office with disposition instructions for certain categories of precious metals-bearing property, including scrap and usable items containing recoverable quantities of these metals. The disposition instructions—

(A) Will remain in effect for the entire fiscal year, unless modified by DRMS; and

(B) Will contain a fund citation to be used when disposition requires shipment of precious metals-bearing property for recovery.

(ii) Plant clearance officers shall obtain disposition instructions for precious metals-bearing property not covered by the annual disposition instructions from the Defense Reutilization and Marketing Service, Attn: DRMS–OC, 74 N. Washington Avenue, Battle Creek, MI 49017–3092.

PART 247—TRANSPORTATION

79. Section 247.105 is amended by revising paragraph (a)(iii)(A) and the Air Force entry in paragraph (a)(iii)(D) to read as follows:

§ 247.105 Transportation assistance.

(a)(i) * * *

(ii) * * *

(iii) * * *

(A) Originating in CONUS, request assistance from the appropriate military activity; i.e., the Air Mobility Command (AMC), Military Sealift Command (MSC), MTMC, or the military service sponsoring the cargo;

* * * * *

(D) * * *

Air Force

Applicable overseas Air Force Command, HQ PACAF/LGT, 25 East Street, suite I–326, Hickam AFB, HI 96853–5427.

HQ USAFE/LGT, Unit 3050, Box 105, APO AE 09049–0105.

HQ AFSPACECOM/LGT, 150 Vandenberg Street, suite 1105, Peterson AFB, CO 80914–4435.

* * * * *

PART 248—VALUE ENGINEERING

§ 248.270 [Amended]

80. Section 248.270 is amended by revising the reference "MIL–STD–480 or 481" to read "MIL–STD–973."

PART 249—TERMINATION OF CONTRACTS

§ 249.105–1 [Amended]

81. Section 249.105–1 is amended by revising in the introductory text the reference "RCS:DD(I&L)(Q&AR)1411" to read "Report Control Symbol DD–ACQ (AR) 1411."

82. Section 249.7001 is amended by revising paragraphs (b)(1), (b)(4) and (b)(12) to read as follows:

§ 249.7001 Congressional notification on significant contract terminations.

* * * * *

(b) * * *

(1) Army—Chief, Legislative Liaison (SALL–SPA)

* * * * *

(4) Advanced Research Projects Agency—CMO

* * * * *

(12) Ballistic Missile Defense Organization—Director of Contracts (BMDO–DCT)

* * * * *

83. Section 249.7003 is revised to read as follows:

§ 249.7003 Notification of proposed program termination or reduction.

(a) Section 1372 of the National Defense Authorization Act for Fiscal Year 1994 (Pub. L. 103–160), is intended to help establish benefit eligibility under the Job Training Partnership Act (29 U.S.C. 1661 and 1662) for employees of DoD contractors and subcontractors adversely affected by termination or substantial reductions in major defense programs.

(b) Departments and agencies are responsible for establishing procedures to:

(1) Determine which defense programs are proposed for termination or substantial reduction as a result of the submission of the President's budget, and which are likely to be terminated or substantially reduced as a result of enactment of an appropriations act.

(2) Within 90 days of such submission or enactment, provide notice of the proposed or anticipated termination or reduction—

(i) By general notice in the **Federal Register**;

(ii) In case of an enactment, to the Secretary of Labor; and

(iii) Through the contracting officer to each prime contractor, unless in the case of an enactment, notice was given at budget submission.

(3) Within 90 days after an enactment provides sufficient funding for a program, provide notice withdrawing the notices provided in 249.7003(b)(2)—

(i) By general notice in the **Federal Register**; and

(ii) Through the contracting officer to each prime contractor.

(c) The notification provided under (b)(2)(iii) shall be substantially as follows:

Section 1372 of the Fiscal Year 1994 National defense Authorization Act (Pub. L. 103–160) requires that each prime contractor under a major defense program be notified if the program is likely to be or proposed for termination or substantial reduction. (The terms *major defense program* and *substantial reduction* are defined in the notification of Proposed Program Termination or Reduction clause of your contract (*insert contract number*).)

You are hereby notified that the (*insert program name*) has been (*contracting officer to insert either (1) or (2)*)—

(1) proposed to be (*insert "terminated" or "substantially reduced"*) by the Fiscal Year (*insert fiscal year*) President's budget; or

(2) identified as likely to be (*insert "terminated" or "substantially reduced"*) by the Fiscal Year (*insert fiscal year*) Defense Appropriations Act.

While this notice is provided pursuant to section 1372, the impact on individual contracts has not yet been determined. This is not a notice of termination under the Termination for Convenience or Default clauses of your contract.

Your responsibilities upon receipt of this notice are set forth in the Notification of Proposed Program Termination or Reduction clause in your contract.

(d) Use the clause at section 252.249–7002, Notification of Proposed Program Termination or Reduction, in all contracts under a major defense program.

PART 250—EXTRAORDINARY CONTRACTUAL ACTIONS

§ 250.201 [Amended]

84. Section 250.201 is amended by revising in paragraph (b) the reference "FAR subpart 50.4" to read "FAR subpart 50.2."

§ 250.303 [Amended]

85. Section 250.303 is amended by revising in paragraph (5) the phrase "Defense Advanced Research Projects Agency—Director, CMO" to read "Advanced Research Projects Agency—Director, CMO"; and by revising in paragraph (13) the phrase "Strategic Defense Initiative Organization, Director, SDIO" to read "Ballistic Missile Defense Organization—Director, BMDO."

PART 251—USE OF GOVERNMENT SOURCES BY CONTRACTORS

§ 251.106 [Removed]

86. Section 251.106 is removed.

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

§ 252.203–7001 [Amended]

87. Section 252.203–7001 is amended by removing in paragraph (h) the extra word "the" between the word "contracting" and the word "The."

§ 252.210–7005 [Removed]

88. Section 252.210–7005 is removed.

§ 252.217–7026 [Amended]

89. Section 252.217–7026 is amended by revising at the end of the clause the words "(End of clause)" to read "(End of provision)".

§ 252.219–7003 [Amended]

90. Section 252.219–7003 is amended by revising the clause date to read "(MAY 1994)" and by revising the phrase "section 832 of the FY 90 DoD Authorization Act, Public Law 101–189" in paragraph (c)(2) to read "10 U.S.C. 2323a."

§ 252.219–7008 [Removed and Reserved]

91. Section 252.219–7008 is removed and reserved.

92. Section 252.223–7002 is amended by revising the clause date to read "(MAY 1994)"; by redesignating paragraphs (a)(2)(Iv) and (a)(2)(v) as paragraphs (a)(2)(iv) and (a)(2)(vi) respectively; by adding a new paragraph (a)(2)(iv) and by revising paragraph (b)(1) to read as follows:

§ 252.233–7002 Safety precautions for ammunition and explosives.

* * * * *

(a) * * *

(2) * * *

(iv) Oxidizers;

* * * * *

(b) * * *

(1) The Contractor shall comply with the requirements of the DoD Contractors' Safety Manual for Ammunition and Explosives, DoD 4145.26–M, hereafter referred to as "the manual," in effect on the date of the solicitation for this contract. The Contractor shall also comply with any other additional requirements included in the schedule of this contract.

* * * * *

§ 252.223–7006 [Amended]

93. Section 252.223–7006 is amended by revising in the introductory sentence the reference "223.7013" to read "223.7103."

§ 252.225–7011 [Removed and Reserved]

94. Section 252.225–7011 is removed.

95. Section 252.225–7012 is amended by revising the clause date to read "(MAY 1994)" and by revising paragraph (b)(1) to read as follows:

§ 252.225–7012 Preference for certain domestic commodities.

* * * * *

(b) * * *

(1) To supplies listed in FAR section 25.108(d)(1), or other supplies for which the Government has determined that a satisfactory quality and sufficient quantity cannot be acquired as and when needed at U.S. market prices;

* * * * *

§ 252.225–7015 [Amended]

96. Section 252.225–7015 is amended by revising the reference section "225.7003–2" in the introductory statement to read section "225.7002–4(d)".

§ 252.225–7018 [Amended]

97. Section 252.225–7018 is amended by revising the clause date to read "(MAY 1994)"; by revising in the section title the words "Strategic Defense Initiative" to read "Ballistic Missile Defense"; by revising in the clause title the words "Strategic Defense Initiative" to read "Ballistic Missile Defense"; by revising in paragraph (b) of the clause the words "Strategic Defense Initiative (SDI)" to read "Ballistic Missile Defense (BMD)"; and by revising in paragraph (c) the two references "SDI" to read "BMD."

§ 252.225–7023 [Removed and Reserved]

98. Section 252.225–7023 is removed and reserved.

§ 252.225–7025 [Amended]

99. Section 252.225–7025 is amended by revising in paragraph (f) the reference "paragraph (g)" to read "paragraph (f)".

§ 252.225–7031 [Amended]

100. Section 252.225–7031 is amended in the introductory prescription statement by revising the reference Section "225.770–4" to read Section "225.770–5."

101. Section 252.225–7034 is added to read as follows:

§ 225.225–7034 Restriction on acquisition of coal and petroleum pitch carbon fiber.

As prescribed in 225.7020–2, use the following clause:

Restriction on Acquisition of Coal and Petroleum Pitch Carbon Fiber (May 1994)

(a) This clause applies only if the end product furnished under this contract contains coal and petroleum pitch carbon fibers.

(b) Coal and petroleum pitch carbon fibers contained in the end product shall be manufactured in the United States or Canada using coal and petroleum pitch precursor produced in the United States or Canada.

(c) The Contracting Officer may waive the requirement in paragraph (b) in whole or in part. The Contractor may request a waiver from the Contracting Officer by identifying the circumstances and including a plan to qualify U.S. or Canadian sources expeditiously.

(End of clause)

§ 252.227–7013 [Amended]

102. Section 252.227–7013, Alternate II, is amended by revising the Alternate II date to read "(May 1994)"; by revising paragraph (b)(2)(i) introductory text; by revising paragraph (b)(3) introductory text; by removing in the first sentence following the heading "Government Purpose License Rights (SBIR Program)" between the word "after" and the word "acceptance" the words "delivery and" and inserting in that same sentence between the word "in" and the word "DFARS" the word "the;" by inserting in the second sentence following the heading "Government Purpose License Rights (SBIR Program)" between the word "in" and the word "DFARS" the word "the"; by revising in the fourth sentence following the heading "Government Purpose License Rights (SBIR Program)" the words "on Government purpose license rights." to read "of Government Purpose License Rights."; by adding to the end of the first sentence of paragraph (c)(1)(i) the words "for a period of four (4) years (or such longer period as may be authorized by the Contracting Officers for good cause shown) after acceptance of the last deliverable item under the contract under which the computer software was generated."; and by revising paragraph (c)(2) to read as follows:

§ 252.227–7013 Rights to technical data and computer software.

* * * * *

Alternate II (May 1994)

* * * * *

(b) * * *

(2) * * *

(i) Unpublished technical data pertaining to items, components or processes developed exclusively at private expense, and unpublished computer software documentation related to computer software that is acquired with restricted rights, other than such data included in (b)(1) of this clause. The limited rights shall be for a period of four (4) years (or such longer period as may be authorized by the Contracting Officer for good cause shown) after acceptance of the last deliverable item under the contract under which the technical data or computer software documentation were generated. Limited rights shall be effective provided that only the portion or portions of each piece of data to which limited rights are to be asserted are identified (for example, by circling, underscoring, or a note), and that the piece of data is marked with the legend below containing:

* * * * *

(3) *Government Purpose License Rights.* After the expiration of the four (4) year limited rights period established in paragraph (b)(2), the Government shall have Government Purpose License Rights in any technical data generated or required to be delivered under this contract or any subcontract hereunder, which is not otherwise subject to unlimited rights under subparagraph (b)(1) of this clause. The Government shall not be liable for unauthorized use or disclosure of the data by third parties. Government Purpose License Rights shall be effective provided that only the portion or portions of each piece of data to which such rights are to be asserted are identified (for example, by circling, underscoring, or a note), and that the piece of data is marked with the legend below:

* * * * *

(c) * * *

(2) *Government Purpose License Rights.* After the expiration of the four (4) year restricted rights period established in paragraph (c)(1), the Government shall have Government Purpose License Rights in:

(i) Computer software generated in the performance of experimental, developmental or research work which was specified as an element of performance in this or any Government contract or subcontract;

(ii) Computer software required to be originated or developed under a Government contract, or generated as a necessary part of performing a contract; and

(iii) Any other computer software required to be prepared or delivered under this contract or any subcontract hereunder, which is not otherwise subject to restricted or unlimited rights under subparagraph (c)(1) or (c)(3) of this clause. Government Purpose License Rights shall be effective provided that each unit of software is marked with an abbreviated license rights legend reciting that the use, duplication, or disclosure of the software is subject to the same restrictions included in the same contract (identified by number) with the same contractor (identified by name). The Government assumes no liability for unauthorized use, duplication, or disclosure by others.

* * * * *

§ 252.231–7001 [Amended]

103. Section 252.227–7001 is amended by revising the clause date to read "(MAY 1994)"; by inserting in paragraph (b) between the word "unallowable" and the word "costs" the word "indirect"; by revising the period at the end of paragraph (d)(2)(i) to a comma and the word "and"; and by adding at the end of paragraph (e) the words "allocated to this contract."

104. Section 252.233–7000 is amended by revising the clause date to read "(May 1994)"; by revising the certification following paragraph (a); and by revising paragraph (d) to read as follows:

§ 252.233–7000 Certification of claims and requests for adjustment or relief.

* * * * *

(a) * * *

I certify that the claim is made in good faith, that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contracting believes the Government is liable; and that I am duly authorized to certify the claim on behalf of the Contractor.

_____

(Official's Name)

_____

(Title)

* * * * *

(d) In those situations where no claim certification for the purposes of 10 U.S.C. 2410e has been submitted prior to the inception of a contract dispute, a single certification, using the language prescribed by the Contract Disputes Act (41 U.S.C. 601 *et seq.*) but signed by an individual who is authorized to bind the contractor and who has knowledge of the basis of the claim or request, knowledge of the accuracy and completeness of the supporting data, and knowledge of the claim or request, will satisfy the certification requirements of both statutes.

* * * * *

§ 252.234–7000 [Amended]

105. Section 252.234–7000 is amended by revising in paragraph (a)(4) the acronym "AFSCP" to read "AFMCP."

§ 252.234–7001 [Amended]

106. Section 252.234–7001 is amended by revising in paragraph (b)(1)(i) the acronym "AFSCP" to read "AFMCP."

107. Section 252.243–7000 is revised to read as follows:

§ 252.243–7000 Engineering change proposals.

As prescribed in 243.205–70, use the following clause:

Engineering Change Proposals (May 1994)

(a) The Contracting Officer may ask the Contractor to prepare engineering change proposals for engineering changes within the scope of this contract. Upon receipt of a written request from the Contracting Officer, the Contractor shall prepare and submit an engineering change proposal in accordance with the instructions of MIL–STD–973, in effect on the date of contract award.

(b) The Contractor may initiate engineering change proposals. Contractor initiated engineering change proposals shall include a "not to exceed" price* or a "not less than" price* and delivery adjustment. If the Contracting Officer orders the engineering change, the increase shall not exceed nor the decrease be less than the "not to exceed" or "not less than" amounts**.

(c) When the price** of the engineering change is $500,000 or more, the Contractor shall submit

(1) A completed SF 1411, Contract Pricing Proposal Cover Sheet, and

(2) At the time of agreement on price*, a signed Certificate of Current Cost or Pricing Data.

(End of clause)

Alternate I (May 1994)

As prescribed in 243.205–70, add the following paragraph (d) to the basic clause:

(d) If the price* of a Contractor initiated engineering change is _____*** or less, the change, if ordered, shall be made at no adjustment in the contract price*.

108. Section 252.245–7001 is added to read as follows:

§ 252.245–7001 Reports of Government Property.

As prescribed in 245.505–14(a), use the following clause:

Reports of Government Property (May 1994)

(a) The Contractor shall provide an annual report—

(1) For all DoD property for which the Contractor is accountable under the contract;

(2) Prepared in accordance with the requirements of DD Form 1662, DoD Property in the Custody of Contractors, or approved substitute, including instructions on the reverse side of the form;

(3) In duplicate, to the cognizant Government property administrator, no later than October 31.

(b) The Contractor is responsible for reporting all Government property accountable to this contract, including that at subcontractor and alternate locations.

(End of clause)

109. Section 252.248–7000 is revised to read as follows:

§ 252.248–7000 Preparation of value engineering change proposals.

As prescribed in 248.270, use the following clause:

Preparation of Value Engineering Change Proposals (May 1994)

Prepare value engineering change proposals, for submission pursuant to the value engineering clause of this contract, in the format prescribed by the version of MIL–STD–973 in effect on the date of contract award.

(End of clause)

110. Section 252.249–7002 is revised to read as follows:

§ 252.249–7002 Notification of proposed program termination or reduction.

As prescribed in 249.7003(d), use the following clause:

Notification of Proposed Program Termination or Reduction (May 1994)

(a) *Definitions.* "Major defense program" means a program that is carried out to produce or acquire a major system (as defined in 10 U.S.C. 2302) (see also DoD Instruction 5000.2, Defense Acquisition Management Policies and Procedures, Acquisition Categories I and II). "Substantial reduction" means a reduction of 25 percent or more in the total dollar value of contracts under the program.

(b) Section 1372 of the National Defense Authorization Act for Fiscal Year 1994 is intended to help establish benefit eligibility under the Job Training Partnership Act (29 U.S.C. 1661 and 1662) for employees of DoD contractors and subcontractors adversely affected by termination or substantial reductions in major defense programs.

(c) *Notice to employees and state and local officials.* Within two weeks after the Contracting Officer notifies the Contractor that a major defense program is proposed for, or likely to be, terminated or substantially reduced, the contractor shall provide notice of such proposed or anticipated termination or reduction to—

(1) Each employee representative of the Contractor's employees whose work is directly related to the program; or

(2) If there is no such representative, each such employee;

(3) The State dislocated worker unit or office described in section 311(b)(2) of the Job Training Partnership Act (29 U.S.C. 1661(b)(2)); and

(4) The chief elected official of the unit of general local government within which the adverse effect may occur.

(d) *Notice to subcontractors.* As soon as practicable, but not later than 45 days after the Contractor receives the Contracting Officer's notice of the proposed termination or reduction in a major defense program, the Contractor shall—

(1) Provide notice of the proposed termination or reduction to each first-tier subcontractor with a subcontract of $500,000 or more under the program; and

(2) Require that each such subcontractor—

(i) Provide notice to each of its subcontractor with a subcontract of $100,000 or more under the program; and

(ii) Impose a similar notice and flowdown requirement to subcontractors with subcontracts of $100,000 or more.

(e) The notice provided an employee under paragraph (c) of this clause shall have the same effect as a notice of termination to the employee for the purposes of determining whether such employee is eligible for training, adjustment assistance, and employment services under section 325 or 325A of the Job Training Partnership Act (29 U.S.C. 1662d, 1662d–1). If the Contractor has specified that the proposed program termination or reduction is not likely to result in plant closure or mass layoff, as defined in 29 U.S.C. 2101, the employee shall be eligible only for services under section 314(b) and paragraphs (1) through (14), (16), and (18) of section 314(c) of the Job Training Partnership Act (29 U.S.C. 1661c(b) and paragraphs (1) through (14), (16), and (18) of section 1661c(c)).

(f) If the Contracting Officer subsequently withdraws a notice referred to in paragraphs (c) and (d) of this clause, the Contractor, as soon as practicable but not later than two weeks after receipt of the withdrawal notice, shall provide notice of the withdrawal to—

(1) The representatives, employees, officers, officials, and subcontractors specified in paragraphs (c) and (d) of this clause; and

(2) Each grantee under section 325(a) or 325A(a) of the Job Training Partnership Act (29 U.S.C. 1662d, 1662d–1), which provides training, adjustment assistance, and employment services to the employees.

(g) An employee who receives notice of withdrawal shall not be eligible for training, adjustment assistance, or employment services under section 325 or 325A of the Job Training Partnership Act (29 U.S.C. 1662d, 1662d–1), beginning on the date the employee receives such notice.

(End of clause)

PART 253—FORMS

§ 253.204–70 [Amended]

111. Section 253.204–70 is amended by revising in paragraph (b)(12)(iii)(B) the words "Strategic Defense Initiative (SDI)" to read "Ballistic Missile Defense Organization."

§ 253.215–70 [Amended]

112. At the end of section 253.215–70, section 253.303–346 is removed from the DFARS Form List.

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* Use a term suitable for the type of contract.

** In cost reimbursement type contracts, replace this sentence with the following: "Change orders issued under the Changes clause of this contract are not an authorization to exceed the estimated cost in the schedule unless there is a statement in the change order, or other contract modification, increasing the estimated cost."

*** Insert a percentage of the contract price or a dollar amount.

§ 253.215–70 [Amended]

113. At the end of section 253.215–70, section 253.303–347 is removed from the DFARS Form List.

Appendix B to Chapter 2 [Amended]

114. DFARS Appendix B to Chapter 2 Part 4—DEFENSE LOGISTICS AGENCY ASSIGNMENTS is amended by adding the designation "P9" to the Defense Logistics Agency Federal Supply Class Code numbers "3611, 3620, 3635, 3650, 3660, 3680, 3685, 3693, 3694"; and by adding footnote "9" reading as follows:

Appendix B—Coordinated Acquisition Assignments

* * * * *

PART 4—DEFENSE LOGISTICS AGENCY ASSIGNMENTS

* * * * *

Footnotes: * * *

This partial assignment applies only to secondary items not otherwise assigned, as listed in the applicable Federal Supply Catalog Management Data lists of each respective service.

Appendix F to Chapter 2 [Amended]

115. Appendix F to chapter 2 is amended in Part 3, Preparation of the DD Form 250 and DD Form 250c, paragraph F–302, Mode/method shipment codes, under the heading DESCRIPTION, by revising the Air Force entry "Military Airlift Command (Channel and Special Assignment Airlift Mission)" to read "Air Mobility Command (Channel and Special Assignment Airlift Mission)", and in Part 4, Distribution of DD Form 250 and DD Form 250c, paragraph F–401, Distribution, Table 2 of *Material Inspection and Receiving Report*, the Air Force entry is revised to read as follows:

PART 4—DISTRIBUTION OF DD FORM 250 AND DD FORM 250c

F–401 Distribution

* * * * *

Material Inspection and Receiving Report

* * * * *

TABLE 2.—SPECIAL DISTRIBUTION

As required	Address	No. of copies
. . . .	. . .	.
Air Force. On shipments of new production of aircraft and missiles, class 1410 missiles, 1510 aircraft (fixed wing, all types), 1520 aircraft (rotary wing), 1540 gliders, 1550 target drones.	HQ Air Force Materiel Command AFMC/LGM–AVDO, 4375 Chidlaw Road, Suite 6, Wright-Patterson AFB, OH 45433–5001.	1
. . . .	. . .	.

116. Appendix G to chapter 2 is revised to read as follows:

Appendix G to Chapter II—Activity Address Numbers

Table of Contents

Part 1—General.
G–100 Scope
G–101 Assignment and use of a number
G–102 Activity address number data base maintenance
Part 2—Army Activity Address Numbers.
Part 3—Navy Activity Address Numbers.
Part 4—Marine Corps Activity Address Numbers.
Part 5—Air Force Activity Address Numbers.
Part 6—Defense Logistics Agency Activity Address Numbers.
Part 7—Defense Information Systems Agency Activity Address Numbers.
Part 8—Defense Mapping Agency Activity Address Numbers.
Part 9—Defense Nuclear Agency Activity Address Numbers.
Part 10—Miscellaneous Defense Activities Activity Address Numbers.
Part 11—On-Site Inspection Agency Activity Address Numbers.
Part 12—Ballistic Missile Defense Organization Activity Address Numbers.
Part 13—Defense Commissary Agency Activity Address Numbers.

PART 1—GENERAL

G–100 Scope.

This appendix identifies the activity address numbers to be used with the uniform procurement instrument identification numbering system prescribed in DFARS subpart 204.70.

G–101 Assignment and use of a number.

(a) Activities coding solicitations, contracts and related instruments shall use only those codes assigned by their respective department/agency activity address monitor(s).

(b) The six-character code is used in the first six positions of the procurement instrument identification number (PIIN). When required, activities also will be assigned a two position code. The two position code is used in the first two positions of the call/order serial number.

(c) Activity address monitors are—

Army
U.S. Army Contracting Support Agency, Attn: Contract Support Office (SFRD–KS), 5109 Leesburg Pike, Suite 916, Falls Church, VA 22041–3201

Navy
* Navy Accounting and Finance Center (NAFC–5511), Washington, DC 20376–5001

Air Force
SAF/AQCO, 1060 Air Force Pentagon, Washington, DC 20330–1060

Defense Logistics Agency
Defense Logistics Agency, Contracting Systems Support Office (DLA–PS), Cameron Station, Alexandria, VA 22304–6100

Marine Corps
* Headquarters, U.S. Marine Corps, (Code LBP), Washington, DC 20380–0001

** Defense Mapping Agency
Director of Acquisition, Defense Mapping Agency, Washington, DC 20305–3000

** Defense Nuclear Agency
Chief, Contract Division, Defense Nuclear Agency, Washington, DC 20305–1000

** Defense Information Systems Agency
Chief, Logistics Management Office, Code 202, Defense Information Systems Agency, Washington, DC 20305–2000

* The Navy and Marine Corps Activity Address Monitor for assignment of two-character call/order serial number is: Office of the Assistant Secretary of the Navy (RD&A), Room 536, Crystal Plaza 5, Washington, DC 20350–1000

** Agency activity address monitors forward requests for Appendix G maintenance to the U.S. Army Contracting Support Agency (SFRD–KS).

G-102 Activity address number data base maintenance.

(a) The Defense Logistics Agency, DLA-PS, Cameron Station, Alexandria, VA 22304-6100 is the executive agent for maintenance of six and two character code assignments. The executive agency distributes blocks of two character codes to department/agency activity address monitors for further assignment.

(b) Contracting activities submit requests for assignment of or changes in either the six character or two character codes to their activity address monitor in accordance with department/agency procedures. Activity address monitors—

(1) Approve request for additions, deletions, or changes;

(2) Notify the executive editor, Defense Acquisition Regulations System, OUSD(A&T)DP(DAR), Washington, DC 20301-3000; and

(3) Provide a copy of the notification to the executive agent.

(c) A copy of the Appendix G data base is available on tape or MS-DOS compatible floppy diskettes from the executive agent.

PART 2—ARMY ACTIVITY ADDRESS NUMBERS

DAAA03—B1
Pine Bluff Arsenal, ATTN: SMCPB-PO, 10020 Kabrich Circle, Pine Bluff, AR 71602-9500

DAAA05—B2
Rocky Mountain Arsenal, Directorate of Contracting, ATTN: AMXRM-DOC, Commerce City, CO 80022-2180

DAAA08—B7
Rock Island Arsenal, ATTN: SMCRI-CT, Rock Island, IL 61299-5000

DAAA09—BA
U.S. Army Armament, Munitions and Chemical Command, ATTN: AMSMC-ABR-TX, Rock Island, IL 61299-6000

DAAA15—ZU
U.S. Army Chemical, and Biological Defense Agency, ATTN: AMSCB-PCS-S (Procurement Directorate), Aberdeen Proving Ground, MD 21010-5423

DAAA21—2T
U.S. Army Armament Research, Development & Engineering Center, ATTN: SMCAR-PCM-O, Building 9, Picatinny Arsenal, NJ 07806-5000

DAAA22—BV
Watervliet Arsenal, ATTN: SMCWV-PPA, Watervliet, NY 12189-4050

DAAA31—GJ
McAlester Army Ammunition Plant, ATTN: SMCMC-PC, McAlester, OK 74501-5000

DAAA32—OP
Crane Army Ammunition Activity, ATTN: SMCCN-CT, 300 Highway 361, Crane, IN 47522-5099

DAAB07—BG
USA Communications-Electronics Command, C3I Acquisition Center, ATTN: AMSEL-ACSP-BM, Fort Monmouth, NJ 07703-5008

DAAB08—2V
USA Communications-Electronics Command, C3I Acquisition Center, ATTN: AMSEL-ACSB-C (Facility ADP Branch), Fort Monmouth, NJ 07703-5008

DAAB10—ZP
USA CECOM C3I Acquisition Center, Vint Hill Farms Station, ATTN: AMSEL-ACVF-A-AA (Stop 42), Building 160, Warrenton, VA 22186-5172

DAAB11—D0
USA CECOM C3I Acquisition Center, Vint Hill Farms Station, ATTN: AMSEL-AC-VHA-HB Base OPS (Stop 42), Warrenton, VA 22186-5172

DAAC01—BH
Anniston Army Depot, ATTN: SDSAN-DOC, Anniston, AL 36201-5003

DAAC02—ZT
Blue Grass Army Depot, Procurement Office, ATTN: SDS-BG-BM-P, Lexington, KY 40511-5001

DAAC07-ZM
Sierra Army Depot, ATTN: SDSSI-CONT, Herlong, CA 96113-5009

DAAC67—ZN
Letterkenny Army Depot, ATTN: SDSLE-P, Chambersburg, PA 17201-4152

DAAC71—ZS
Tobyhanna Army Depot, ATTN: SDSTO-K, Tobyhanna, PA 18466-5100

DAAC79—D7
Red River Army Depot, ATTN: SDSRR-P, Texarkana, TX 75507-5000

DAAC83—BJ
Corpus Christi Army Depot, ATTN: SDSCC-C, Corpus Christi, TX 78419-6170

DAAC89—BK
Tooele Army Depot, ATTN: SDSTE-DCBO, Tooele, UT 84074-0839

DAAD01—B5
USA Yuma Proving Ground, Directorate of Contracting, ATTN: ATEYP-CR, Yuma, AZ 85365-9106

DAAD03—B6
USA Jefferson Proving Ground, ATTN: STEJP-EH-C, Madison, IN 47250-5100

DAAD05—BM
USA Aberdeen Proving Ground Support Activity, ATTN: STEAP-PR/M (Building 314), Aberdeen Proving Ground, MD 21005-5001

DAAD07—BN
USA White Sands Missile Range, Directorate of Contracting, ATTN: STEWS-PR, White Sands, NM 88002-5201

DAAD09—BP
USA Dugway Proving Ground, Directorate of Contracting, ATTN: STEDP-DOC, Dugway, UT 84022-0538

DAAE07—BR
USA Tank-Automotive Command, ATTN: AMSTRA-IDXR, Warren, MI 48397-5000

DAAE20
Armament and Chemical Acquisition and Logistics Activity (ACALA), ATTN: Acquisition Center Rock Island, IL 61299

DAAE30
Armament RD&E Center (ARDEC), ATTN: Procurement and Production Directorate, Picatinny Arsenal, NJ 07806-5000

DAAG60—G8
USA Military Academy, Purchasing & Contracting Division, ATTN: MAPC, Building 667A, West Point, NY 10996-1594

DAAG99—ZY
USA Program Manager-SANG, ATTN: AMCPM-NGA, Unit 61304, APO AE 09803-1304

DAAH01—CC
USA Missile Command, ATTN: AMSMI-AC, Redstone Arsenal, AL 35898-5280

DAAH03—D8
USA Missile Command, ATTN: AMSMI-AC, Redstone Arsenal, AL 35898-5280

DAAH04—YU
U.S. Army Research Office, P.O. Box 12211, ATTN: AMXRO-PR, Research Triangle Park, NC 27709-2211

DAAJ02—D9
Aviation Applied Technology Directorate, ATTN: AMSAT-R-TC, Building 401, Fort Eustis, VA 23604-5577

DAAJ04—0V
USA Charles Melvin Price Support Center, ATTN: SATAS-P, Granite City, IL 62040-1801

DAAJ05—ZF
USA Aviation and Troop Command, ATTN: IAS21WG, Building 404, Fort Eustis, VA 23604-5577

DAAJ09—BS
USA Aviation and Troop Command, ATTN: AMSAT-A-AD, 4300 Goodfellow Boulevard, St. Louis, MO 63120-1798

DAAK01—BB
USA Aviation and Troop Command, ATTN: AMSAT-A-AD, 4300 Goodfellow Boulevard, St. Louis, MO 63120-1798

DAAK60—C5
USA Natick Research, Development and Engineering Center, Directorate of Procurement, ATTN: SATNC-PP (Procurement Support Division), Natick, MA 01760-5011

DAAK70—E1
USA Belvoir Research, Development and Engineering Center, ATTN: SATBE-PMA (Policy & Compliance), Fort Belvoir, VA 22060-5606

DAAL01—1Y
U.S. Army Research Laboratory, ATTN: AMSLC-PR, 2800 Powder Mill Road, Adelphi, MD 20783-1145

DAAM01—ZU
U.S. Army Chemical and Biological Defense Command, ATTN: AMSCB-PC, Procurement Directorate, Aberdeen Proving Ground, MD 21010-5423

DAAM02—B2
Program Manager, Rocky Mountain Arsenal, ATTN: AMXRM-PM, Commerce City, CO 80022-2180

DABT01—F6
U.S. Army Aviation Center, Contracting Office, ATTN: ATZQ-C, Building T-00116, Fort Rucker, AL 36362-5000

DABT02—2A
U.S. Army Chemical and Military Police Centers and Fort McClellan, ATTN: ATZN-DOC, Building 241-C, Transportation Road, Fort McClellan, AL 36205-5000

DABT10—2B
U.S. Army Infantry Center and Fort Benning, ATTN: ATZB-KT, Building 6,

P.O. Box 5–5179, Fort Benning, GA 31905–5179
DABT11—2C
U.S. Army Signal Center and Fort Gordon, ATTN: ATZI–CT, Building 2050B, Fort Gordon, GA 30905–5110
DABT15—F9
U.S. Army Soldier Support Center and Fort Benjamin Harrison, ATTN: ATZI–CT, Fort Benjamin Harrison, IN 46216–5230
DABT19—2D
U.S. Army Combined Arms Center and Fort Leavenworth, ATTN: ATZL–GCC, Pope & Thomas Avenues, Fort Leavenworth, KS 66027–5031
DABT23—2E
U.S. Army Armor Center and Fort Knox, ATTN: ATZK–DC, Building 4022, Fort Knox, KY 40121–5000
DABT31—2F
U.S. Army Engineer Center and Fort Leonard Wood, ATTN: ATZT–DOC, Fort Leonard Wood, MO 65473–5000
DABT39—2H
U.S. Army Field Artillery Center and Fort Sill, ATTN: ATZR–Q, Building 1803, P.O. Box 3501, Fort Sill, OK 73503–0501
DABT43—2J
Carlisle Barracks, ATTN: ATZE–DOC–C, Building 46, Carlisle Barracks, PA 17013–5002
DABT47—2K
U.S. Army Training Center and Fort Jackson, ATTN: ATZJ–DOC, Building 4340, Magruder Street, Fort Jackson, SC 29207–5420
DABT51—2L
U.S. Army Air Defense Artillery Center & Fort Bliss, ATTN: ATZC–DOC, Building 2021, P.O. Box 6078, Fort Bliss, TX 79916–0058
DABT57—2N
Directorate of Peninsula Contracting, ATTN: ATZF–DPC, Building 2746, Harrison Loop, Fort Eustis, VA 23604–5293
DABT58—2P
Fort Monroe, ATTN: ATZG–C# 62, Building T–195, Fort Monroe, VA 23651–6000
DABT59—2Q
U.S. Army Combined Arms Support Command and Fort Lee, ATTN: ATZM–DC, Building T–7124, 19th & Quartermaster Road, Fort Lee, VA 23801–5172
DABT60—1L
TRADOC Contracting Agency, ATTN: ATCA, Building 1748, Fort Eustis, VA 23604–5538
DABT61—BF
The Judge Advocate General's School, USA, University of Virginia, ATTN: JAGS–SSL–B, 600 Massie Road, Charlottesville, VA 22903–1781
DABT63—BL
U.S. Army Information Systems Command, ATTN: ATZS–DKS, Fort Huachuca, AZ 85613–5000
DABT64—YV
Chief, Purchasing and Contracting Office, ATTN: ATZR–ZQ, Building 1390, Fort Chaffee, AR 72905–5000
DABT65—BO
Mission Contracting Activity at Fort Leavenworth, ATTN: ATOB–AL, 614 Custer Road, Fort Leavenworth, KS 66027–7203
DACA01, DACW01—CK
USA Engineer District, Mobile, ATTN: CESAM–CT, P.O. Box 2288, Mobile, AL 36628–0001
DACA03, DACW03—CL
USA Engineer District, Little Rock, ATTN: CESWL–CT, P.O. Box 867, Little Rock, AR 72203–0867
DACA05, DACW05—CM
USA Engineer District, Sacramento, ATTN: CESPK–CT, 1325 J Street, Sacramento, CA 95814–2922
DACA07, DACW07—CP
USA Engineer District, San Francisco, ATTN: CESPN–CT, 211 Main Street, San Francisco, CA 94105–1905
DACA09, DACW09—CQ
USA Engineer District, Los Angeles, ATTN: CESPL–CT, P.O. Box 2711, Los Angeles, CA 90053–2325
DACA10, DACW10—CN
Engineer Procurement Activity for Information Resources, ATTN: CEEP, Kingman Building #1A09, Fort Belvoir, VA 22060–5582
DACA17, DACW17—CS
USA Engineer District, Jacksonville, ATTN: CESAJ–CT, P.O. Box 4970, Jacksonville, FL 32232–0019
DACA21, DACW21—CV
USA Engineer District, Savannah, ATTN: CESAS–CT, P.O. Box 889, Savannah, GA 31402–0889
DACA23, DACW23—CX
USA Engineer District, Chicago, ATTN: CENCR–CT, 111 North Canal Street, Chicago, IL 60606–7206
DACA25, DACW25—CD
USA Engineer District, Rock Island, Clock Tower Building, ATTN: CENCR–CT, P.O. Box 2004, Rock Island, IL 61202–2004
DACA27, DACW27—CY
USA Engineer District, Louisville, ATTN: CEORL–CT, P.O. Box 59, Louisville, KY 40201–0059
DACA29, DACW29—CZ
USA Engineer District, New Orleans, ATTN: CELMN–CT, P.O. Box 60267, New Orleans, LA 70160–0267
DACA31, DACW31—DA
USA Engineer District, Baltimore Contracting Division, P.O. Box 1715, Baltimore, MD 21203–1715
DACA33, DACW33—DB
USA Engineer District, New England, ATTN: CENED–CT, 424 Trapelo Road, Waltham, MA 02254–9149
DACA35, DACW35—DC
USA Engineer District, Detroit, ATTN: CENCE–CT, P.O. Box 1027, Detroit, MI 48231–1027
DACA37, DACW37—DD
USA Engineer District, St. Paul, ATTN: CENCS–CT, 180 Kellogg Boulevard East, Room 1421, St. Paul, MN 55101–1479
DACA38, DACW38—DE
USA Engineer District, Vicksburg, ATTN: CELMK–CT, 3515 I–20 Frontage Road, Vicksburg, MS 39180–5191
DACA39, DACW39—DF
USA Engineer, Waterways Experiment Station, ATTN: CEWES–CT–Z (Contracting Division), 3909 Halls Ferry Road, Vicksburg, MS 39180–6199
DACA41, DACW41—DH
USA Engineer District, Kansas City, 700 Federal Building, ATTN: CEMRK–CT, 601 East 12th Street, Kansas City, MO 64106–2896
DACA43, DACW43—DJ
USA Engineer District, St. Louis, ATTN: CELMS–CT, 1222 Spruce Street, St. Louis, MO 63101–2833
DACA45, DACW45—DK
USA Engineer District, Omaha, ATTN: CEMRO–CT, 215 North 17th Street, Omaha, NE 68102–4978
DACA47, DACW47—DM
USA Engineer District, Albuquerque, ATTN: CESWA–CT, P.O. Box 1580, Albuquerque, NM 87103–1580
DACA49, DACW49—DN
USA Engineer District, Buffalo, ATTN: CENCB–CT (Contracting Division), 1776 Niagara Street, Buffalo, NY 14207–3199
DACA51, DACW51—CE
USA Engineering District, New York, Contracting Division, ATTN: CENAN–CT, 26 Federal Plaza, New York, NY 10028–0090
DACA54, DACW54—DQ
USA Engineer District, Wilmington, ATTN: CESAW–CT, P.O. Box 1890, Wilmington, NC 28402–1890
DACA55, DACW55—DR
USA Engineer Division, Ohio River, ATTN: CEORD–CT, P.O. Box 1159, Cincinnati, OH 45201–1159
DACA56, DACW56—DS
USA Engineer District, Tulsa, ATTN: CESWT–CT, P.O. Box 61, Tulsa, OK 74121–0061
DACA57, DACW57—DT
USA Engineer District, Portland, ATTN: CENPP–CT, P.O. Box 2946, Portland, OR 97208–2946
DACA59, DACW59—DV
USA Engineer District, Pittsburgh, ATTN: CEORP–CT–SADBUS, 1000 Liberty Avenue, Pittsburgh, PA 15222–4186
DACA60, DACW60—DW
USA Engineer District, Charleston, ATTN: CESAJ–CT, P.O. Box 919, Charleston, SC 29402–0919
DACA61, DACW61—CF
USA Engineer District, Philadelphia, ATTN: CENAP–CT, Contracting Division, 110 Penn Square East, Wanamaker Building, Philadelphia, PA 19107–3390
DACA62, DACW62—DX
USA Engineer District, Nashville, ATTN: CEORN–CT, P.O. Box 1070, Nashville, TN 37202–1070
DACA63, DACW63—DY
USA Engineer District, Fort Worth, ATTN: CESWF–CT, P.O. Box 17300, Fort Worth, TX 76102–0300
DACA64, DACW64—DZ
USA Engineer District, Galveston, ATTN: CESWG–CT, P.O. Box 1229, Galveston, TX 77553
DACA65, DACW65—EA
USA Engineer District, Norfolk, Contracting Division, ATTN: CENAO–CT, 803 Front Street, Norfolk, VA 23510–1096
DACA66, DACW66—EB
USA Engineer District, Memphis, ATTN: CEIMM–CT, B–202 Clifford Davis

Federal Building, Memphis, TN 38103–1894

DACA67, DACW67—EC
USA Engineer District, Seattle, ATTN: CENPS–CT, P.O. Box C–3755, Seattle, WA 98124–2255

DACA68, DACW68—YW
USA Engineer District, Walla Walla, ATTN: CENPW–CT, Building 602, City-County Airport, Walla Walla, WA 99362–9265

DACA69, DACW69—CG
USA Engineer District, Huntington, ATTN: CEORH–CT, 502 8th Street, Huntington, WV 25701–2070

DACA72, DACW72—ZA
USA Humphreys Engineer Center, Support Activity, ATTN: CEHEC–CT, Kingman Building, Fort Belvoir, VA 22060–5580

DACA75, DACW75—ZC
USA Engineer Ordnance Program Division, ATTN: CETAD–OP–C, APO AE 09803–1303

DACA76, DACW76—ZD
USA Engineer Topographic Laboratories, ATTN: CETEC–CT, Cude Building #2592, Fort Belvoir, VA 22060–5546

DACA78, DACW78—9V
USA Engineer Transatlantic Division, ATTN: CETAD–CT–P, P.O. Box 2250, Winchester, VA 22604–1450

DACA79, DACW79—2R
USA Engineer District Japan, ATTN: CEPOJ–CT, Unit 45010, APO AP 96343–0061

DACA81, DACW81
USA Engineer District, Far East, APO AP 96205–0610

DACA83, DACW83—ZH
USA Engineer Division—Pacific Ocean, ATTN: CEPOD–CT, Building 230, Fort Shafter, HI 96858–5540

DACA85, DACW85—ZJ
USA Engineer District, Alaska, P.O. Box 898, Anchorage, AK 99506–0898

DACA86, DACW86
USA Engineer District, Riyadh, Resident Office, P.O. Box 390, Unit 61303, APO AE 09803–1303

DACA87, DACW87—ZW
USA Engineer Division, Huntsville, ATTN: CEHND–CT, P.O. Box 1600, Huntsville, AL 35807–4301

DACA88, DACW88—0S
USA Construction Engineering Research Laboratory, ATTN: CECER–CT, P.O. Box 4005, Champaign, IL 61820–1305

DACA89, DACW89—1Z
USA Cold Regions Research and Engineering Laboratory, ATTN: CECRL–LM–CT, 72 Lyme Road, Hanover, NH 03755–1290

DACA90, DACW90
USA Engineer District, Europe, ATTN: CETAE–CT, Unit 25727, APO AE 09242–5301

DACA91, DACW91
Engineer Procurement Activity for Information Resources, ATTN: CEEP, Kingman Building #1A09, Fort Belvoir, VA 22060–5582

DADA03—8W
Fitzsimons Army Medical Center, Directorate of Contracting, ATTN: HSHG–DC, Building 205, 10th Street & McCloskey Avenue, Aurora, CO 80045–5001

DADA08—BT
Dwight David Eisenhower Medical Center, Contracting Office, ATTN: HSAA–D, Building 39706, 40 A Street, Fort Gordon, GA 30905–5650

DADA09—YY
William Beaumont Army Medical Center, ATTN: HSAA–W, Building 7777, Piedras Street, room 4J18, El Paso, TX 79920–5001

DADA10—ZQ
U.S. Army Health Services Command, Central Contracting Office, ATTN: HSAA–C, Building 2015, Beebe Loop, Fort Sam Houston, TX 78234–6000

DADA13—0W
Madigan Army Medical Center, Contracting Office, ATTN: HSAA–M, Building 9933–A, Johnson Street, Tacoma, WA 98431–5100

DADA15—0X
Walter Reed Army Medical Center, Directorate of Contracting, ATTN: HSHL–ZC, Building T–20, 1st Floor, Washington, DC 20307–5001

DADA16—0Y
Tripler Army Medical Center, Contracting Office, ATTN: HSAA–T, Building 160, Krukowski Street, Tripler AMC, HI 96859–5000

DAEA08—E4
U.S. Army Information Systems Command, Office of Acquisition, ATTN: ASPC–RA, Building 134, Malbrouk Street, Fort Ritchie, MD 21719–5010

DAEA16—E7
Headquarters, 5th Signal Command, DCSLOG, Contract Management Division, ATTN: ASQE–LG–C, CMR 421, APO AE 09056–3104

DAEA20—E8
Commander, 1st Signal Brigade (USAISC), Office of Acquisition Management, ATTN: ASQK–AM, Unit #15271, APO AP 96205–0044

DAEA30—E0
Television Audio Support Activity, Directorate of Contracting, ATTN: ASQB–RTV–C, 8350 Fruitridge Road, Sacramento, CA 95813–5045

DAEA32—Y6
U.S. Army Information Systems Command, Contracting Office (USAISCCO), ATTN: ASPC–T, Building 61801, room 2408, Fort Huachuca, AZ 85613–5000

DAHA01—9B
USPFO for Alabama, P.O. Box 3715, Montgomery, AL 36193–4801

DAHA02—0G
USPFO for Arizona, 5636 E. McDowell Road, Phoenix, AZ 85008–3495

DAHA03—9D
USPFO for Arkansas, Camp Robinson, North Little Rock, AR 72118–2200

DAHA04—9N
USPFO for California, P.O. Box 8104, San Luis Obispo, CA 93403–8104

DAHA05—Z0
USPFO for Colorado, Camp George West, Golden, CO 80401–3997

DAHA06—1S
USPFO for Connecticut, State Armory, ATTN: Contracting Officer, 360 Broad Street, Hartford, CT 06105–3795

DAHA07—9A
USPFO for Delaware, Grier Building, 1161 River Road, New Castle, DE 19720–5199

DAHA08—2W
USPFO for Florida, P.O. Box 1008, St. Augustine, FL 32085–1008

DAHA09—C0
USPFO for Georgia, P.O. Box 17882, Atlanta, GA 30316–0882

DAHA10—CU
USPFO for Idaho, P.O. Box 45, Boise, ID 83707–4501

DAHA11—9E
USPFO for Illinois, 1301 North McArthur Boulevard, Springfield, IL 62702–2399

DAHA12—4E
USPFO for Indiana, P.O. Box 41346, Indianapolis, IN 46241–0346

DAHA13—9L
USPFO for Iowa, Camp Dodge, 7700 NW Beaver Drive, Johnston, IA 50131–1902

DAHA14—4Z
USPFO for Kansas, P.O. Box 2099, Topeka, KS 66601–2099

DAHA15—6P
USPFO for Kentucky, Boone National Guard Center, Frankfort, KY 40601–6192

DAHA16—0A
USPFO for Louisiana, Jackson Barracks, New Orleans, LA 70146–0330

DAHA17—0B
USPFO for Maine, Camp Keys, Augusta, ME 04333–0032

DAHA18—0C
USPFO for Maryland, State Mil Reservation, 301 Old Bay Lane, Havre de Grace, MD 21078–4094

DAHA19—0D
USPFO for Massachusetts, ATTN: Contracting Officer, 143 Speen Street, Natick, MA 01760–2599

DAHA20—9F
USPFO for Michigan, 3111 West St. Joseph Street, Lansing, MI 48913–5102

DAHA21—9K
USPFO for Minnesota, Camp Ripley, P.O. Box 288, Little Falls, MN 56345–0288

DAHA22—CW
USPFO for Mississippi, 144 Military Drive, Jackson, MS 39208–8880

DAHA23—9H
USPFO for Missouri, 1715 Industrial Avenue, Jefferson City, MO 65101–1468

DAHA24—9P
USPFO for Montana, P.O. Box 1157, Helena, MT 59624–1157

DAHA25
USPFO for Nebraska, 1234 Military Road, Lincoln, NE 68508–1092

DAHA26
USPFO for Nevada, 2601 South Carson Street, Carson City, NV 89701–5596

DAHA27
USPFO for New Hampshire, P.O. Box 2003, Concord, NH 03301–2003

DAHA28—ZK
USPFO for New Jersey, 131 Eggert Crossing Road, Lawrenceville, NJ 08648–2805

DAHA29
USPFO for New Mexico, ATTN: Contracting Officer, P.O. Box 4277, Santa Fe, NM 87502–4277

DAHA30—D2
USPFO for New York, 330 Old Niskayuna Road, Latham, NY 12110–2224

DAHA31—D3

USPFO for North Carolina, 4201 Reedy Creek Road, Raleigh, NC 27607–6412
DAHA32—D6
USPFO for North Dakota, P.O. Box 5511, Bismarck, ND 58502–5511
DAHA33—9M
USPFO for Ohio, 2811 West Granville Road, Columbus, OH 43235–2712
DAHA34—9J
USPFO for Oklahoma, 3501 Military Circle, N.E., Oklahoma City, OK 73111–4398
DAHA35—1X
USPFO for Oregon, ATTN: USPFO–P, P.O. Box 14840, Salem, OR 97309–5008
DAHA36—DL
USPFO for Pennsylvania, Department of Military Affairs, ATTN: Contracting Officer, Annville, PA 17003–5003
DAHA37
USPFO for Rhode Island, 330 Camp Street, Providence, RI 02906–1954
DAHA38—DU
USPFO for South Carolina, 9 National Guard Road, Columbia, SC 29201–4766
DAHA39—VQ
USPFO for South Dakota, Camp Rapid, Rapid City, SD 57702–8186
DAHA40—YX
USPFO for Tennessee, Powell Avenue, P.O. Box 40748, Nashville, TN 37204–0748
DAHA41—9C
USPFO for Texas, ATTN: Contracting Officer, P.O. Box 5218, Austin, TX 78563–5218
DAHA42
USPFO for Utah, P.O. Box 2000, Draper, UT 84020–2000
DAHA43
USPFO for Vermont, Camp Johnson, Building #3, P.O. Box 2000, Colchester, VT 05446–3004
DAHA44—ZR
USPFO for Virginia, 501 East Franklin Street, Richmond, VA 23219–2317
DAHA45—ZX
USPFO for Washington, Camp Murray, Tacoma, WA 98430–5000
DAHA46
USPFO for West Virginia, 50 Armory Road, Buckhannon, WV 26201–2396
DAHA47—9G
USPFO for Wisconsin, Camp Douglas, WI 54618–9002
DAHA48
USPFO for Wyoming, P.O. Box 1709, Cheyenne, WY 82003–1709
DAHA49
USPFO for the District of Columbia, Anacostia Naval Air Station, Building 350, Washington, DC 20315–0001
DAHA50
USPFO for Hawaii, 3949 Diamond Head Road, Honolulu, HI 96816–4495
DAHA51—2Z
USPFO for Alaska, ATTN: P&C Division, Camp Denali, P.O. Box B, Fort Richardson, AK 99505–5000
DAHA70
USPFO for Puerto Rico, P.O. Box 3786, San Juan, PR 00904–3786
DAHA72
USPFO for Virgin Islands, #9 Estate Diamond, Frederiksted, St. Croix, VI 00840
DAHA74
USPFO for Guam, PSC456 Box 56, FPO AP 96539–1256
DAHA90—2Y
National Guard Bureau, Contracting Support, 5109 Leesburg Pike, suite 401–B, Falls Church, VA 22041–3201
DAHC21—G3
MTMC Eastern Area, Acquisition Division, ATTN: MTEA–LOA, Building 427, Military Ocean Terminal, Bayonne, NJ 07002–5302
DAHC22—DP
HQ MTMC, Acquisition Division, ATTN: MTAQ–AT, room B24–L, 5611 Columbia Pike, Falls Church, VA 22041–5050
DAHC23—G4
MTMC, Western Area, Oakland Army Base, ATTN: MTWA–LOA, Building 1, Alaska Street, room 2336, Oakland, CA 94626–5000
DAHC24—1B
HQ MTMC Acquisition Division, ATTN: MTAQ–AS, room 725, 5611 Columbia Pike, Falls Church, VA 22041–5050
DAHC25—1W
HQ MTMC, Directorate of Personal Property, ATTN: MTPP, 5611 Columbia Pike, Falls Church, VA 22041–5050
DAHC26—0E
HQ MTMC, Program Support Division, ATTN: MTAQ–AF, Stop 898, Fort Belvoir, VA 22060–5898
DAHC30—0F
U.S. Army Military District of Washington, Directorate of Contracting, ATTN: ANOC–Z, Building 15, Cameron Station, Alexandria, Va 22304–5050
DAHC32—0M
National Defense University, Contracting Office, ATTN: NDU–LG–P, Building 62, Fort Leslie J. McNair, Washington, DC 20319
DAHC35—2M
Fort Belvoir Directorate of Contracting, ATTN: ANFB–OC, 9410 Jackson Loop, Suite 101, Fort Belvoir, VA 22060–5075
DAHC36—1J
Fort Meade Directorate of Contracting, Fort George G. Meade, MD 20755–5081
DAHC38—2S
Fort Ritchie Directorate of Contracting, Fort Ritchie, MD 21719
DAHC75—0U
U.S. Army, Pacific, Office of the ACSAM, ATTN: APAM, Building T115, Palm Circle Drive, Fort Shafter, HI 96858–5100
DAHC76—8U
U.S. Army Garrison, Alaska, Directorate of Contracting, ATTN: APVR–DOC, P.O. Box 5–525, Fort Richardson, AK 99505–0525
DAHC77—CJ
U.S. Army Support Command, Hawaii, Directorate of Contracting, ATTN: APVG–GK, Building 520, Pierce Street, Fort Shafter, HI 96858–5025
DAHC90—YJ
U.S. Army Intelligence and Security Command, ATTN: IAPARC, Building 2444 (Stop 370), Fort Belvoir, VA 22060–5368
DAHC92—1V
USAG SOCO–CO–S, Directorate of Contracting, Unit 7116, APO AA 34002–5000
DAHC94—BD
U.S. Army Info Sys Sel & Acq Activity, ATTN: ISSA–PP, 2461 Eisenhower Avenue, Alexandria, VA 22331–0700
DAJA01—9Q
RCO Vicenza, ATTN: AEUCC–I, Unit 31401, Box 33, APO AE 09630
DAJA02—G5
RCO Seckenheim, ATTN: AEUCC–S, Unit 29331, APO AE 09266
DAJA04—9R
RCO Fuerth, ATTN: AEUCC–FU, Unit 28130, APO AE 09222
DAJA06—9S
RCO Stuttgart, Suboffice of Seckenheim, ATTN: AEUCC–ST, Unit 30616, APO AE 09154
DAJA10—9U
RCO Augsburg, ATTN: AEUCC–A, Unit 25047, APO AE 09178
DAJA16—8X
RCO Grafenwoehr, ATTN: AEUCC–G, Unit 28130, APO AE 09114
DAJA23—9W
RCO Berlin, ATTN: AEUCC–BN, Unit 26704, Box 360, APO AE 09235
DAJA37—G6
USAREUR Contracting Center, ATTN: AEUCC–C, Unit 25602, Box 49, APO AE 09228
DAJA61—9Z
RCO Benelux, ATTN: AEUCC–B, PSC 79, Box 003, APO AE 09724
DAJA76—8V
RCO Frankfurt, ATTN: AEUCC–F, Unit 25601, Box 73, APO AE 09228
DAJA85—B8
RCO Hanau, ATTN: AEUCC–H, Box 169, APO AE 09165
DAJA89—F0
RCO Wuerzburg, Suboffice of Fuerth, ATTN: AEUCC–W, River Building, 3rd Floor, APO AE 09244
DAJA90—0T
RCO Bad Kreuznach, ATTN: AEUCC–BK, Unit 24307, APO AE 09252
DAJB03—F4
U.S. Army Korea Contracting Command, ATTN: EAKC–CO, APO AP 96205–0062
DAKF01—1A
Directorate of Contracting, ATTN: AFKC–ZM–DOC, Building 103A, Presidio of San Francisco, CA 94129–5000
DAKF03—0Q
Directorate of Contracting, ATTN: AFZW–DOC, P.O. Box 27, Fort Ord, CA 93941–0027
DAKF04—ZE
Directorate of Contracting, ATTN: AFZJ–DC, P.O. Box 10039, Fort Irwin, CA 92310–5000
DAKF06—1C
Directorate of Contracting, ATTN: AFZC–DOC, Building 6222, Fort Carson, CO 80913–5022
DAKF10—1D
Directorate of Contracting, ATTN: AFZP–DC, Building 622, 2nd Floor, Fort Stewart, GA 31314–5189
DAKF11—1E
Directorate of Contracting, ATTN: AFZK–DOC, Building 184, Fort McPherson, GA 30330–5000
DAKF12—BC
FORSCOM Central Contracting Office, ATTN: FCJ4–PRC, Building 130, Fort McPherson, GA 30330–6000
DAKF19—1G

Directorate of Contracting, ATTN: AFZN–DOC, P.O. Box 2248, Fort Riley, KS 66442–0248
DAKF23—1H
Directorate of Contracting, ATTN: AFZB–DOC, Building 2174, Street 13A, Fort Campbell, KY 42223–1100
DAKF24—G1
Directorate of Contracting, ATTN: AFZX–DOC, P.O. Drawer 3918, Fort Polk, LA 71459–5000
DAKF29—2G
Directorate of Contracting, ATTN: AFZI–DOC, Building 5418, South Scott Plaza, Fort Dix, NJ 08640–6150
DAKF31—1K
Directorate of Contracting, ATTN: AFZD–DOC, Building 227, Fort Devens, MA 01433–5340
DAKF36—1M
Directorate of Contracting, ATTN: AFZS–DOC, West Street, building T–45, Fort Drum, NY 13602–5220
DAKF40—1N
Directorate of Contracting, ATTN: AFZA–DC, Drawer 70120, Fort Bragg, NC 28307–0120
DAKF48—1Q
Headquarters, III Corps and Fort Hood, Directorate of Contracting, ATTN: AFZF–DOC, Building 1001 (Room W103), Fort Hood, TX 76544–5059
DAKF49—1R
Directorate of Contracting, ATTN: AFZG–DOC, Building 4201, Fort Sam Houston, TX 78234–5000
DAKF57—1T
Directorate of Contracting, ATTN: AFZH–DOC, Rainer Drive, Building 9504, Fort Lewis, WA 98433–5000
DAKF61—1U
Directorate of Contracting, ATTN: AFZR–DOC, Building 2103, Fort McCoy, WI 54656–5000
DAMD17—B3
U.S. Army Medical Research, Acquisition Activity, ATTN: SGRD–RMA, Building 820, Chandler Street, Frederick, MD 21702–5014
DASA01—G0
Commander, ARCENT HQ SWA, ATTN: DOC, APO AE 09808
DASA02
Commander, ARTAS–K, ATTN: AFRD–KU–KO, APO AE 09889
DASA03
Commander, ARCENT Contracting Division, ATTN: AFRD–PARC, Building 363, Fort McPherson, GA 30330–6000
DASG60—CB
USA Strategic Defense Command, Deputy Commander, ATTN: CSSD–CM–AC, P.O. Box 1500, Huntsville, AL 35807–3801
DASG62—CH
U.S. Army Space Command, ATTN: MOSC–SC, 1670 North Newport Road, Suite 211, Colorado Springs, CO 80916–2749
DASW01—F7
Defense Supply Service—Washington, ATTN: Policy and Compliance, 5200 Army Pentagon, Room 1D245, Washington, DC 20310–5200
DATM01—0R
U.S. Army OPTEC Contracting Activity, ATTN: CSTE–ZOC, P.O. Box Y, Fort Hood, TX 76544–5065

PART 3—NAVY ACTIVITY ADDRESS NUMBERS

* An asterisk indicates a two-digit code of a major command, which is shared with subordinate activities. Such subordinate activities will indicate the Unit Identification Code of the major command in parentheses, e.g. (MAJ00011).

N00011—LB*, LBZ
Chief of Naval Operations, Washington, DC 20350–2000
N00012—HX*, V8*, V8Y
Assistant for Administration, Under Secretary of the Navy, Washington, DC 20350
N00013—MR
Judge Advocate General, Navy Department, 200 Stovall Street, Alexandria, VA 22332
N00014—EE*, EE0–9
Office of Naval Research, Arlington, VA 22217
N00015—L0*, L0Z
Naval Intelligence Command HQ, (Suitland, MD), 4600 Silver Hill Road, Washington, DC 20389
N00018—MC*, MD*, J5*, QA*, MCZ
Bureau of Medicine and Surgery, Washington, DC 20372–5120
N00019—EF*, GU*, EF0–9
Naval Air Systems Command, Washington, DC 20361
N00022—ML*, MQ*, NV*, MLZ
Chief of Naval Personnel, Washington, DC
N00023—4J*, L5*, 4J0–9
Commander, Naval Supply Systems Command, Washington, DC 20376
N00024—EH*, U0*, EH0–9
Naval Sea Systems Command, Washington, DC 20360
N00025—EJ*, FZ*, EJ0–9
Naval Facilities Engineering Command, 200 Stovall Street, Alexandria, VA 22332
N00030—EK*, EK0–9
Strategic Systems Programs, Department of the Navy, Washington, DC 20376–5002
N00033—EL*, EL0–9
Commander, Military Sealift Command, Washington, DC 20390
N00039—NS*, NS0–9
Space and Naval Warfare Systems Command, Washington, DC 20360
N00060—LH*, J0*, NM*, LHZ
Commander-in-Chief, Atlantic Fleet, Norfolk, VA 23511
N00061—NL*, NLZ
Commander-in-Chief, U.S. Naval Forces, Europe, (London, U.K.), FPO AE 09499
N00062—8A*, L9*, R0*, 8A0–9
Chief of Naval Education and Training, Code 013, NAS, Pensacola, FL 32508–5100
N00063—NT*, NTZ
Naval Computer and Telecommunications Command, 4401 Massachusetts Avenue NW., Washington, DC 20394–5290
N00065—S0*, S0Z
Naval Oceanography Command, Stennis Space Center, Bay St. Louis, MS 39529–5000
N00069—8Q*, 8QZ
Naval Security Group HQ, 3801 Nebraska Avenue NW., Washington, DC 20390–0008
N00070—LP*, V5*, 4L*, LPZ
Commander in Chief, Pacific Fleet, NAVBASE, Pearl Harbor, HI 96860–7000
N00072—9T*, LC*, 9TZ
Commander, Naval Reserve Force, Code 17, New Orleans, LA 70146
N00074—QH*, QHZ
Naval Special Warfare Command, NAVPHIBASE Coronado, San Diego, CA 92155
N00101—3R
Naval Air Station, South Weymouth, MA 02190
N00102—EN
Portsmouth Naval Shipyard, Portsmouth, NH 03801
N00104—EP, EQ
Navy Ships Parts Control Center, Mechanicsburg, PA 17055
N00105—JT
Naval Medical Clinic, NAVSHIPYD, Portsmouth, NH 03801
N00109—F1
Naval Weapons Station, Yorktown, VA 23491
N00123—ES
Commanding Officer, Naval Regional Contracting Center, 937 N. Harbor Drive, San Diego, CA 92132–5106
N00124—M5
Naval War College, Newport, RI 02840
N00127—H1
Naval Air Station, Quonset Point, RI 02819
N00128—EU
Supply Department, Naval Administrative Command, Naval Training Station, Great Lakes, IL 60088
N00129—EV
Submarine Base, New London, Groton, CT 06340
N00140—EX, LA
Commanding Officer, Naval Regional Contracting Center, Naval Base Bldg. No. 600, Philadelphia, PA 19112
N00146—QK
Marine Corps Air Station, Cherry Point, NC 28533
N00151—EY
Philadelphia Naval Shipyard, Philadelphia, PA 19112
N00153—N0
Governor, Naval Home, 01800 East Beach Blvd., Gulfport, MS 39501
N00158—3V
Naval Air Station, Willow Grove, PA 19090
N00161—FA
Naval Academy, Annapolis, MD 21402
N00162 (MAJ00018)—MDG–H
Naval Medical Clinic, Annapolis, MD 21402–5050
N00163—FB
Naval Air Warfare Center, Aircraft Division Indianapolis, 21st and Arlington Avenue, Indianapolis, IN 46218
N00164—FC
Naval Surface Warfare Center, Crane Division, Crane, IN 47522
N00166 (MAJ00072)—LC0–1
Naval Air Facility, Bldg 3086, Andrews AFB, Washington, DC 20396–5130
N00167—FD
Naval Surface Warfare Center, Carderock Division, Bethesda, MD 20084–5000
N00168—FE
National Naval Medical Center, National Capital Region, Bethesda, MD 20014
N0017A

Atlantic Fleet Weapons Training, Facility (Code 51) (Roosevelt Roads, PR), Naval Station, Box 3023, FPO AA 34051
N00171—N5
HQ, Naval District Washington, Washington Navy Yard, Washington, DC 20374
N00173—FF
Naval Research Laboratory, Washington, DC 20390
N00174—FG
Naval Surface Warfare Center, Indian Head Division, Indian Head, MD 20640
N00178
Naval Surface Warfare Center, Dahlgren Division, Dahlgren, VA 22448
N00181—FJ
Norfolk Naval Shipyard, Portsmouth, VA 23709
N00183—JX
Commanding Officer, Naval Hospital, Portsmouth, VA 23708–5100
N00187—3J
Navy Public Works Center, Norfolk, VA 23511
N00188—H2
Naval Air Station, Norfolk, VA 23511
N00189—FK, H3
Naval Supply Center, Norfolk, VA 23512
N00191—FL
Charleston Naval Shipyard, Naval Base, Charleston, SC 29408
N00193 (MAJ00024)—EHD–G
Commanding Officer (Code 11), Naval Weapons Station, Charleston, SC 29408–7000
N00196—3K
Commanding Officer (Code 60), Naval Air Station, Atlanta, Marietta, GA 30060
N00197—FM
Naval Surface Warfare Center, Naval Ordnance Station, Crane Division, Louisville, KY 40214
N00203 (MAJ00018)—MCL
Commanding Officer, Naval Hospital, Pensacola, FL 32512
N00204—FN
Naval Air Station (Code 19P10), Pensacola, FL 32508
N00205—FP
Naval Support Activity (Code N443), New Orleans, LA 70146
N00206
Naval Air Station, New Orleans, LA 70146
N00207—FQ
Naval Air Station, Jacksonville, FL 32212
N00211 (MAJ00018)—MCQ–S
Naval Hospital, Great Lakes, IL 60088–5230
N00213—H4
Naval Air Station, Key West, FL 33040
N00215—3W
Naval Air Station (Code 60), Dallas, TX 75211
N00216—FR
Commanding Officer (Code 194), Naval Air Station, Bldg 10, Corpus Christi, TX 78419
N00221—K5
Mare Island Naval Shipyard, Vallejo, CA 94592
N00228—FU
Naval Supply Center, Oakland, CA 94625
N00231
Commanding Officer, Naval Medical Clinic, Quantico, VA 22134
N00232 (MAJ00018)—MCB–F
Naval Hospital, Jacksonville, FL 32214–5222
N00236—NX
Naval Air Station, Alameda, CA 94501
N00244—NW
Naval Supply Center, Naval Base, 937 North Harbor Drive, San Diego, CA 92132
N00245 (MAJ00070)—LPN
Naval Station, San Diego, CA 92136–5000
N00246—H5
Naval Air Station, North Island, San Diego, CA 92135
N00247—HC
Naval Training Center, San Diego, CA 92133
N00249
Commanding Officer, Civil Engineer Support Office, Naval Construction Battalion Center, Port Hueneme, CA 93043
N00250—FW
Commander, Navy Exchange Service Command, NAVSTA New York, Staten Island, NY 10305
N00251—FX
Puget Sound Naval Shipyard, Bremerton, WA 98314
N00253—FY
Commanding Officer, Naval Undersea Warfare Center, Division Keyport, Keyport, WA 98345
N00255 (MAJ00070), LPS–T—LPW–Y
Naval Station Puget Sound, Seattle, WA 98115–5000
N00267 (MAJ00018)—MC0–1
Commanding Officer, Navy Medical Clinic, Key West, FL 33040
N00274 (MAJ00072)—LCA–B
Naval Air Facility, Detroit, Selfridge Air Force Base, Supply Department, Mt. Clemens, MI 48045
N00275—3M
Naval Air Station, Glenview, IL 60026
N00276
Naval Air Station, Twin Cities, Minneapolis, MN 55450
N00281 (MAJ00062)—L90–1
Commanding Officer, Fleet Combat Training Center, Atlantic, Dam Neck, Virginia Beach, VA 23461
N00285 (MAJ00018)—MDR
Commanding Officer, Naval Hospital, Corpus Christi, TX 78419
N00288
Naval Publications and Forms Center, 5801 Tabor Avenue, Philadelphia, PA 19120
N00296—NY
Naval Air Station, Moffett Field, CA 94035
N00311—GA
Pearl Harbor Naval Shipyard, Box 400 Pearl Harbor, HI 96860
N0031A (MAJ00060), J0K–M—J0Y–Z
Commander, Naval Special Warfare Group Two, Naval Amphibious Base, Little Creek, Norfolk, VA 23521–5340
N00314—M7
Submarine Base, Pearl Harbor, HI 96860
N00334—N6
Naval Air Station, Barbers Point, HI 96862
N00383, GB—GC
Navy Aviation Supply Office, 700 Robbins Avenue, Philadelphia, PA 19111
N00389, KL—MM
Contracting Officer (Code 192), U.S. Naval Station (Roosevelt Roads, PR), Box 3002, FPO AA 34051
N00406—GE
Naval Supply Center, Puget Sound, Bremerton, WA 98314
N00421—M8
Naval Air Warfare Center, Aircraft Division, Patuxent River, MD 20670
N00600—GG
Naval Regional Contracting Center, Washington Navy Yard, Washington, DC 20374
N00604—NQ
Naval Supply Center, Pearl Harbor, Pearl Harbor, HI 96860
N00612—GH
Commanding Officer, Naval Supply Center, RCD, Code 200M, Charleston, SC 29408
N00619 (MAJ00018)—QA0–9
Naval Hospital Oakland, CA 94627–5000
N00620—H6
Naval Air Station, Whidbey Island, Oak Harbor, WA 98277
N00639—H7
Commanding Officer, Naval Air Station, Memphis (84), Millington, TN 38054
N00702 (MAJ00069)—8QM–N
Naval Security Group Activity, Winter Harbor, ME 04693
N00743—8N
Commanding Officer, Naval Computer and Telecommunications Station (Roosevelt Roads, PR), Box 3022, FPO AA 34051
N00788 (MAJ00063)—NTR–S
Commanding Officer, Naval Communications Det., Washington, (Cheltenham, MD), Washington, DC 20390
N00849 (MAJ00069)—8QC
Naval Security Group Activity, Skaggs Island, Sonoma, CA 95476–5000
N00886—QB
Naval Communications Station, San Francisco, Rough and Ready Island, Stockton, CA 95203
N00950—8R
Naval Computer and Telecommunications Area, Master Station, EASTPAC, Wahiawa, HI 96786
N0417A (MAJ00025)—EJA
Naval Support Facility, P.O. Box 1000, Thurmont, MD 21788
N0428A—3Q
Naval Air Station, Patuxent River, MD 20670
N0429A—3A
Naval Air Warfare Center, Weapons Division, Point Mugu, CA 93042
N0434A (N00022)—MQL
United States Navy Band, Washington Navy Yard, Washington, DC 20374–1052
N0463A (MAJ00024)—EHC
Commanding Officer, Navy Experimental Diving Unit, NAVCOASTSYSCEN, Bldg. 321, Panama City, FL 32401
V04697 (MAJ00060)—LHA
USS Simon Lake, FPO AA 34085–2590
N0597A (MAJ00012)—HXP–W
Director, Office of Civilian Personnel Management, Southeast Region, Bldg A–67, Naval Base, Norfolk, VA 23511–6098
N0598A (MAJ00012)—HXN
Director, Office of Civilian Personnel Management, Pacific Division, Box 119, Pearl Harbor, HI 96860–5060
N0604A (MAJ00012)—HXJ–L

Director, Office of Civilian Personnel Management, Northwest Region, 2890 North Main Street, Suite 301, Walnut Creek, CA 94596–2739
N0605A (MAJ00012)—HXG–H
Director, Office of Civilian Personnel Management, Northeast Region, Bldg 75–3 Naval Base, Philadelphia, PA 19112–5006
N0618A (MAJ00062)—8AE
School of Music, Naval Amphibious Base, Little Creek, Norfolk, VA 23521–5240
N0619A—8E
Naval Health Sciences Education & Training Command, NAVMEDCOM NATCAPREG, Bethesda, MD 20814
N0708A (MAJ00024)—U0A–B
Naval Warfare Engineering Activity, Port Hueneme Division, Naval Surface Warfare Center, Yorktown, VA 23961–5076
N08939
Navy Section, US Military Group (Caracas, Venezuela), Department of State, Washington, DC 20521
N09534
Navy Section, US Military Group (Lima, Peru), APO AA 34031
N09550—4G
Commander Fleet Air Mediterranean (Naples, Italy), FPO AE 09619
N30492 (MAJ00039)—NSC
David W. Taylor Naval Ship Research and Development Center Detachment Puget Sound, Bremerton, WA 98324–5215
N30776—4N
Naval Air Station, Kingsville Auxiliary Landing Field Detachment, Orange Grove, TX 77630
N30779—3Z
Naval Auxiliary Landing Field, Goliad, TX 77963
N30829 (MAJ00061)—NL0–2
Officer in Charge, Naval Support Activity, Naples Detachment (Gaeta, Italy), FPO AE 09609
N30929
Commanding Officer, Navy Flight Demonstration Squadron (Blue Angels), Naval Air Station, (Attn: Supply Officer), Pensacola, FL 32508
N31149 (MAJ00024)—EHA–B
Naval Sea Logistics Center Det Philadelphia, Naval Base, Philadelphia, PA
N31699 (MAJ00012)—V8Z
Office of Under Secretary of the Navy, Washington, DC 20350–1000
N31863
Director, Naval Audit Service, Capital Region, P.O. Box 1206, Falls Church, VA 22041
N31954 (MAJ00062)—R0X
Submarine Training Facility, San Diego, CA 92106
N32525—8S
U.S. Naval Communication Station, Naples Detachment (Sigonella, Italy), FPO AE 09627
N32778 (MAJ00070)—4LE
Fleet Activities, Chinhae (Korea), FPO AP 96269–1100
N32832—7K
Naval Aviation Logistics Center, European Repair and Rework, Activity Representative (Alverca, Portugal), APO AE 09642
N32960—K2
Navy Support Office, La Maddalena (Sardinia Italy), FPO AE 09612
N33137 (MAJ00015)—L0A–C
Naval Intelligence Operations Group DET CTG 168.4 (Munich, Germany), APO AE 09108
N35316 (MAJ00060)—J0G
Patrol Combatant Missile Squadron Two, Mobile Logistic Support Group, Trumbo Point Annex, NAS Key West, FL 33040
N35949 (MAJ00018)—J5S
Naval Hospital, Twentynine Palms, CA 92278–5008
N39167
Commanding Officer, Naval Branch Medical Clinic, Naval Air Station, Meridian, MS 39309
N39353—GV
Commanding Officer, Integrated Combat Systems Test Facility, San Diego, CA 92152
N41756—LE
Navy Engineering Logistics Office, Washington, DC 20000
N42237—7A
Commanding Officer, Naval Submarine Base, Code N411, Kings Bay, GA 31547
N44405 (MAJ00062)—8AA
Antilles Consolidated School System, Box 3200 (Roosevelt Roads, PR), FPO AA 34051
N44416 (MAJ00023)—4JL
Defense Printing Service Northeast Area, 700 Robbins Avenue, Philadelphia, PA 19111–5093
N44930—KN
Intra-Fleet Supply Support Operations Program, Norfolk, VA 23512
N44967—KP
Naval Sea Systems Command Detachment (PERA CSS), San Francisco, CA 94124–2995
N45045 (MAJ00012)—V8A
Navy Comptroller Standard Systems Activity Det., Raleigh Oaks Plaza Office Building, 3606 Austin Peay Highway, Memphis, TN 38128–3757
N45405—HS
Naval Sea Systems Command Det., PERA (Surface) Atlantic Office, Portsmouth, VA 23709–5000
N45406—LD
Officer in Charge, Naval Sea Systems Command Detachment (PERA CV), Puget Sound Naval Shipyard, Bremerton, WA 98310–0206
N45411 (MAJ00070)—LPE
Assault Craft #5, MCB Camp Pendleton, CA 92055–5003
N45534 (MAJ00024)—EHN
AEGIS Combat Systems Center, Bldg D–11, Wallops Island, VA 23337
N45854 (MAJ00011)—LBE
Fleet Surveillance Support Command, Chesapeake, Chesapeake, VA 23322–5010
N46079
Military Sealift Command Office, Northern Europe, (Bremerhaven, Germany), APO AE 09069–0006
N46450 (MAJ00023)—L50–9
Naval Supply Center, Charleston Detachment, Naval Submarine Base, Kings Bay, GA 31547
N46531 (MAJ00012)—HX0–E
Office of Civilian Personnel Management, National Capital Region, 801 N. Randolph Street, Arlington, VA 22203
N46656—NP
Telecommunication Management Detachment West, 937 North Harbor Drive, San Diego, CA 92132–5104
N46657 (MAJ00063)—NT0–NT1
Telecommunication Management Detachment Pacific, Wahiawa, HI 96786–3050
N46659—KJ
Telecommunications Management Detachment Europe, (Naples, Italy), FPO AE 09620
N46904 (MAJ00060)—J00–1
Commanding Officer, Precommissioned Unit, Antisubmarine Warfare Training Group Atlantic, Bldg CEP 104, Naval Station, Norfolk, VA 23511–6495
N47408 (MAJ00025)—EJP–W
Naval Facilities Engineering Command Contracts Office, Naval Construction Battalion Center, Port Hueneme, CA 93043–5000
N47427 (MAJ00070)—V5G
Naval Air Pacific Repair Activity Detachment, New Zealand (Christchurch), c/o U.S. Naval Support Force Antarctic Det., FPO AP 96531
N47875 (MAJ00019)—GUP–S
Naval Technical Representative Detachment Bethpage, Grumman Aerospace Corporation, Bethpage, NY 11714–3593
N47876 (MAJ00019)—GUJ–L
Naval Technical Representative Detachment Burbank, Lockheed Aeronautical Systems Company, P.O. Box 551, Burbank, CA 91503
N47877—GD
Naval Technical Representative Detachment St. Louis, McDonnell Douglas Corporation, P.O. Box 516, St. Louis, MO 63166–0516
N47878 (MAJ00019)—GUV
Naval Technical Representative Detachment Lynn, General Electric Company, Aircraft Engine Business Group, 1000 Western Avenue, Lynn, MA 01910–0445
N47879 (MAJ00019)—GUO–B
Naval Technical Representative Detachment Stratford, United Technologies Corporation, Sikorsky Aircraft Divison, Stratford, CT 06497
N48142 (MAJ00012)—V80–1
Assistant Secretary of the Navy, Research Development and Acquisition, Washington, DC 20350–1000
N48398 (MAJ00070)—4LD
Commander, U.S. Naval Forces Alaska, P.O. Box 25517, Juneau, AK 99802–5517
N48521 (MAJ00019)—GUX
Naval Technical Representative Detachment Bell, Bell Helicopter Textron, P.O. Box 482, Bldg. 2, Fort Worth, TX 76101
N48758 (MAJ00070)—V5R
Naval Air Pacific Repair Activity Plant Rep. Office, Box 39, (Atsugi, Japan), FPO AP 96306
N49399 (MAJ00060)—NM0–9

Naval Submarine Support Facility, Supply Operations, New London, Box 500, Groton, CT 06349–5500
N52731 (MAJ00072)—LCU
Reserve Naval Construction Force, First Reserve Naval Construction Brigade Support Detachment, Naval Construction Battalion Center, Bldg 121, Gulfport, MS 39501–5016
N52846 (MAJ00019)—EFA–B
Naval Aviation Depot Operations Center Detachment, European Repair and Rework Activity (NERRA), (Naples, Italy), Box 50, FPO AE 09619
N52855—LZ
FPO New York 09520–5000, Special Boat Unit 11, FPO AP 96601–4517
N53210 (MAJ00060)—LHJ–K
Assault Craft Unit 2, Naval Amphibious Base, Little Creek, Norfolk, VA 23520
N53825—GY
Naval Surface Force, US LANTFLT, Norfolk, VA 23511–6002
N53999 (MAJ00060)—J0Q–R
Seal Team Six, Naval Amphibious Company, Norfolk, VA 23521
N55131 (MAJ00060)—J0A–B
Cargo Handling and Port Group, Williamsburg, VA 23187–5792
N55322 (MAJ00060)—LHN
Explosive Ordnance Disposal Group Two, Fort Story, VA 23459–5024
N55418 (MAJ00070)—V50
Naval Antarctic Support Unit, (Christchurch, New Zealand), FPO AP 96531
N57007—VO
Commander, Middle East Force, (Jufair, Bahrain), FPO AE 09834
N57012—GQ
Commander Naval Air Force, U.S. Atlantic Fleet, Naval Air Station, Norfolk, VA 23511
N57016 (MAJ00060)—J0N
Commander Submarine Force, U.S. Atlantic Fleet, Norfolk, VA 23511–6296
N57023—GT
Commander, Operational Test and Evaluation Force, Naval Base, Norfolk, VA 23511
N57032 (MAJ00061)—NLF–H
Naval Air Facility, (Mildenhall, UK), FPO AE 09459
N57049 (MAJ00060)—JOE–F, V–X
Naval Support Facility (Antigua, West Indies), FPO AA 34054
N57053 (MAJ00070)—LPQ
Naval Facility, Centreville Beach, Ferndale, CA 95536–9766
N57070 (MAJ00060)—LH7
Commander, Undersea Surveillance, U.S. Atlantic Fleet, Norfolk, VA 23511–6687
N57075 (MAJ00060)—LH9
Commanding Officer, Naval Facility (Argentia, Canada), FPO AE 09730
N57095 (MAJ00060)—LH0–1
Atlantic Fleet Headquarters Support Activity, CINCLANTFLEET, Norfolk, VA 23511
N57100 (MAJ00070)—LP0–1
Naval Special Warfare Group One, NAVPHIBASE Coronado, San Diego, CA 92155
N60002 (MAJ00018)—QAD
Commanding Officer, Naval Hospital, Millington, TN 38054
N60028—QC
Naval Station, Treasure Island, San Francisco, CA 94130
N60036—QD
Naval Weapons Station, Concord, CA 94520
N60042 (MAJ00070)—LPU
Naval Air Facility, El Centro, CA 92243
N60050—HD
Marine Corps Air Station, El Toro, Santa Ana, CA 92709
N60087—3P
Naval Air Station, Brunswick, ME 04011
N60169—W0
Commanding Officer, Marine Corps Air Station, Beaufort, SC 29904
N60191—4A
Naval Air Station, Oceana, Virginia Beach, VA 23460
N60200—3G
Commanding Officer, Naval Air Station, Cecil Field, FL 32215
N60201—L7
Commanding Officer, Naval Air Station, P.O. Box M, Mayport, FL 32228
N60211—3D
Naval Auxiliary Landing Field, Crows Landing, CA 95313
N60234—4R
Naval Air Station, Whiting Field, OLF Saufley Field, Pensacola, FL 32508
N60241—3X
Commanding Officer, Naval Air Station, Bldg. 2701, Kingsville, TX 78363
N60258—GK
Long Beach Naval Shipyard, Long Beach, CA 90801
N60259—H9
Naval Air Station, Miramar, San Diego, CA 92145–5000
N60268 (MAJ62980)—MQ0–1
Navy Recruiting District Chicago, Glenview, IL 60026–5200
N60376—3Y
Commanding Officer, Naval Air Station, Chase Field, Beeville, TX 78103
N60462—WE
Naval Air Station, Adak (Alaska), FPO AP 98506–1200
N60478—3C
U.S. Naval Weapons Station, Earle, Colts Neck, NJ 07722
N60495—3T
Naval Air Station, Fallon, NV 89406
N60508—4Q
Commanding Officer, Naval Air Station, Whiting Field, Milton, FL 32570
N60514—GL
Commanding Officer, Naval Station (Guantanamo Bay, Cuba), Box 33, FPO AE 09593
N60530—GM
Naval Air Warfare Center, Weapons Division, China Lake, CA 93555
N60656—GN
Navy Exchange, Naval Station, Annapolis, MD 21402
N60663—GR
Officer in Charge, Navy Resale Activity, Commissary Support Office, Naval Base, Bldg 2600, Great Lakes, IL 60088
N60666—GS
Navy Exchange, Naval Air Station, Key West, FL 33040
N60676—GX
Navy Resale and Services Support Office, Field Support Office Commissary Div., Naval Air Station, Mechanicsburg, PA 17055
N60681—HA
Commissary OPS Division, NAVRESSOFSO, Naval Station, San Diego, CA 92136
N60693—HB
Navy Resale Activity, Commissary Support Office, Naval Base Pearl Harbor, Box 110, Pearl Harbor, HI 96860
N60701—4M
Naval Weapons Station, Seal Beach, CA 90740
N60865 (MAJ00070)—V5X
Naval Forces, Marianas (Guam), FPO AP 96540
N60872 (MAJ00070)—V5T
Naval Magazine (Guam) FPO AP 96540-1300
N60895—HF
Commissary OPS Division, NAVRESSOFSO, Naval Air Station, Alameda, CA 94501
N60921 HG—FH
Commander, Naval Surface Warfare Center, Dahlgren Division, Detachment White Oak, 10901 New Hampshire Avenue, Silver Spring, MD 20903
N60935—HH
Commissary OPS Div, NAVRESSOFSO, Naval Air Station, Jacksonville, FL 32212
N60936—HJ
Navy Resale Activity Commissary Support Office, Naval Air Station, Pensacola, FL 32508
N60937—HK
Navy Exchange Det., Naval Support Activity, New Orleans, LA 70140
N60938—HL
Navy Resale Activity, Commissary Support Office, Naval Air Station, Corpus Christi, TX 78419
N60939—HM
Navy Exchange, Naval Air Station, Memphis 32, Millington, TN 38054
N60951 (MAJ00060)—LHU
Fleet Accounting and Disbursing Center, Operating Forces Accounting, U.S. Atlantic Fleet, Norfolk, VA 23511–6096
N60956 (MAJ00012)—V8J–N
Navy Regional Finance Center, Great Lakes, IL 60088–5797
N61115—HN
Navy Exchange Activity, Submarine Base, New London, Groton, CT 06340
N61119—HP
Naval Supply Depot, Guam, PSC 455, Box 190, FPO AP 96540–1500
N61165—NN
Supply Officer, Bldg NS46, Naval Station, Charleston, SC 29408–5000
N61174—7B
Naval Station, New York, Brooklyn, NY 11251
N61189 (MAJ00060)—J0T
Naval Station, Philadelphia, PA 19112
N61217—HQ
Navy Exchange, Naval Air Station, Bermuda, FPO AE 09727
N61331—HR
Naval Surface Warfare Center, Dahlgren Division, Coastal Systems Station, Panama City, FL 32407
N61337—H0
Commanding Officer, Naval Hospital, Beaufort, SC 29904
N61339—HT

Commanding Officer, Naval Training Systems Center (N–601), 12350 Research Parkway, Orlando, FL 32826–3275
N61414—4B
Naval Amphibious Base, Little Creek, Norfolk VA 23521
N61463 (MAJ00060)—LHB–D
Naval Base, Norfolk, VA 23511–6002
N61466
Commander, Naval Base, Bldg NH48, Charleston, SC 29408
N61510—HU
Navy Exchange, Naval Station (Guam), Box 179, FPO AP 96540
N61533—HW
David W. Taylor Naval Ship Research and Development Laboratory, Annapolis, MD 21402
N61564—FS
Naval Hospital, NAVBASE (Guantanamo Bay, Cuba), FPO AE 09593
N61577 (MAJ00070)—V5P
Naval Air Station, Agana (Guam), Box 60, FPO AP 96540–1200
N61581 (MAJ00070)—4LT
Fleet Activities, Naval Base (Yokosuka, Japan), FPO AP 96349–1100
N61685 (MAJ00065)—S0A
Naval Oceanography Command Center (Guam), Box 12, FPO AP 96540–2926
N61726—QL
Naval Hospital, Naval Submarine Base, New London, Groton, CT 06349
N61751 (MAJ00018)—MCK,M,N,P
Naval Medical Research Unit No. 3, Cairo (Egypt), PSC 452, Box 5000, FPO AE 09835–1600
N61755 (MAJ00070)—V5E
Naval Station (Guam), FPO AP 96540–1000
N61762—HY
Naval Ordnance Missile Test Station, White Sands Missile Range, NM 88002
N62021—7V
Naval Amphibious Base, Coronado, San Diego, CA 92155
N62161—HZ
Navy Exchange Det, NAVCOMSTA, Rough and Ready Island, Stockton, CA 95203
N62190 (MAJ00014)—EEY
Commanding Officer, Naval Research Laboratory, Underwater Sound Reference Detachment, P.O. Box 8337, Orlando, FL 32856
N62191 (MAJ00062)—L97
Commanding Officer, Naval Reserve Officers Training Corps, and Naval Administrative Unit, Room 20E–125, Massachusetts Institute of Technology, Cambridge, MA 02139
N62254 (MAJ00070)—4LX
Commander Fleet Activities, Okinawa, Naval Air Facility, Kadena (Ryukyu Islands Southern), Box SU/CR, FPO AP 96370–1100
N62269—JC
Commander, Naval Air Warfare Center, Aircraft Division Warminster, Warminster, PA 18974
N62271—QE
Naval Postgraduate School, Monterey, CA 93940
N62285 (MAJ00065)—S00–1
Naval Observatory, Washington, DC, 34th and Massachusetts Avenue, NW, Washington, DC 20390–5100
N62306—7C
Commanding Officer (Code 4410), Naval Oceanographic Office, Stennis Space Center, Bay St. Louis, MS 39552
N62367 (MAJ00023)—4JC
Navy Clothing and Textile Research Facility, 21 Strathmore Road, Natick, MA 01760–2490
N62376—4K
Commanding Officer, Naval Air Warfare Center, Aircraft Division Trenton, P.O. Box 7176, Trenton, NJ 08628
N62381—JG
Military Sealift Command, Atlantic, Military Ocean Terminal, Building 42, Bayonne, NJ 07002
N62382
Military Sealift Command Office, Gulf Subarea, 4400 Dauphin Street, New Orleans, LA 70146
N62383—JH
Military Sealift Command, Pacific, Naval Supply Center, Oakland, CA 94625
N62387
Commander, Military Sealift Command, Central Technical Activity (Code M10–3), 4228 Wisconsin Avenue, Washington, DC 20016
N62395—JK
Navy Public Works Center, (Mariana Islands, Guam), FPO AP 96540–2937
N62401—3F
Defense Printing Service Branch Office, The Pentagon, Washington, DC 20350–3000
N62404—JJ
Military Sealift Command, Far East, (Yokohama, Japan), FPO AP 96347
N62410 (MAJ00022)—MQ6
Navy Recruiting District, P.O. Box 8667, Albuquerque, NM 87198–8667
N62412 (MAJ00022)—MLR
Commanding Officer, Navy Recruiting District, Perry Hill Office Park, 3815 Interstate Court, Montgomery, AL 36109–5294
N62415 (MAJ00022)—MLX
Commanding Officer, Navy Recruiting District, Strom Thurmond Federal Bldg., Suite 771, 1835 Assembly Street, Columbia, SC 29201–2430
N62416 (MAJ00022)—NV0–1
Navy Recruiting District Columbus, Room 609 Federal Building, 200 North High Street, Columbus, OH 44142–2474
N62419
Commanding Officer, Navy Recruiting District, Melrose Bldg., 1121 Walker Street, Houston, TX 77002
N62421 (MAJ00022)—MQM
Commanding Officer, Navy Recruiting District, 8925 North Meridian Street, Room 250, Indianapolis, IN 46260
N62422
Commanding Officer, Navy Recruiting District, 2974 Woodcock Drive, Jacksonville, FL 32207
N62423
Commanding Officer, Navy Recruiting District, 301 Center Street, Little Rock, AR 72201
N62425 (MAJ00022)—MQ8
Commanding Officer, Navy Recruiting District, 1808 West End Avenue, Suite 1312, Nashville, TN 37203
N62427 (MAJ00022)—MLP
Navy Recruiting District Omaha, Overland-Wolf Building, 6910 Pacific, Omaha, NE 68106
N62429 (MAJ00022)—MLE
Navy Recruiting District Portland, 1220 SW Third Avenue, Suite 576, Portland, OR 97204
N62430
Commanding Officer, Navy Recruiting District, 1001 Navaho Drive, Raleigh, NC 27609
N62432 (MAJ00022)—MQG
Navy Recruiting District, St. Louis, 1222 Spruce Street, St. Louis, MO 63103–2814
N62435 (MAJ00022)—MQE
Navy Recruiting District Boston, 495 Summer Street, Boston, MA 02210–2103
N62437 (MAJ00022)—MQ4
Commanding Officer, Navy Recruiting District, 918 So. Ervay Street, Dallas, TX 75201
N62438 (MAJ00022)—MLQ
Navy Recruiting District Denver, Capital Life Center, 3rd Floor, 1600 Sherman Street, Denver, CO 80203–1668
N62440 (MAJ00022)—MLT
Navy Recruiting District, 2420 Broadway, Kansas City, MO 64108
N62441 (MAJ00022)—MLG
Navy Recruiting District Los Angeles, 5051 Rodeo Road, Los Angeles, CA 90016
N62442
Commanding Officer, Navy Recruiting District Atlanta, 612 Tinker Street, Suite C, Marietta, GA 30060
N62443 (MAJ00022)—MLV
Navy Recruiting District, Federal Office Building, 2nd & Washington Avenues, S., Minneapolis, MN 55401
N62444 (MAJ00022)—NVA
Commanding Officer (Code 602–2C), Navy Recruiting District, 4400 Dauphine Street, New Orleans, LA 70146
N62448 (MAJ00022)—MLN
Navy Recruiting District San Francisco, 1500 Broadway, Room 210, Oakland, CA 94612–1430
N62449 (MAJ00022)—MLC
Navy Recruiting District Seattle, Naval Station, Building 30, Seattle, WA 98115–5105
N62467—JM
Commanding Officer, Naval Facilities Engineering Command, Southern Division, (SOUTHNAVFACENGCOM), 2155 Eagle Drive, P.O. Box 10068, Charleston, SC 29411–0068
N62470—JN
Naval Facilities Engineering Command, Atlantic Division, Norfolk, VA 23511
N62471—N7
Officer in Charge of Construction, Naval Facilities Engineering Command, Contracts, Mid-Pacific, Pearl Harbor, HI 96860
N62472—JP
Naval Facilities Engineering Command, Northern Division, U.S. Naval Base, Philadelphia, PA 19112
N62474—JR
Naval Facilities Engineering Command, Western Division, San Bruno, CA 94066
N62477—JU
Naval Facilities Engineering Command, Chesapeake Division, Washington Navy Yard Washington, DC 20374
N62481—N8

Naval Air Station (Bermuda), FPO AE 09727
N62507 (MAJ00070)—4LJ
Commanding Officer, Naval Air Facility (Atsugi, Japan), Box 3, FPO AP 96306–1200
N62522—JV
Military Sealift Command, Europe, (London, UK), Box 3, FPO AE 09499–3700
N62535—HE
Marine Corps Air Station (HELO), Tustin, CA 92710
N62537
Military Sealift Command, Mediterranean Sub-Area, (Naples, Italy), Box 23, FPO AE 09619–0600
N62538—K1
Military Sealift Command Office, Middle Atantic, NSC, Bldg Y100A, Norfolk, VA 23512
N62539
Military Sealift Command Office, United Kingdom, (London, UK), Box 29, FPO AE 09499–3700
N62573—K8
Marine Corps Air Station, New River Plaza, Jacksonville, NC 28540
N62576 (MAJ00023)—4JG
Defense Printing Service Branch Office, 700 Robbins Avenue, Philadelphia, PA 19111–5094
N62578—J2
Naval Construction Battalion Center, Davisville, RI 02854
N62583—J3
Naval Construction Battalion Center, Port Heuneme, CA 93041
N62585—K3
Commander, Naval Activities, United Kingdom, (London, UK), FPO AE 09499
N62586 (MAJ00070)—V5A–B
Naval Ship Repair Facility (Guam), FPO AP 96540
N62588—NR
Naval Support Activity (Naples, Italy), FPO AE 09619
N62593
Director, Defense Printing Service Det Office, Southeast Div., 4400 Dauphine St., Unit 601–3–B, New Orleans, LA 70146
N62603
Commanding Officer Fleet & Mine Warfare Training Center Naval Base, Bldg 647 Charleston, SC 29408
N62604—J4
Commanding Officer, Naval Construction Battalion Center, Gulfport, MS 39501
N62613 (MAJ00027)—MUE
Commanding Officer, Marine Corps Air Station, (Iwakuni, Japan), FPO AP 96310
N62638 (MAJ00072)—LCN
Naval Inshore Undersea Warfare Group Two, NSC Cheatham Annex, Bldg. 111, Williamsburg, VA 23187–8792
N62645—EG
Naval Medical Logistics Command, Fort Detrick, Frederick, MD 21701–5015
N62649—JY
Naval Supply Depot (Yokosuka, Japan), FPO AP 96349
N62651
Director, Defense Printing Service Office, Southeast Division, Pensacola, FL 32508
N62653 (MAJ00023)—4JW–X
Director, Defense Printing Service Branch Office, Southeast Division, Bldg. 1628, Naval Base, Charleston, SC 29408
N62654 (MAJ00019)—EFE
Naval Weapons Evaluation Facility, Kirtland AFB, Albuquerque, NM 87117
N62661 (MAJ00062)—L97
Naval Education and Training Center, Newport, RI 02841–5000
N62665—JQ
Supervisor of Shipbuilding, Conversion, and Repair, USN, Barnes Building—6th Floor, 495 Summer Street, Boston, MA 02210
N62670—8B
Supervisor of Shipbuilding, Conversion and Repair, USN, Drawer T, Mayport Naval Station, Jacksonville, FL 32228
N62673—8P
Supervisor of Shipbuilding, Conversion and Repair, USN, Naval Base, Charleston, SC 29408
N62678—8C
Supervisor of Shipbuilding, Conversion and Repair, USN, P.O. Box 215, Portsmouth, VA 23705
N62686—T0
Defense Printing Service Office, Naval District Washington, Building 157–2, Washington Naval Yard, Washington, DC 20374–1572
N62688—GW
Naval Station, Naval Base, Norfolk, VA 23511–6002
N62695
Auditor General of the Navy, Naval Audit Services Headquarters, P.O. Box 1206, Falls Church, VA 22041
N62700 (MAJ00023)—4JJ
Defense Printing Service Detachment Office, Northern Division, Bldg 2A, Great Lakes, IL 60088–5708
N62703 (MAJ00023)—4JA
Defense Printing Service Branch Office, Bldg 530, Puget Sound Naval Shipyard, Bremerton, WA 98314
N62705 (MAJ00023—4JN
Defense Printing Service Detachment Office, Naval Supply Center, Oakland, CA 94625–5045
N62706—JS
Defense Printing Service Branch Office, Western Division, Bldg. 154, San Diego, CA 92136–5148
N62707 (MAJ00023)—4JS–U
Defense Printing Service Detachment Office, Western Area, Pearl Harbor, Box 126, Pearl Harbor, HI 96860–5120
N62735 (MAJ00070)—4LP
Commander, Fleet Activities, (Sasebo, Japan), PSC 476, Box 1, FPO AP 96322–1100
N62741—MB
Commanding Officer, Navy Supply Corps School, Code 60, Athens, GA 30606
N62742—KB
Naval Facilities Engineering Command, Pacific Division, Pearl Harbor, HI 96860
N62745 (MAJ00025)—FZC–E
Officer in Charge of Construction, Naval Facilities Engineering Command Contracts, Mediterranean (Madrid, Spain), APO AE 09642
N62755—J7
Commanding Office, Navy Public Works Center, Pearl Harbor, HI 96860–5470
N62757 (MAJ00072)—9TV–Y
Naval Reserve Center, 7410 West Roosevelt Road, Forest Park, IL 60130–2592
N62762 (MAJ00024)—EHU–W
Navy Shipbuilding Liaison Office, Spain, Box 36, (Madrid, Spain), APO AE 09642
N62766—L1
Officer in Charge of Construction, Naval Facilities Engineering Command Contracts (Guam), FPO AP 96540
N62786—ER
Supervisor of Shipbuilding, Conversion and Repair, USN, 574 Washington Street, Bath, ME 04530–0998
N62789—L8
Supervisor of Shipbuilding, Conversion and Repair, USN, Groton, CT 06340
N62791—NU
Supervisor of Shipbuilding, Conversion and Repair, USN, Naval Station, Box 119, San Diego, CA 92136–5119
N62793—4T
Supervisor of Shipbuilding, Conversion and Repair, USN, Newport News, VA 23607–2785
N62794—7D
Supervisor of Shipbuilding, Conversion and Repair, USN, Flushing & Washington Avenues, Brooklyn, NY 11251–9000
N62795—7F
Supervisor of Shipbuilding, Conversion and Repair, USN, Pascagoula, MS 39568–2210
N62798—4X
Supervisor of Shipbuilding, Conversion and Repair, USN, San Francisco, CA 94124–2996
N62799—7M
Supervisor of Shipbuilding, Conversion and Repair, USN, Seattle, WA 98115–5001
N62802 (MAJ00012)—V8P
Naval Audit Service Northeast Region, 5 Executive Campus, Suite 200, Cherry Hill, NJ 08002–4104
N62808 (MAJ00025)—FZ0
Public Works Center, Subic Bay (Luzon, Republic of the Philippines), FPO AP 96451–2900
N62816 (MAJ00023)—L5A–C
Defense Printing Service Det. Br. Office (Naples, Italy), Box 108, FPO AE 09619
N62832
Naval Activities (Rota, Spain), FPO AE 09645
N62836—L4
Officer in Charge of Construction, Naval Facilities Engineering Command Contracts, Far East, Yokosuka, Box 61, FPO AP 96349
N62841 (MAJ00030)—EKA
Commanding Officer, Naval Ordnance Test Unit, Cape Canaveral, FL 32920–1623
N62844—K0
Naval Imaging Command, Washington Navy Yard, Washington, DC 20350–2000
N62849 (MAJ00019)—EFC
Naval Aviation Engineering Service Unit, Philadelphia, PA 19112–5088
N62852
Naval Electronic System Security Engineering Center, Naval Security Station, 3801 Nebraska Avenue, NW., Washington, DC 20390
N62856 (MAJ00060)—LHW–X

Naval Air Facility (Lajes Azores, Portugal), APO AE 09720–5000
N62863—K4
Naval Station (Rota, Spain), FPO AE 09645
N62864—L2
Officer in Charge of Construction, Naval Facilities Engineering Command Contracts, Southwest Pacific (Manila, Philippines), APO AP 96440
N62892 (MAJ00069)—8QA
Commanding Officer, Naval Security Group Activity, Site "B", Card Sound Road, Homestead, FL 33039–6428
N62894 (MAJ00070)—4LA
Commander, U.S. Naval Forces Korea (Yongsan, South Korea), APO AP 96205–0023
N62907—KG
Naval Plant Representative Office, Applied Physics Laboratory, Johns Hopkins Road, Laurel, MD 20810
N62908—8D
Naval Weapons Engineering Support Activity, Washington Navy Yard, Washington, DC 20374
N62911 (MAJ00022)—MQC
Navy Recruiting Area One, Scotia, NY 12302–9462
N62913 (MAJ00022)—MLL
Commander, Naval Recruiting Area Three, 451 College Street, P.O. Box 4887, Macon, GA 31208–4887
N62915 (MAJ00022)—MQJ
Navy Recruiting Area Five, Building 3, NTC, Great Lakes, IL 60088–5135
N62917 (MAJ00022)—ML0–1
Commander, Navy Recruiting Area Seven, 1499 Regal Row, Suite 501, Dallas, TX 75247
N62918 (MAJ00022)—MLA
Naval Recruiting Area Eight, 7677 Oakport Street, Suite 650, Oakland CA 94621–1929
N62922—7W
Resident Officer in Charge of Construction, Pacific, Department of the Navy, P.O. Box 418, San Bruno, CA 94067
N62954 (MAJ00022)—MQN
Navy Recruiting District Cleveland, 17535 Rosbough Boulevard, Middleburgh Heights, OH 44130
N62974—JB
Marine Corps Air Station, Yuma, AZ 85364
N62980 (MAJ00022)—MQR–Z
Bureau of Naval Personnel, Washington, DC 20370–5000
N62990—L3
Supervisor of Shipbuilding, Conversion and Repair, USN, P.O. Box 26, Sturgeon Bay, WI 54235
N62995—4H
Naval Air Station, Sigonella (Italy), FPO AE 09627
N63005 (MAJ00011)—LBL–N
Commanding Officer, Administrative Support Unit, Bahrain, FPO AE 09834
N63007 (MAJ00060)—LHS
Nuclear Weapons Training Group, Atlantic, Norfolk, VA 23511
N63015—7Y
Naval Education and Training Support Center, Pacific, Fleet Station PO Bldg, San Diego, CA 92132
N63026 (MAJ00027)—MUJ
Marine Corps Air Station (Futenma, Japan), FPO AP 96372–5001
N63028—U2
Polaris Missile Facility Atlantic, Charleston, SC 29408
N63032—KS
U.S. Naval Station, Keflavik (Iceland), FPO AE 09728
N63038—8M
U.S. Naval Computer and Telecommunications Station, Cutler, East Machias, ME 04630
N63042—NZ
Naval Air Station, Lemoore, CA 93245
N63043—3S
Commanding Officer, Naval Air Station, Meridian, MS 39301
N63051 (MAJ0004)—LB8
Commanding Officer, Naval Investigative Service, Southeast Region, Naval Base, Building NH 53, Charleston, SC 29408–6425
N63053
Commanding Officer, Naval Investigative Service Regional Office, P.O. Box 6438, New Orleans, LA 70174
N63055 (MAJ00011)—LBJ
Naval Investigative Service, Mid-Atlanta Region Norfolk, 293 Independence Blvd, Suite 525, Pembroke 5, Virginia Beach, VA 23462
N63058 (MAJ00011)—LBC
Naval Investigative Service, Northwest Region, P.O. Box 4247, Walnut Creek, CA 94596
N63073 (MAJ00069)—8Q6–8
U.S. Naval Security Group Activity RAF (Edzell UK), FPO AE 09419
N63080—KT
Navy Resale Activity, Chinhae (South Korea), FPO AP 96269
N63082
Commanding Officer, Naval Technical Training Center, Corry Station (Code 4460), Pensacola, FL 32511
N63110
Commanding Officer, Chief of Naval Air Training (Code N–73), Naval Air Station, Corpus Christi, TX 78419
N63111
Commanding Officer, Chief of Naval Technical Training, Naval Air Station, Memphis, Millington, TN 38054
N63124 (MAJ00024)—U00–9
Supervisor of Shipbuilding, Conversion and Repair, USN, New Orleans, LA 70146
N63134—7R
Fleet Numerical Oceanography Center, Monterey, CA 93940
N63135 (MAJ00023)—4JD–E
Defense Printing Service Management Office, Washington, DC 20374–1762
N63136
Navy Section, U.S. Military Group, Argentina (Buenos Aires), Department of State, Washington, DC 20521
N63143—8K
Naval Computer and Telecommunications Station (Keflavik, Iceland), Box 22, FPO AE 09728
N63152—GZ
Fleet Combat Direction Systems Support Activity, San Diego, CA 92147–5081
N63165—7U
Navy Regional Data Automation Center, Washington, Washington Navy Yard, Washington, DC 20374
N63182—8T
Naval Computer and Telecommunications Station (Rota, Spain), FPO AE 09644
N63200 (MAJ00011)—LBB
Commanding Officer, Naval Satellite Operations Center, Point Mugu, CA 93042–5013
N63204—KV
Naval Plant Representative Office, Goodyear Aerospace Corp., Akron, OH 44305
N63209 (MAJ00062)—L9A
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of New Mexico, Albuquerque, NM 87106
N63210 (MAJ00062)—L9B
Commanding Officer, Naval Reserve Officers Training Corps Unit, Iowa State University of Science and Technology, Ames, IA 50011–3010
N63211 (MAJ00062)—L9C
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Michigan, Ann Arbor, MI 48109–1085
N63212 (MAJ00062)—L9G
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Texas at Austin, Austin, TX 78712
N63213 (MAJ00062)—L9J
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of California, Berkeley, CA 94720–0001
N63214 (MAJ00062)—L9M
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Colorado, Box 374, Boulder, CO 80309–0374
N63215 (MAJ00062)—L9U
Commanding Officer, Naval Reserve Officers Training Corps Unit, Illinois Institute of Technology, 3300 S. Federal Street, Chicago, IL 60616–3793
N63216 (MAJ00062)—L9W
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Missouri, Columbia, MO 65201
N63217 (MAJ00062)—L9Z
Commanding Officer, Naval Reserve Officers Training Corps Unit, Oregon State University, Corvallis, OR 97331
N63218 (MAJ00062)—R0B
Commanding Officer, Naval Reserve Officers Training Corps Unit, Northwestern University, Evanston, IL 60201
N63219 (MAJ00062)—R0E, L99
Commanding Officer, Naval Reserve Officers Training Corps Unit, Rice University, P.O. Box 1892, Houston, TX 77001
N63220 (MAJ00062)—R0L
Commanding Officer, Naval Reserve Officers Training Corps Unit, UCLA, Mens Gym Room 123, 405 Milgard Avenue, Los Angeles, CA 90024–1399
N63221 (MAJ00062)—8AB
Commanding Officer, Naval Reserve Officers Training Corps Unit, PED 101, University Park MC 0654, University of Southern California, Los Angeles, CA 90089–0654
N63222 (MAJ00062)—R0H
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Kansas, Lawrence, KS 66044
N63223 (MAJ00062)—R0K

Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Nebraska, Lincoln, NE 68508
N63224 (MAJ00062)—8AD
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Wisconsin, 1610 University Avenue, Madison, WI 53705
N63225 (MAJ00062)—8AH
Commanding Officer, Naval Reserve Officers Training Corps Unit, Marquette University, Milwaukee, WI 53233
N63226 (MAJ00062)—8AJ
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Minnesota, Minneapolis, MN 55455–0108
N63227 (MAJ00062)—8AK
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Idaho, Moscow, ID 83843–3244
N63228 (MAJ00062)—8AM
Commanding Officer, Naval Reserve Officers Training Corps Unit, Tulane University, New Orleans, LA 70118
N63229 (MAJ00062)—8AN
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Oklahoma, Norman, OK 73019
N63230 (MAJ00062)—8AR
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Notre Dame, Notre Dame, IN 46556–5601
N63231 (MAJ00062)—8AW
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Utah, Salt Lake City, UT 84112–1107
N63232 (MAJ00062)—8AY
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Washington, Seattle, WA 98195
N63234 (MAJ00062)—J9Q
Commanding Officer, Naval Reserve Officers Training Corps Unit, 505 East Armory Street, University of Illinois, Champaign, IL 61820–6288
N63235 (MAJ00062)—R05
Commanding Officer, Naval Reserve Officers Training Corps Unit, Purdue University, West Lafayette, IN 47907–0001
N63273—4S
Fleet Combat Direction Systems Support Activity, Dam Neck, Port Hueneme Division, Naval Surface Warfare Center, Virginia Beach, VA 23461
N63285 (MAJ00011)—LB0
Naval Security and Investigative Command, Washington, DC 20388
N63290 (MAJ00062)—R00–1
Commanding Officer, Combat Systems Technical Schools Command, Mare Island, Vallejo, CA 94592
N63291 (MAJ00062)—R0F
Commanding Officer, Naval Reserve Officers Training Corps Unit, Barton Hall, Cornell University, Ithaca, NY 14853
N63294 (MAJ00062)—8AV
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Rochester, Rochester, NY 14627
N63295 (MAJ00062)—R0M
Commanding Officer, Naval Reserve Officers Training Corps Unit, Rensselaer Polytechnic Institute, Troy, NY 12180–3590
N63296 (MAJ00062)—L9F
Commanding Officer, Naval Reserve Officers Training Corps Unit, Auburn University, Auburn, AL 36830
N63299 (MAJ00062)—R0A
Commanding Officer, Naval Reserve Officers Training Corps Unit, Duke University, Durham, NC 27706
N63301 (MAJ00062)—L9D
Commanding Officer, Naval Reserve Officers Training Corps Unit, Georgia Tech, Atlanta, GA 30313
N63303 (MAJ00062)—R0U
Commanding Officer, Naval Reserve Officers Training Corps Unit, College of the Holy Cross, Worcester, MA 01610–2389
N63306 (MAJ00062)—8AS
Commanding Officer, Naval Reserve Officers Training Corps Unit, Miami University, Oxford, OH 45056–1698
N63307 (MAJ00062)—R0N
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Mississippi, Box 69, University, MS 38677
N63308 (MAJ00062)—L9R
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of North Carolina, Chapel Hill, NC 27515
N63309 (MAJ00062)—L9Y
Commanding Officer, Naval Reserve Officers Training Corps Unit, The Ohio State University, Columbus, OH 43210–1169
N63310 (MAJ00062)—R0P
Commanding Officer, Naval Reserve Officers Training Corps Unit, Wagner Bldg., The Pennsylvania State University, University Park, PA 16802
N63311 (MAJ00062)—8AT
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Pennsylvania, Philadelphia, PA 19104
N63313 (MAJ00062)—L9X
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of South Carolina, Columbia, SC 29208
N63315 (MAJ00062)—8AL
Commanding Officer, Naval Reserve Officers Training Corps Unit, Vanderbilt University (Westside Hall), Nashville, TN 37240
N63316 (MAJ00062)—R0R
Commanding Officer, Naval Reserve Officers Training Corps Unit, Villanova University, Villanova, PA 19085–1699
N63317 (MAJ00062)—L9T
Commanding Officer, Naval Reserve Officers Training Corps Unit, Maury Hall, University of Virginia, Charlottesville, VA 22903–3194
N63325—7X
Naval Education & Training Support Center, Atlantic, Bldg. Z–86, Naval Station, Norfolk, VA 23511
N63339—LL
Navy Exchange, Naval Air Station, Adak (Alaska), FPO AP 96506
N63340—LM
Navy Exchange, Newfoundland (Argentia, Canada), FPO AE 09730
N63341—LN
Navy Exchange Det., Naval Air Station, Chase Field, Beeville, TX 78102
N63344—LR
Navy Commissary Store Region, Charleston, SC 29408
N63345—LS
Navy Exchange, Naval Station, Guantanamo Bay (Cuba), FPO AE 09731
N63346—LT
Navy Resale Activity, Commissary Support Office, Naval Station, Keflavik (Iceland), FPO AE 09728
N63348—LV
Navy Exchange Det., Naval Air Station, Kingsville, TX 78364
N63349—LW
Navy Exchange, Naval Air Station, Lemoore, CA 93246
N63350—3L
Navy Exchange (Dunstable, UK), FPO AE 09499
N63351—LY
Navy Commissary Store Region, Naval Station, Long Beach, CA 90802
N63352—KE
Navy Exchange Det., Naval Air Station, Meridian, MS 39301
N63353—MA
Officer in Charge, Navy Resale Activity, Commissary Support Office, Naval Support Activity, Naples (Italy), FPO AE 09619
N63357—ME
Navy Exchange, Naval Station, Rota (Spain), FPO AE 09645
N63362—MK
Officer in Charge, Navy Resale Activity, Commissary Support Office, Naval Station (Subic Bay, Philippines), P.O. Box 28, FPO AP 96451
N63365—MN
Navy Resale Activity, Commissary Support Office (Yokosuka, Japan), Box 33, FPO AP 96349
N63367—MP
Officer in Charge, Commissary OPS Div., Navy Resale and Services Support Office, Field Support Office, Norfolk, VA 23511
N63369
Military Sealift Command Office, Benelux (Rotterdam, Netherlands), APO AE 09715
N63381 (MAJ00011)—LBA
Joint U.S. Military Advisory Group, Thailand (Bangkok, Thailand), APO AP 96546
N63387—JD
Navy Public Works Center, Naval Base, San Diego, CA 92136
N63394—L6
Naval Surface Warfare Center, Port Hueneme Division, Port Hueneme, CA 93043
N63395—8L
U.S. Naval Communication Station Thurso (Caithness, UK), FPO AE 09418
N63402—K7
Commanding Officer, Strategic Weapons Facility, Pacific, Bremerton, WA 98383
N63406 (MAJ00070)—V5C
Naval Submarine Base San Diego, 140 Sylvester Road, San Diego, CA 92106–3521
N63408—HV

Navy Material Transportation Office, Norfolk, VA 23511–6691
N63410—KA
Navy Manpower and Material Analysis Center, Atlantic, Norfolk, VA 23511
N63427—8F
U.S. Naval Communication Station, Harold E. Holt, Exmouth, Western Australia, FPO AP 96550
N63429—MH
Naval Computer and Telecommunications Station London (UK), FPO AE 09499
N63439—K9
Naval Ophthalmic Support and Training Activity, Yorktown, VA 23690
N63543 (MAJ00072)—9TC
Naval Reserve Center, 3070 Ross Lane, Central Point, OR 97502–1399
N63821 (MAJ00039)—NSA–B
Officer in Charge, Naval Underwater Systems Center, AUTEC Andros Range Detachment (Andros Island, Bahama Islands), FPO AA 34058
N63886 (MAJ00069)—8Q0–1
Naval Security Group Activity (Adak, AK), FPO AP 96505
N63891 (MAJ00069)—8QG
Naval Security Group, Northwest, Chesapeake, VA 23322
N64165 (MAJ00062)—R0Z
Naval Unit, Lowry Air Force Base, CO 80230
N64181 (MAJ00062)—R0W
Department of Naval Science, Texas Maritime Academy, Galveston, TX 77553–1675
N64267—M9
Naval Warfare Assessment Center, Corona Annex, Corona, CA 91720
N64281—3U, KX
Commanding Officer, Naval Sea Combat Systems Engineering Station, Naval Station, Norfolk, VA 23511
N64356—KF
Commanding Officer, Naval Administrative Command, Armed Forces Staff College, Norfolk, VA 23511–6097
N64980 (MAJ00061)—NLA–C
Officer in Charge, Naval Weapons Facility, Detachment Machrihanish (UK), FPO AE 09422
N64981 (MAJ00061)—NL5–7
Commanding Officer, Naval Weapons Facility, (St. Mawgan, UK), FPO AE 09415
N65113—EZ
Navy Public Works Center, Bldg 1A, Great Lakes, IL 60088–5600
N65114 (MAJ00025)—EJC
Commanding Officer, Navy Public Works Center, Naval Air Station, Pensacola, FL 32508–6500
N65115 (MAJ00025)—FZA
Navy Public Works Center, Box 13 (Yokosuka, Japan), FPO AP 96349–3100
N65116—MZ
Officer in Charge, Navy-Marine Corps Appellate Review Activity, Office of the Judge Advocate General, Washington Navy Yard, Washington, DC 20374–2001
N65146—7E
Procurement Branch, OP–09B31, Office of the Chief of Naval Operations Support Activity, Washington DC 20350
N65198—3H
Naval Administrative Unit, 550 First Street, Idaho Falls, ID 83401
N65236—V7
Naval Electronic Systems Engineering Center, 4600 Goer Road, North Charleston, SC 29406
N65256 (MAJ00012)—V8C
Navy Office of Information, East, 133 East 58th Street, 1st Floor, New York, NY 10022
N65428 (MAJ00018)—MDP
Commanding Officer, Naval Hospital (Roosevelt Roads, PR), FPO AA 34051–8100
N65440—4V
Officer in Charge, Navy Exchange, NAVCOMMSTA Harold E. Holt, (Exmouth, Australia), FPO AP 96550
N65491 (MAJ00018)—J5P
Naval Hospital, (Subic Bay, Philippines), FPO AP 96452–1600
N65492 (MAJ00018)—MCA
Commanding Officer, Naval Hospital, Fiscal & Supply Service, Code 32C, Orlando, FL 32813–5200
N65497—4U
Commissary OPS Division, NAVRESSO, Field Support Office, 2801 "C" Street, SW, Auburn, WA 98001
N65538 (MAJ00024)—U0D
Naval Sea Logistics Center, 5450 Carlisle Pike, P.O. Box 2060, Mechanicsburg, PA 17055–0795
N65540 (MAJ00024)—EHP–S
Naval Ship System Engineering Station, Carderock Division, Naval Surface Warfare Center Naval Base, Philadelphia, PA 19112–5083
N65575 (MAJ00018)—MCY
Naval Medical Clinic, Seattle, WA 98115
N65576
Navy Space Systems Activity, P.O. Box 92960, Worldway Postal Center, Los Angeles, CA 90009
N65580—M2
Naval Electronic Systems Engineering Center, P.O. Box 55, Portsmouth, VA 23705
N65849 (MAJ00012)—HXY–Z
Office of Civilian Personnel Management, Southwest Region, San Diego, CA 92188
N65870—M4
Supervisor of Shipbuilding, Conversion and Repair, USN, Long Beach Naval Shipyard, Long Beach, CA 90822
N65886
Commanding Officer, Aviation Depot, Naval Air Station, Jacksonville, FL 32212
N65888—ED
Aviation Depot, North Island, San Diego, CA 92135
N65889
Commanding Officer, Aviation Depot, Naval Air Station, Code 56000, Pensacola, FL 32508
N65912—GP
Commanding Officer, Naval Sea Support Center, Atlantic, St. Juliens Creek Annex, Portsmouth, VA 23702
N65913—7L
Naval Sea Support Center, Pacific, San Diego, CA 92138
N65918—FT
Shore Intermediate Maintenance Activity, Naval Station, San Diego, CA 92136–5000
N65926 (MAJ00039)—NSA–B
Officer in Charge, Naval Underwater Systems Center Detachment, AUTEC West Palm Beach, West Palm Beach, FL 33402
N65928 (MAJ00062)—N3
Naval Training Center, Orlando, FL 32813
N65980 (MAJ00039)—NSL–N
Naval Electronic Systems Engineering Activity, St. Inigoes, MD 20684
N65995—KM
Officer in Charge, Naval Support Activity, (Holy Loch, UK), FPO AE 09416
N66001—7N
Naval Command Control and Ocean Surveillance Center, RDT&E Division, San Diego, CA 92152–5000
N66021—7G
Naval Air Pacific Repair Activity, (Atsugi, Japan), FPO AP 96306
N66022 (MAJ00018)—MDW
Naval Dental Center, San Diego, CA
N66032—LK
Information Technology Acquisition Center, Building 218, Washington Navy Yard, Washington, DC 20374
N66074 (MAJ00062)—8AU
Commanding Officer, Naval Reserve Officers Training Corps Unit, Prairie View A&M University, Prairie View, TX 77445
N66094 (MAJ00018)—QAA–B
Naval Hospital, Cherry Point, NC 28533–5008
N66095 (MAJ00018)—J5E
Naval Hospital, NAS, Lemoore, CA 93246
N66096 (MAJ00018)—QAJ
Naval Hospital Naples, Box 19 (Naples, Italy), FPO AE 90619
N66097 (MAJ00018)—MDE
Naval Hospital, Oak Harbor, WA 98278–8800
N66125 (MAJ00070)—V5J
Naval Facility (Guam), FPO AP 96540–2903
N66231 (MAJ00072)—9TS
Naval Reserve Readiness Center, Bldg 2711, Naval Training Center, Great lakes, IL 60088–5707
N66398 (MAJ00022)—ML6–7
Navy Motion Picture Service, Flushing & Washington Avenues, Brooklyn, NY 11251–8400
N66458 (MAJ00065)—S0C
Naval Oceanography Command Facility, NAS, Brunswick ME 04011–5000
N66540 (MAJ00022)—NVZ
Morale, Welfare and Recreation Division, Bureau of Naval Personnel, Washington, DC 20370–5000
N66604—N4
Naval Undersea Warfare Center, Division Newport, Newport, RI 02840
N66612 (MAJ00062)—L95
Commanding Officer, Naval Reserve Officers Training, Corps Unit, The Citadel, Charleston, SC 29409–0770
N66630 (MAJ00072)—LCS
Naval Air Reserve, Naval Air Station, Point Mugu, CA 93042–5018
N66691—4P
Commanding Officer, Naval Support Activity, (Souda Bay, Crete, Greece), FPO AE 09865
N66715—VJ
Commander, Navy Recruiting Command, Washington, DC 22203–1191
N66753 (MAJ00062)—R0G

Commanding Officer, Naval Reserve Officers Training Corps Unit, Jacksonville University, Jacksonville, FL 32211
N66754 (MAJ00069)—8QX
Commanding Officer, Naval Security Group Activity, (Sabana Seca, PR), FPO AA 34053
N66809 (MAJ00062)—R0V
Commanding Officer, Naval Reserve Officers Training Corps Unit, Savannah State College, Savannah, GA 31404
N66810 (MAJ00062)—L9H
Commanding Officer, Naval Reserve Officers Training Corps Unit, Southern University and A&M College, Baton Rouge, LA 70813
N66833 (MAJ00060)—LHL
Commanding Officer, U.S. Naval Station Panama (Rodman, Canal Zone), FPO AA 34061–1000
N66863 (MAJ00018)—MCU–X
Commanding Officer, Naval Biodynamics Laboratory, 13800 Old Gentilly Road, Michout Assembly Facility, New Orleans, LA 70189
N66890—LJ
Naval Station, Mare Island, Supply and Fiscal Code 90, Bldg 851, Vallejo, CA 94592
N66898 (MAJ00018)—QAF
Commanding Officer, Naval Medical Clinic, New Orleans, LA 70142
N66957
Defense Printing Service Det. Office, Bldg. 2049, NTC, Orlando, FL 32813
N66959 (MAJ00023)—4JR
Defense Printing Service Det. Office, P.O. Box 3, NAS, Jacksonville, FL 32212
N66965 (MAJ00023)—4JQ
Defense Printing Service Det. Office, Point Mugu, CA 93042–5027
N66972
Commanding Officer, Navy Recruiting District, 5901 S.W. 74th Street, Miami, FL 33143
N67596
Commanding Officer, Navy Recruiting District, 102 W Rector Street, San Antonio, TX 78216
N68011
Commanding Officer, Navy Recruiting District, 8 North Third Street, Sterick Bldg., Memphis, TN 38103
N68047 (MAJ00070)—4L0
Naval Regional Contracting Center, (Singapore), FPO AP 96534–2100
N68056—JE
Naval Medical Command Southwest Region, San Diego, CA 92134
N68057—VZ
Commanding Officer, Naval Regional Data Automation Center, Code 212, Norfolk, VA 23511
N68064 (MAJ00062)—R0D
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Florida, Van Fleet Hall, Room 26, Gainesville, FL 32601
N68072 (MAJ00062)—L9V
Commanding Officer, Naval Reserve Officers Training Corps Unit, Texas A&M University, College Station, TX 77843
N68073 (MAJ00063)—NTU
Naval Computer and Telecommunications Station Diego Garcia, (British Indian Ocean Territory), FPO AP 96464–0008
N68084 (MAJ00081)—MDJ–M
Commanding Officer (Code 206), Naval Hospital, Charleston, SC 29408–6900
N68086—7S
Naval Hospital, Newport, RI 02841
N68088 (MAJ00061)—NLL–N
National Support Unit Headquarters, Commander-in-Chief Iberian Atlantic Area, (Lisbon, Portugal), APO AE 09726–0001
N68090 (MAJ00018)—MD0–9
Naval Hospital, Long Beach, CA 90822–5199.
N68092
Naval Medical Command Northeast Region, Great Lakes, IL 60088
N68093 (MAJ00018)—MCG–H
Naval Hospital, Camp LeJeune, NC 28542–5008
N68094—V9
Naval Hospital, Camp Pendleton, CA 92055–5008
N68095—JF
Naval Hospital, Boone Road, Bremerton, WA 98312–1898
N68096 (MAJ00018)—J50
Commanding Officer, Naval Hospital (Guam), FPO AP 96540–1600
N68097
Naval Medical Command Northwest Region, Oakland, Ca 94627
N68098 (MAJ00018)—QAL–M
Naval Medical Clinic, Box 121 Code 01.3, Pearl Harbor, HI 96860–5080
N68101 (MAJ00018)—MDT–V
Naval Medical Clinic 17th Street and Pattison Avenue, Philadelphia, PA 19145–5199
N68139 (MAJ00062)—8AZ
Commanding Officer, Naval Reserve Officers Training Corps Unit, Florida A&M University, Tallahassee, FL 32307
N68141 (MAJ00062)—L9P—
Commanding Officer, Naval Reserve Officers Training Corps Unit, Maine Maritime Academy, Castine, ME 04421–0902
N68142—NK
Naval Computer & Telecommunications Station, Naval Air Station, Pensacola, FL 32508–6100
N68165 (MAJ00060)—J06–8
Naval Facility, (Brawdy, Wales, UK), FPO AE 09420
N68166 (MAJ00015)—L01–2k
Naval Technical Intelligence Center, 4301 Suitland Road, Washington, DC 20390
N68171—M3
Commanding Officer, Naval Regional Contracting Center, (Naples, Italy), PSC 810, Box 50, FPO AE 09619–3700
N68175 (MAJ00022)—MQA
Navy Recruiting District New Jersey, Parkway Towers, Building A, 485 US Route 1, So., Iselin, NJ 08830–3012
N68199
Commanding Officer, Navy Office of Information, Southeast, 1459 Peachtree Street, NE—Suite 300, Atlanta, GA 30309
N68200—VM
Dirctor, Navy Office of Information, Southwest, 1114 Commerce Street, Suite 811, Dallas, TX 75242
N68221—7J
Commanding Officer, Navy Personnel Research and Development Center, San Diego, CA 92152
N68246 (MAJ00070)—4LL–N
Officer in Charge, U.S. Naval Supply Depot Yokosuka Det., (Sasebo, Japan), FPO AP 96322–1500
N68248—V6
Officer in Charge of Construction, Naval Facilities Engineering Command Contracts, Naval Submarine Base, Kings Bay, GA 31547
R68251 (MAJ00070)—LPC
Shore Intermediate Maintenance Activity, Box 141, Pearl Harbor, HI 96860
N68292 (MAJ00018)—J5A
Naval Hospital (Yokosuka, Japan), FPO AP 96350–1615
N68297—ET
Naval Magazine, Laualualie, Oahu HI 96792–4301
N68303 (MAJ00062)—R0C
Commanding Officer, Naval Reserve Officers Training Corps Unit, State University of New York, Maritime College, Fort Schuyler, Bronx, NY 10465–4198
N68306 (MAJ00072)—9TF
Commander, Naval Reserve Readiness Command, Region Six, WNY Bldg 200, Washington, DC 203774–2003
N68307 (MAJ00072)—LCJ
Commander, Code 431, Naval Reserve Readiness Command Region Ten, New Orleans, LA 70142
N68308 (MAJ00072)—9TQ
Naval Reserve Readiness Command, Region 20, Bldg 1, NAVSTA Treasure Island, San Francisco, CA 94130–5032
N68311—JL
Naval Station, Long Beach, CA 90822
N68322—7Z
Naval Education & Training Program Management Support Activity, Code SU1, Saufley Field, Pensacola, FL 32509
N68323 (MAJ00011)—LBC
Naval Legal Service Office, 200 Stovall Street, Alexandria, VA 22332–2400
N68327 (MAJ00022)—ML8
Commanding Officer, Naval Reserve Personnel Center, New Orleans, LA 70149–7800
N68328 (MAJ00072)—9TJ
Naval Reserve Readiness Command, Region 22, Bldg 9, Naval Station, Seattle, WA 98115–5009
N68329 (MAJ00072)—LCL
Naval Reserve Readiness Command, Region Five, Bldg. 1033, USAAP, Ravenna, OH 44266–9211
N68330 (MAJ00072)—9TN
Naval Reserve Readiness Command, Region 13, Bldg 1, Code 712, NTC, Great Lakes, IL 60088–5026
N68331 (MAJ00072)—LCE–F
Naval Reserve Readiness Command, Region Four, Bldg. 662, Naval Base, Philadelphia, PA 19112
N68332 (MAJ00072)—9T0–1
Commander, Naval Reserve Readiness Command, Region 18, 301 Navy Drive, Industrial Airport, KS 66031–0031
N68335–4Y
Commanding Officer, Naval Air Warfare Center, Aircraft Division Lakehurst,

Supply Dept., Purchase Division, Lakehurst, NJ 08733
N68348 (MAJ00072)—9TG
Commander, Naval Reserve Readiness Command, Region Nine, NAS Memphis (76), Bldg E–35, Millington, TN 38054
N68349
Commander, Naval Reserve Readiness Command, Region 16, Bldg. 715, Minneapolis-St. Paul IAP, Minneapolis, MN 55450–2996
N68350 (MAJ00072)—LCH
Naval Reserve Readiness Command, Region 19, 960 North Harbor Drive, San Diego, CA 92132–5108
N68351 (MAJ00072)—LCQ
Naval Reserve Readiness Command, Region One, Newport, RI 02840–5016
N68355 (MAJ00062)—R0J
Commanding Officer, Naval Reserve Officers Training Corps Unit, Virginia Military Institute, Lexington, VA 24450–2697
N68356 (MAJ00072)—9TD
Commander, Naval Reserve Readiness Command, Region Seven, Naval Base, Charleston, SC 29408
N68357 (MAJ00072)—9TL
Commander, Naval Reserve Readiness Command, Region Two, Scotia, NY 12302–9465
N68358 (MAJ00072)—9TA
Commander, Naval Reserve Readiness Command, Region Eight, Naval Air Station, Jacksonville, FL 32212
N68359 (MAJ00072)—9TB
Commander, Naval Reserve Readiness Command, Region Eleven, Bldg 11, Naval Air Station, Dallas, TX 75211
N68378—KQ
Navy Public Works Center, San Francisco Bay, Oakland, CA 94623
N68391 (MAJ00022)—MLB
Navy Recruiting District, Harrisburg, 310 North Second Street, Harrisburg, PA 17101–1304
N68401 (MAJ00022)—MLJ
Navy Recruiting District, San Diego, Naval Training Center, Building 335, San Diego, CA 92133–6800
N68402 (MAJ00012)—V8E
Navy Office of Information, New England Branch, 408 Atlantic Avenue, Boston, MA 02210–2203
N68409 (MAJ00018)—QAU
Naval Dental Center, San Francisco, CA 94130–5030
N68436—KC, J6
Naval Submarine Base, Bangor, Code 863, Bremerton, WA 98315
N68441
Commanding Officer, Naval Dental Clinic, Naval Air Station, Pensacola, FL 32508
N68443—7T
Commanding Officer, Naval Dental Clinic, Bremerton, WA 98314
N68451—MF
Navy Regional Data Automation Center San Francisco, Naval Air Station, Alamenda, CA 94501
N68470 (MAJ00018)—J5J–M
Naval Hospital, (Okinawa, Japan), FPO AP 96362
N68497
Commanding Officer, Code 40, Naval Administrative Command, Naval Training Station, Orlando, FL 32813
N68499—LX
Director, Naval Council of Personnel Boards, Ballston Center Tower #2, 801 North Randolph Street, Arlington, VA 2203–1989
N68518
Commanding Officer, Naval Reserve Financial Information Processing Center, Code S43, 4400 Dauphine Street, New Orleans, LA 70146
N68520—7P
Aviation Depot Operations Center, Naval Air Station, Patuxent River, MD 20670
N68527 (MAJ00072)—9TT
Naval & MC Reserve Readiness Center, Armed Forces Reserve Center, Floyd Bennett Field, Brooklyn, NY 11234–7097
N68546—QG
Navy Environmental Health Center, Naval Station, Norfolk, VA 23511
N68547 (MAJ00060)—LHQ
Personnel Support Activity, Naval Station, Norfolk, VA 23511–5115
N68560—QM
Naval Computer & Telecommunications Station, Jacksonville, FL 32212–0111
N68561 (MAJ00039)—NSE
Navy Management Systems Support Office, 1441 Crossways Blvd., Chesapeake, VA 23320–2843
N68593 (MAJ00060)—LHE
Naval Ocean Processing Facility, Dam Neck, VA 23461–5450
N68608 (MAJ00011)—LBP–Y
Naval Computer Telecommunications Station, 4400 Dauphine Street, New Orleans, LA 70145–7700
N68610—GF
Officer in Charge, Fleet Hospital Support Office, 620 Central Ave., Bldg #5, Alameda, CA 94501–3874
N68636 (MAJ00024)—EHJ–K
Naval Sea Systems Command, Automated Data Systems Activity, P.O. Box 100, Indian Head, MD 20640–0100
N68689 (MAJ00024)—U0F
Human Resources Office, Crystal City, Washington, DC 20376
N68691—JW
Naval Plant Representative Office, (Melbourne, Australia), APO AP 96551
N68692 (MAJ00062)—8AX
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of San Diego/San Diego State University, Alcala Park, San Diego, CA 92110–2496
N68695 (MAJ00060)—LHG
Shore Intermediate Maintenance Activity, Naval Reserve Maintenance Facility, Bldg. 133, Naval Base, Philadelphia, PA 19112–5066
N68699 (MAJ00062)—8AP
Commanding Officer, Naval Reserve Officers Training Corps Unit, Old Dominion University/Hampton Institute, Norfolk State University, 5215 Hampton Blvd., Norfolk, VA 23508–8556
N68707 (MAJ00072)—9TU
Naval Reserve Maintenance Training Facility, Puget Sound Naval Shipyard, Bremerton, WA 98314–5270
N68709 (MAJ00060)—J0C
Naval Air Station, Mayport, FL 32228
N68710 (MAJ00062)—L9K
Commanding Officer, Naval Reserve Officers Training Corps Unit, Virginia Polytechnic Institute and State University, Blacksburg, VA 24061–2306
N68717 (MAJ00062)—L9L
Commanding Officer, Naval Reserve Officers Training Corps Unit, Boston University, 116 Bay State Road, Boston, MA 02215
N68725 (MAJ00062)—R0Q
Commanding Officer, Naval Reserve Officers Training Corps Unit, University of Arizona, Tucson, AZ 85721
N68726 (MAJ00062)—R0T
Commanding Officer, Naval Reserve Officers Training Corps Unit, The George Washington University, Washington, DC 20052
N68727 (MAJ00062)—8AF
Commanding Officer, Naval Reserve Officers Training Corps Unit, Memphis State University, Memphis, TN 38152–0001
N68728 (MAJ00062)—8AQ
Commanding Officer, Naval Reserve Officers Training Corps Unit, Norwich University, Northfield, VT 05663–1097
N68733 (MAJ00030)—EKC
Strategic Weapons Facility, Atlantic, Kings Bay, GA 31547–6600
N68742 (MAJ00070)—LPA
Naval Base, Seattle, WA 98115–5012
N68753 (MAJ00070)—V5L
Naval Air Pacific Repair Activity Det., Singapore, SAE Singapore, FPO AP 96536–2700
N68829 (MAJ00060)—J0J
Shore Intermediate Maintenance Activity (NRMF), Pier 2, Bldg. 68 NETC, Newport RI 02841–5001
N68831 (MAJ00070)—LPG
Shore Intermediate Maintenance Activity San Francisco, Bldg. 162, NAS, Alameda, CA 94501–5065
N68836—J9
Commanding Officer, Naval Supply Center, Jacksonville, FL 32212
N68857 (MAJ00062)—8AC
Commanding Officer, Naval Reserve Officers Training Corps Unit, Texas Tech University, Lubbock, TX 79409–4559
N68860—KR
Naval Supply Center—Pensacola, Pensacola, FL 32508–6200
N68875 (MAJ00018)—QAP–S
Naval Hospital (Keflavik, Iceland), PSC 1003, Box 8, FPO AE 09728–0308
N68877 (MAJ00062)—R0Y
Commanding Officer, Naval Reserve Officers Training Corps Unit, Carnegie Mellon University, Pittsburgh, PA 15213
N68881 (MAJ00062)—L9E
Commanding Officer, Naval Reserve Officers Training Corps Unit, Morehouse College, Atlanta, GA 30314
N68891 (MAJ00060)—LH5
Naval Station, Ingleside, TX 78362–5000
N68899 (MAJ00072)—LCW
Naval Reserve Intelligence Command, Bldg. 11, Naval Air Station, Dallas, TX 75211–9541
N68925—8J
Navy Public Works Center, Building 175, Washington Navy Yard, 901 M Street, SE, Washington, DC 20374–5041
N68944—4F, 4W, EW, 3E, KU, 3B

Naval Command, Control and Ocean Surveillance Center, ISE West Coast Division (NISE West), San Diego, CA 92186–5137
N70092, (MAJ00069)—8QJ–K, Q–R
Naval Security Station, 3801 Nebraska Avenue, NW, Washington, DC 20390–8230
N70240—M6
Commanding Officer, Naval Computer and Telecommunications Station, Naval Air Station, 937 N. Harbor Drive, San Diego, CA 92132
N70272—8G, ND, LQ
Naval Computer and Telecommunications Area, Master Station Atlantic, Norfolk, VA 23511–6898
N70273—V3
Naval Radio Station, Jim Creek, Oso, WA 98223
N70278—V4
Naval Computer and Telecommunications Station, (Yokosuka, Japan), Box 3, FPO AP 96349
N70283 (MAJ00069)—8QE
Commanding Officer, Code 30, Naval Security Group Activity, (Galeta Island, Canal Zone), FPO AA 34060–9998
N70294—8H
U.S. Naval Computer and Telecommunications Area, Master Station MED, (Naples, Italy), FPO AE 09620
N70310—N2
Naval Radio Station R, Sugar Grove, WV 26815.

PART 4—MARINE CORPS ACTIVITY ADDRESS NUMBERS

M00027—MS*, MU*, MS0–9
Headquarters, U.S. Marine Corps, Washington, DC 20380
M00146—MT
Marine Corps Air Station, Cherry Point, NC 28533
M00243—NE
Marine Corps Recruit Depot, San Diego, CA 92140
M00263—MX
Marine Corps Recruit Depot, Parris Island, SC 29905
M00264 (MAJ00027)—MUT
Marine Corps Combat Development Command, Marine Corps Air Facility, Quantico, VA 22134–5001
M00318
Marine Corps Air Station, Kaneohe Bay, Oahu, HI 96744
M00681—NG
Marine Corps Base, Camp Pendleton, Oceanside, CA 92054
M60050—MV
Marine Corps Air Station, El Toro, Santa Ana, CA 92709
M62204—MW
Marine Corps Logistics Base, Barstow, CA 92311
M62974—NA
Marine Corps Air Station, Yuma, AZ 85364
M67001—NB
Marine Corps Base, Camp Lejeune, NC 28542
M67004—NC
Marine Corps Logistics Base, Albany, GA 31704
M67011 (MAJ00027)—MSA
Director, 1st Marine Corps District, Garden City, Long Island, NY 11530
M67013 (MAJ00027)—MSC
Director, 4th Marine Corps District, Philadelphia, PA 19112–5072
M67015 (MAJ00027)—MSE
Director, 6th Marine Corps District, Atlanta, GA 30303
M67016 (MAJ00027)—MSG
Director, 8th Marine Corps District, New Orleans, LA 70113
M67017 (MAJ00027)—MSJ
Director, 9th Marine Corps District, Shawnee Mission, KA 66204
M67019 (MAJ00027)—MSL
Director, 12th Marine Corps District, San Francisco, CA 94130
M67021 (MAJ00027)—MUC
Marine Aircraft Wing 4, New Orleans, 4400 Dauphine Street, New Orleans, LA 70146–9125
M67025
Headquarters, Fleet Marine Force, Pacific, Pearl Harbor, HI 96860
M67029 (MAJ00027)—MSN
Marine Barracks, Washington, DC 20003
M67030 (MAJ00027)—MUP
Marine Corps Security Force Battalion Pacific NAVSTA Mare Island Vallejo, CA 94592–5022
M67290 (MAJ00027)—MSY
Marine Aviation Training Support Group-90, NATTC, NAS Memphis, Millington, TN 38054–5123
M67351
Marine Corps Security Force Company (London, UK) APO AE 09499
M67353 (MAJ00027)—MSQ
Headquarters Battalion, Marine Corps, Henderson Hall, Arlington, VA 22214
M67354
Post Supply Officer, Headquarters Marine Corps, Navy Annex, Arlington, VA 20380
M67355 (MAJ00027)—MUN
Landing Force Training Command Atlantic Naval Surface Force, U.S. Atlantic Fleet, Naval Amphibious Base, Little Creek, Norfolk, VA 23521–2350
M67385 (MAJ00027)—MU0–1
Camp H.M. Smith, U.S. Marine Corps, Halawa Heights, Oahu, Hawaii 96861
M67391—KY
Marine Corps Camp Det. (Camp Elmore), Norfolk, VA 23511
M67399—NF
Marine Corps Air-Ground Combat Center, Twentynine Palms, CA 92278
M67400—QJ
Marine Corps Procurement Office, Okinawa, Marine Corps Base, Camp Smedley D. Butler (Ryuku Island, Southern), FPO AP 96373
M67428—JA
Marine Corps Air Bases Western Area, MCAS El Toro, Santa Ana, CA 92709
M67443—LG
Defense Finance and Accounting Service, Kansas City Center, Kansas City, MO 64197
M67840 (MAJ00027)—MUV
USMC, Marine Corps Detachment, 1420 Hughes Avenue, Lackland Training Center, Lackland AF Base, TX 78236–5411
M67842—K6
East Coast Commissary Complex, Marine Corps Base, Camp LeJeune, NC 28542
M67853 (MAJ00027)—MUR
Marine Corps Security Force Battalion Atlantic, Naval Base, Norfolk, VA 23511–5697
M67854 (MAJ00027)—MU6–9
Marine Corps Research, Development and Acquisition Command, Washington, DC
M68479 (MAJ00027)—MSU
4th Marine Division (Rein), FMF, USMCR, 4400, Dauphine Street, New Orleans, LA 70146–5400
M68522 (MAJ00027)—MSW
Marine Corps Reserve Support Center, Purchasing Department, 16950 El Monte Overland Park, KS 66211–1408

PART 5—AIR FORCE ACTIVITY ADDRESS NUMBERS

F01600—5A
3800 LS/LGC, Maxwell AFB, AL 36112–5320
F01620—6K
SSC/PK Gunter AFS, AL 36114–6343
F02600—5B
82 SG/LGC, Williams AFB, AZ 85240–5004
F02601—5C
355 CONS/CC, Davis-Monthan AFB, AZ 85707–5320
F02604—5D
58 CONS/CC, Luke AFB, AZ 85309–5320
F03601—5E
97 LOGSS/LGLC, Eaker AFB, AR 72317–5320
F03602—5F
314 CONS/LGC, Little Rock AFB, AR 72076–5320
F04604—5G
93 CONS/LGC, Castle AFB, CA 95342–5320
F04605—5H
22 CONS/LGC, March AFB, CA 92518–5320
F04606—SM
SM-ALC/PK, Directorate of Contracting, Sacramento Air Logistics Center, McClellan AFB, CA 95652–5320
F04607—5J
63 MAW/LGC, Norton AFB, CA 92409–5320
F04609—5K
35 FW/LGC, George AFB, CA 92394–5320
F04611—QQ
AFFTC/PK, Edwards AFB, CA 93523–5320
F04612—5L
323 LG/LGC, Mather AFB CA 95655–5320
F04626—5M
60 MAW/LGC, Travis AFB, CA 94535–5320
F04666—5N
9 CONS/LGC, Beale AFB, CA 95903–5320
F04684—QW
4392 AEROSW/LGC, Vandenberg AFB, CA 93437–5320
F04689—RN
2nd Satellite Tracking Group/LKD, Onizuka Air Force Base, P.O. Box 3430, Sunnyvale, CA 94088–3430
F04690
CSTC/PM, P.O. Box 3430, Sunnyvale, CA 94088–3430
F04693—MG

SSD/PMB, Base Contracts, P.O. Box 92960, Worldway Postal Center, Los Angeles, CA 90009–9260
F04699—Q5
SM–ALC/PKO, Operational Contracting, McClellan AFB, CA 95652–5320
F04700—Q2
AFFTC/PKO Operational Contracting Edwards AFB, CA 93523–5000
F04701—TB
SSD/PK, Space Systems Division, P.O. Box 92960, Worldway Postal Center, Los Angeles, CA 90009–9260
F04702
1352 AVS/PK, Norton AFB, CA 92409–5996
F04703—R8
30 SW/PK, Vandenberg AFB, CA 93437–6021
F04704—R9
BMO/PK, Ballistic Missile Organization, Norton AFB, CA 92409–6463
F04709—S5
Det 42, SM–ALC Norton AFB, CA 92409–6447
F05600—5P
3415 CONSL/LGC, Lowry AFB, CO 80230–5320
F05603
HQ Air Force Space Command/PKD, Director of Systems Contracting, Stop 7, Peterson AFB, CO 80914–5001
F05604—SX
3d Space Support Wing/PKB, Stop 20, Peterson AFB, CO 80914–5000
F05611—5Q
USAFA/LGC, USAF Academy, CO 80840–0189
F07603—5R
436 AW/LGC, Dover AFB, DE 19902–5320
F08602—5S
56 CONS/CC, MacDill AFB, FL 33608–5320
F08606—RG
45SW/PK, Patrick AFB, FL 32925–5472
F08620—5T
1SOW/SGC, Hurlburt Field, FL 32544–5320
F08621—5U
31 CONS/CC, Homestead AFB, FL 33039–5320
F08626—QU
ASD–OL/PK, Aeronautical Systems Division, Eglin AFB, FL 32542–5000
F08630—S1
WL/MNK, Eglin AFB, FL 32542–5000
F08635—RH
AFDTC/PK, Air Force Development Test Center, Eglin AFB, FL 32542–5000
F08637—5V
325 CONS/CC, Tyndall AFB, FL 32403–5320
F08650—TJ
ESMC/PMK, Base Contracts, Patrick AFB, FL 32925–5472
F08651—Q3
AFDTC/PKO, Operational Contracting, Eglin AFB, FL 32542–5320
F09603—RJ, RR
WR–ALC/PK, Warner Robins Air Logistics Center, Robins AFB, GA 31098–5320
F09604—RU
Det 8, 2762 Logistics Sq Special (AFMC), Robins AFB, GA 31098
F09607—5W
347 CONS/CC, Moody AFB, GA 31699–5320
F09609—5X
94 CSG/LGC, Dobbins AFB, GA 30069–5320
F09634—5Y
HQ AFRES/LGC Robins AFB, GA 31098–6001
F09650—Q6
WR–ALC/PKO, Operational Contracting, Robins AFB, GA 31098–5320
F10603—5Z
366 CONS/CC, Mountain Home AFB, ID 83648–5320
F11602—6A
3345 LG/LGC, Chanute AFB, IL 61868–5320
F11603—6B
928 TAG/LGC, Chicago O'Hare ARFF, IL 60666–5000
F11623—6C
375 AAW/LGC, Scott AFB, IL 6225–5320
F11624—X4
CSPO/PGZ, Scott AFB, IL 62225–6001
F11626—RL
HQ AMC/XOK, Scott AFB, IL 62225–5001
F12617—6D
305 CONS/LGC, Grissom AFB, IN 46971–5320
F14614—6E
384 CONS/LGC, McConnell AFB, KS 67221–5320
F16600—6F
23 FW/LGC, England AFB, LA 71311–5320
F16602—6G
2 CONS/LGC, Barksdale AFB, LA 71110–5320
F17600—6H
42 CONS/LGC, Loring AFB, ME 0475–5320
F17608
101 AREFW/LGC, Bangor International Airport, ME 04401–5320
F19617—R5
439 CSG/LGC, Westover AFB MA 01022–5320
F19628—RS
ESD/PK, Electronic Systems Division, Hanscom AFB, MA 01731–5000
F19630—RV
AFCAC/PK, Hanscom AFB, MA 01731–6340
F19650—SH
ESD/PKO, Operational Contracting, Hanscom AFB, MA 01731–5320
F20603—6J
379 LOGSS/LGLC, Wurtsmith AFB, MI 48753–5320
F20613—6L
410 CONS/LGC, K.I. Sawyer AFB, MI 49843–5320
F21611—6N
934 CSS/LGC, Minneapolis-St. Paul IAP, MN 55450–5000
F22600—RC
3380 CONS/LGC, Keesler AFB, MS 39534–5000
F22608—6Q
14 CONS/LGC, Columbus AFB, MS 39701–5000
F23606—6R
351 CONS/LGC, Whiteman AFB, MO 65305–5320
F23608—6S
442 CSG/LGC, Richards-Gebaur AFB, MO 64030–5000
F24604—6T
301 CONS/LGC, Malmstrom AFB, MT 59402–5320
F25600—6U
55 CONS/LGC, Offutt AFB, NE 68113–5320
F25606—TD
3908 CONS/LGC, Offutt AFB, NE 68113–5000
F26600—S4
554 CONS/CC, Nellis AFB, NV 89191–5320
F26606—6M
37 FW/LGC, Nellis AFB, NV 89191–5320
F28609—6V
438 MAW/LGC, McGuire AFB, NJ 08641–5320
F28620—SN
OL–A, 1605 MASW/LGC, McGuire AFB, NJ 08641–5000
F29601—RW
PL/PK, Phillips Laboratory, Kirtland AFB, NM 87117–5320
F29605—6W
27 CONS/CC, Cannon AFB, NM 88103–5320
F29650—R3
PL/PKO, Operational Contracting, Phillips Laboratory, Kirtland AFB, NM 87117–5320
F29651—6X
49 CONS/CC, Holloman AFB, NM 88330–5320
F30602—RX
RL/PK, Rome Lab, Griffiss AFB, NY 13441–5700
F30617—6Y
914 TAG/LGC, Niagara Falls IAP, NY 14304–5320
F30635—S3
416 CONS/LGC, Griffiss AFB, NY 13441–5320
F30636—6Z
380 CONS/LGC, Plattsburgh AFB, NY 12903–5320
F31601—BU
317 CONS, Pope AFB, NC 28308–5320
F31610—BW
4 CONS/CC, Seymour Johnson AFB, NC 27531–5320
F32604—BX
5 CONS/LGC, Minot AFB, ND 58705–5320
F32605—BY
319 CONS/LGC, Grand Forks, AFB, ND 58205–5320
F33600—RZ
WPCC/PKR, PKS, PKT & PKY, Wright-Patterson AFB, OH 45433–5320
F33601—Q7
WPCC/PKO, Operational Contracting, Wright-Patterson AFB, OH 45433–5320
F33615—SG
WL/PK, Wright Laboratory, Wright-Patterson AFB, OH 45433–6503
F33630—C1
910 TAG/LGC, Youngstown MAP, OH 44473–0910
F33657—SC
ASD/PK, Aeronautical Systems Division, Wright-Patterson AFB, OH 45433–6503
F33659—Q8
AGMC/PK, Directorate of Contracting, Newark AFS, OH 43055–5320
F33660—TA
AGMC/PKO, Operational Contracting, Newark AFB, OH 43057–5320
F33733—J8
WL/MTD, Wright-Patterson AFB, OH 45433–6503
F34600—C2

71 FTW/CVC, Vance AFB, OK 73705–5000
F34601—SD
OC–ALC/PK, Directorate of Contracting, Oklahoma City Air Logistics Center, Tinker AFB, OK 73145–5320
F34608—TF
HQ CSC/PK, Tinker AFB, OK 73145–6343
F34612—C3
443 CON SQ/LGC, Altus AFB, OK 73523–5320
F34650—Q9
OC–ALC–PKO, Operational Contracting, Tinker AFB, OK 73145–5320
F35610—C4
114 TFTS/LGC, Kingsley Field, Klamath Falls, OR 97601
F36629—C7
911 TAG/LGC, Greater Pittsburgh IAP, PA 15231–5320
F36700—C8
913 TAG/LGC, Willow Grove ARF, PA 19090–5130
F38601—C9
363 CONS/CC, Shaw AFB, SC 29152–5320
F38604—T3
HA USCENTAF/LGC, Shaw AFB, SC 29152–5002
F38606—CA
354 FW/LGG, Myrtle Beach AFB, SC 29579–5320
F38610—CR
437 MAW/LGC, Charleston AFB, SC 29404–5320
F39601—CT
28 CONS/LGC, Ellsworth AFB, SD 57706–5320
F40600—Q4
AEDC/PK, Arnold Engineering Development Center, Arnold AFB, TN 37389–5000
F40650—D1
AEDC/PKO, Operational Contracting, Arnold AFB, TN 37389–5000
F41608—SA
SA–ALC/PK, Directorate of Contracting, San Antonio Air Logistics Center, Kelly AFB, TX 78241–5320
F41612—D4
3750 CONS/LGC Sheppard AFB, TX 76311–5000
F41613—D5
7 LOGSS/LGLC Carswell AFB, TX 76127–5320
F41614—E2
3499 CONS/LGC Goodfellow AFB, TX 76908–5000
F41620—E3
64 CONS/LGC Reese AFB, TX 79489–5000
F41621—SJ
HQ AFIC/LEC San Antonio, TX 78243–5000
F41622—QY
HSD/PKO Operational Contracting Brooks AFB, TX 78235–5320
F41624—RQ
HSD/PK Brooks AFB, TX 78235–5320
F41636—ZV
3700 CONS/CC Lackland AFB, TX 78236–5000
F41640
HQ AFCOMS/DOC Kelly AFB, TX 78241–6290
F41650—YA
SA–ALC/PKO, Operational Contracting, Kelly AFB, TX 78241–5320
F41652—E5
96 CONS/LGC, Dyess AFB, TX 79607–5320
F41685—E6
47 CONS Laughlin AFB, TX 78840–5000
F41687—E9
67 RW/LGC Bergstrom AFB, TX 78743–5320
F41689—SK
3303 CONS/CC Randolph AFB, TX 78150–5001
F41691—Y0
12 CONS/LGC Randolph AFB, TX 78150–5000
F41999
AFNAF Purchasing Office HQ AFMPC/DPMSK 9504 IH 35 North, Rm 330 San Antonio, TX 78233
F42600—QP, SY
OO–ALC/PK Directorate of Contracting Ogden Air Logistics Center Hill AFB, UT 84056–5320
F42610—TE
OO–ALC/PK ICBM Directorate Contracting Ogden Air Logistics Center Hill AFB, UT 84056–5320
F42620—TG
OO–ALC/PK Aircraft Directorate Contracting Ogden Air Logistics Center Hill AFB, UT 84056–5320
F42630—XP
OO–ALC/PK, Commodities Directorate Contracting, Ogden Air Logistics Center, Hill AFB, UT 84056–5320
F42650—R2
OO–ALC/PKO, Operational Contracting, Hill AFB, UT 84056–5320
F44600—F3
1 CONS/CC Langley AFB, VA 23665–5320
F44650—Q1
4400 CONS/LGCN Langley AFB, VA 23665–5000
F45603—F5
62 CONS McChord AFB, WA 98438–5320
F45613—F8
92 CONS/LGC Fairchild AFB, WA 99011–5320
F47606—G7
440 TAW/LGC Gen. Billy Mitchell Field 00 College Ave. Milwaukee, WI 53207–5000
F48608—G9
90 CONS/LGC F.E. Warren AFB, WY 82001–5320
F49620—
AFOSR/PK Bolling AFB, DC 20332–6448
F49642—J1
1100 CNS/CN (AFDW) Operational Contracting Andrews AFB, DC 20331–5320
F49650—X0
1100 CNS/SP (AFDW) Specialized Contracting Andrews AFB, DC 20331–5320
F61040—M1
1605 MASW/LGC, APO AE 09720–5320
F61051
USDAO, American Embassy—Brussels, APO AE 09724
F61060
USDAO, American Embassy—Sofia APO AE 09242
F61080
USDAO, American Consulate General—Prague APO AE 09242
F61100
USDAO, American Embassy—Copenhagen APO AE 09716
F61101—T1
Det 1, Space Combat Operations Staff/LGC APO AE 09716–5000
F61130
USDAO, American Embassy—Helsinki APO AE 09723
F61171
USDAO, American Embassy—Athens APO AE 09840
F61180
USDAO, American Consulate General—Budapest APO AE 09242
F61210
USDAO, American Embassy—Rome APO AE 09624
F61211—N9
401 FW/LGC APO AE 09601–5320
F61214—U9
7275 ABG/LGC APO AE 09605–5320
F61230—XV
OL–PM WR–ALC/PKE, Blg 519, APO AE 09094–5000
F61260
USDAO, American Embassy—The Hague, APO AE 09715
F61270
USDAO, American Embassy—Oslo, APO AE 09707
F61271—T8
USAFE Contracting Office OL–D Det 4, 7000 CONS/LGC, APO AE 09707–5320
F61280
USDAO, American Consulate General—Belgrade, APO AE 09242
F61290
USDAO, American Embassy—Lisbon, APO AE 09726
F61301
USDAO, American Embassy—Bucharest, APO AE 09242
F61308—W3
USAFE Contracting Region—Spain, OL–B Det 5, 7000 CONS/LGC APO AE 09643–5320
F61310
USDAO, American Embassy—Madrid, APO AE 09285
F61354—W8
7241 ABG/LGC, APO AE 09821–5320
F61355—T4
7217 ABG/LGC, APO AE 09822
F61358—W9
39 TACG/LGC, APO AE 09824–5320
F61503—UC
435 TAW/LGC, APO AE 09097–5320
F61504—T6
7350 ABG/LGC, APO AE 09187–5320
F61517—UF
USAFE Contracting Region—Eifel, Det 3, 7000 CONS/LGC, APO AE 09132–5320
F61521—UH
USAFE Contracting Office, Det 2, 7000 CONS/LGC, APO AE 09094–5320
F61546—UJ
USAFE Contracting Center, OL A, Det 2/7000 CONS/LG, APO AE 09196–5320
F61708—UK
USAFE Contracting Region—Thames Valley OL–E Det 4, 7000 CONS/LGC APO AE 09466–5320
F61712—UM
USAFE Contracting Office, OL–B Det 4, 7000 CONS/LGC, APO AE 09405–5320
F61730—UQ
USAFE Contracting Office,—OL–C Det 4, 7000 CONS/LGC, APO AE 09470–5320
F61775—UV

USAFE Contracting Region—UK North, Det 4, 7000 CONS/LGC, APO AE 09461–5320
F61815—T7
32 FG/LGC, APO AE 09719–5320
F61817—UW
USAFE Contracting Office, OL–A Det 5, 7000 CONS/LGC, APO AE 09646–5320
F61910—WJ
USAFE Contracting Office, OL–A Det 3, 7000 CONS/LGC, APO AE 09122–5320
F62032—4D
HQ USMTM/SAS–LGC, APO AE 09803–1300
F62321—RA
18 CONS/LGC, APO AE 96368–5320
F62509—QZ
432 CONS/LGC, APO AE 96319–5320
F62562—SW
475 CONS/LGC, APO AE 96328–5320
F62600
5 DSCS/LGC, APO SF 96287–5000
F63197—UX
7276 ABG/LGC, APO AE 09846–5320
F64133—S9
633 CONS/LGC, APO AP 96542–5320
F64605—TN
15 CONS/LGC, Hickam AFB, HI 96853–5320
F64620—SZ
HQ PACAF/LGC, Hickam AFB, HI 96853–5001
F64719—TK
13 AF/OLAB, FPO AP 96534
F65501—WF
3 CONS/LGC, Elmendorf AFB, AK 99506–5001
F65503—WH
343 CONS/LGC, Eielson AFB, AK 99702–5320
F66501—R7
24 CONS/LGC, APO AA 34001–5320

PART 6—DEFENSE LOGISTICS AGENCY ACTIVITY ADDRESS NUMBERS

DLAH00—YK
Defense Logistics Agency, ADP/Telecommunications Contracting Office, Cameron Station, Alexandria, VA 22304–6100
DLA003—TT
Defense Depot Ogden, Ogden, UT 84407–5000
DLA004—WX
Defense Distribution Region East (DDRE), Office of Contracting, New Cumberland, PA 17070–5001
DLA005—TV
Defense Distribution Region West (DDRW), Office of Contracting, Bldg S–4, Lathrop, CA 95330–5000
DLA006—UN
Defense Distribution Region Central, Office of Contracting, ATTN: DDRC–P, Memphis, TN 38114–5210
DLA100—TW
Defense Personnel Support Center, Directorate of Clothing & Textiles, 2800 South 20th Street, Philadelphia, PA 19101–8419
DLA120—TX
Defense Personnel Support Center, Directorate of Medical Materiel, 2800 South 20th Street, Philadelphia, PA 19101–8419
DLA13H—UE
Defense Personnel Support Center, Directorate of Subsistence, 2800 South 20th Street, Philadelphia, PA 19101–8419
DLA132
Defense Subsistence Office, Kansas City, 601 E. 12th Street, Room 1768, Kansas City, MO 64106–2895
DLA136—W5
Defense Subsistence Office, Cheatham, Cheatham Annex, Bldg 113, Williamsburg, VA 23185–0001
DLA137—W6
Defense Subsistence Region, Pacific, 2155 Mariner Square Loop, Alameda, CA 94501–1022
DLA139—U6
Defense Subsistence Region, Europe, APO New York, NY 09052
DLA140—W7
Defense Personnel Support Center, (Installation Support), 2800 South 20th Street, Philadelphia, PA 19101–8419
DLA200—X1
Defense Reutilization and Marketing Service, Federal Center—Hazardous System, Battle Creek, MI 49017–3092
DLA210—X1
Defense Reutilization and Marketing Service, Federal Center—Supply System, Battle Creek, MI 49017–3092
DLA300—VS
Defense National Stockpile Center, 1745 Jefferson Davis Hwy, Suite 100, Arlington, VA 22202–5000
DLA301—VT
Defense National Stockpile Center, Zone 1 Management Office, Room 19–116, 26 Federal Plaza, New York, NY 10278–5000
DLA302—VU
Defense National Stockpile Center, Zone 2 Management Office, 3200 Sheffield Avenue, Hammond, IN 46327–5000
DLA303—VY
Defense National Stockpike Center, Zone 3 Management Office, 819 Taylor Street, Fort Worth, TX 76102–5000
DLA400—TY
Defense General Supply Center, 8000 Jefferson Davis Highway, Richmond, VA 23297–5000
DLA410—XH
Defense General Supply Center, Contracts Division III, Special Acquisition and Base Support Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5312
DLA411—TY
Defense General Supply Center, Contracts Division III, Emergency Supply Operations Center Support, 8000 Jefferson Davis Highway, Richmond, VA 23297–5313
DLA412—TY
Defense General Supply Center, Contracts Division III, Electronic Source Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5314
DLA413—TY
Defense General Supply Center, Contracts Division III, Special Purchase Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5320
DLA414—TY
Defense General Supply Center, Contracts Division III, Systems Automated Small Purchase I, 8000 Jefferson Davis Highway, Richmond, VA 23297–5316
DLA420—XK
Defense General Supply Center, Educational Supplies Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5320
DLA430—TY
Defense General Supply Center, Commodity Oriented Logistics Office, 8000 Jefferson Davis Hwy, Richmond, VA 23297–5330
DLA440—TY
Defense General Supply Center, Contracts Division I, Branch A, 8000 Jefferson Davis Highway, Richmond, VA 23297–5341
DLA441—TY
Defense General Supply Center, Contracts Division I, Branch B, 8000 Jefferson Davis Highway, Richmond, VA 23297–5344
DLA450—TY
Defense General Supply Center, Contracts Division III, Branch A, 8000 Jefferson Davis Highway, Richmond, VA 23297–5351
DLA451—TY
Defense General Supply Center, Contracts Division II, Branch B, 8000 Jefferson Davis Highway, Richmond, VA 23297–5355
DLA460—TY
Defense General Supply Center, Aviation Division, Aircraft Structural Components Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5361
DLA461—Ty
Defense General Supply Center, Aviation Division, Aircraft Accessories & Components Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5362
DLA490—TY
Defense General Supply Center, Industrial Plant Equipment Branch, 8000 Jefferson Davis Highway, Richmond, VA 23297–5100
DLA500—TZ
Defense Industrial Supply Center, 700 Robbins Avenue, Philadelphia, PA 19111–5096
DLA510—W2
Defense Industrial Supply Center, Base Operating Support System (BOSS), 700 Robbins Avenue, Philadelphia 19111–5096
DLA520
Defense Industrial Supply Center, Product Verification Testing (PVT) Acquisitions, 700 Robbins Avenue, Philadelphia, PA 19111–5096
DLA600—UA
Defense Fuel Supply Center, Cameron Station, Alexandria, VA 22304–6160
DLA700—UB
Defense Construction Supply Center, P.O. Box 3990, Columbus, OH 43216–5000
DLA710—YL
Defense Construction Supply Center, Commercial Activities & Services

Branch, P.O. Box 16704, Columbus, OH 43216–5010
DLA720—YM
Defense Construction Supply Center, Wood Products Branch, P.O. Box 16704, Columbus, OH 43216–5010
DLA730—WZ
Defense Construction Supply Center, Military Interdepartmental Purchase Request, MIPR Division, P.O. Box 3990, Columbus, OH 43216–5000
DLA740—XJ
Defense Construction Supply Center, High Demand Group (MINI–ICP), P.O. Box 3990, Columbus, OH 43216–5000
DLA750—UB
Defense Construction Supply Center, Contracts Division I, P.O. Box 16704, Columbus, OH 43216–5010
DLA760—UB
Defense Construction Supply Center, Contracts Division II, P.O. Box 16704, Columbus, OH 43216–5010
DLA770—UB
Defense Construction Supply Center, Contracts Division III, P.O. Box 16704, Columbus, OH 43216–5010
DLA8AC—UG
DCMAO, Santa Ana, 34 Civic Center Plaza, P.O. Box C 12700, Santa Ana, CA 92712–2700
DLA8AL—Y1
DCMAO, Atlanta, 805 Walker Street, Marietta, GA 30060–2789
DLA8AM—YQ
DPRO McDonnell Douglas, P.O. Box 5669, Titusville, FL 32783–5669
DLA8AN—Z4
DCMAO Clearwater, 1100 Cleveland Street, Suite 200, Clearwater, FL 34615–4822
DLA8AP—Z5
DPRO Grumman St. Augustine, 5000 US HWY 1, North, P.O. Drawer 3447, St. Augustine, FL 32085–3447
DLA8AQ—U8
DCMC Aircraft Program Management Office, 805 Walker Street, Marietta, GA 30060–2789
DLA8AR
DPRO Michoud, 13800 Old Gentilly Highway, Bldg. 350, P.O. Box 29503, New Orleans, LA 70189–0503
DLA8AS
DCMAO Atlanta, Termination Settlement Division, 805 Walker Street, Marietta, GA 30060–2789
DLA8AT—UL
DCMD South, 805 Walker Street, Marietta, GA 30060–2789
DLA8AU—QV
DPRO Aerojet, Sacramento, P.O. Box 15846, Sacramento, CA 95852–1846
DLA8BC—UP
DCMAO Bridgeport, 555 Lordship Blvd, Stratford, CT 06497–5000
DLA8BF—W1
DPRO Bell Helicopter Textron, P.O. Box 1605, Fort Worth, TX 76101–1605
DLA8BG—WM
DPRO, Stewart and Stevenson Inc, Attn: DCMDS–RXD, 5000 Interstate 10 West, P.O. Box 457, Sealy, TX 77474–0457
DLA8BL—Y4
DPRO Textron Lycoming Division, 550 Main Street, Stratford, CT 06497–7593
DLA8BM—UR
DCMAO Baltimore, 200 Towsontown Blvd., West, Towson, MD 21204–5299
DLA8BN—US
DPRO AT&T Technologies, Inc., 204 Graham Hopedale Road, Burlington, NC 27217–2941
DLA8BP—UT
DCMD Northeast, 495 Summer Street, Boston, MA 02210–2184
DLA8BQ—TU
DPRO Boeing Helicopter, P.O. Box 16859, Philadelphia, PA 19142–0859
DLA8BR—SP
DPRO Boeing, Seattle, P.O. Box 3707, Seattle, WA 98124–3707
DLA8BS—Y3
DCMAO Boston, 495 Summer Street, Boston, MA 02210–2184
DLA8BT—UU
DPRO Allied Signal, Route 46, Teterboro, NJ 07068–1173
DLA8BU—XC
DCMAO Buffalo, 1103 Federal Building, 111 W. Huron Street, Buffalo, NY 14202–2392
DLA8BV—YT
DPRO General Electric, Lakeside Avenue, Burlington, VT 05401–4984
DLA8BW—RP
DPRO Boeing Military Airplanes, P.O. Box 7730, Wichita, KS 62777–7730
DLA8CD—UZ
DCMAO Cedar Rapids, 1231 Park Place, NE, Cedar Rapids, IA 52402–2023
DLA8CH—UY
DCMD North Central, O'Hare International Airport, P.O. Box 66475, Chicago, IL 60666–0475
DLA8CL—VB
DCMAO Cleveland, A.J. Celebreeze Federal Building, 1240 East Ninth Street, Cleveland, OH 44199–2063
DLA8CM—U5
DPRO BMY Marysville, 13311 Industrial Parkway, Marysville, OH 43040–9599
DLA8CO—X6
DPRO Loral, 1432 Exeter Road, Akron, OH 44306–3893
DLA8CS—VE
DPRO General Dynamics, 5001 Kearny Villa Road, P.O. Box 85375, San Diego, CA 92138–5357
DLA8DB—Z7
DCMAO Dallas, P.O. Box 50500, Dallas, TX 75250–5050
DLA8DC—VH
DCMAO San Diego, 7675 Dagget Street, Suite 200, San Diego, CA 92111–2241
DLA8DD—U4
DPRO Rockwell International, 3200 E Renner Road, MS 462–115, Richardson, TX 75082–2402
DLA8DL—TC
DPRO Douglas, Long Beach, 3855 Lakewood Boulevard, Long Beach, CA 90846–0001
DLA8DM—Y7
DCMAO Detroit, McNamara Federal Building, 477 Michigan Avenue, Detroit, MI 48226–2506
DLA8DN—VK
DCMAO, Denver, Orchard Place 2, 5975 Greenwood Plaza Building, Englewood, CO 80111-5000
DLA8DP—VL
DCMAO, Dayton, c/o Defense Electronics Supply Center, Building 1, Dayton, OH 45444–5300
DLA8EC—YP
DCMAO, Chicago, O'Hare International Airport, P.O. Box 66911, Chicago, IL 60666–0911
DLA8EG—ST
DPRO, Eaton, AIL DIV, Commack Road, Deer Park, NY 11729–9998
DLA8FL—VN
DPRO, ITT, Defense Group, 500 Washington Ave, Nutley, NJ 07110–3698
DLA8FM—3N
DPRO, FMC, Minneapolis, 4800 East River Road, Minneapolis, MN 55421–1402
DLA8FS—VR
DPRO, FMC, 1125 Coleman Avenue, P.O. Box 367, San Jose, CA 95103–0367
DLA8FT—Y2
DPRO, Ford Newport Beach, Administration Building, Room 303, Ford Road, Newport Beach, CA 92658–8900
DLA8GB—KK
DPRO, Grumman Aerospace, Bethpage, Bethpage, NY 11714–3531
DLA8GC—SB
DPRO, GE Aircraft Engines, Cincinnati, Mail Drop N–1, Cincinnati, OH 45215–6303
DLA8GD—YB
DPRO, Westinghouse, 18901 Euclid Ave, Cleveland, OH 44117–1388
DLA8GE—7Q
DPRO, General Electric, Aircraft Engines, Lynn, 1000 Western Avenue, Lynn, MA 0910–0445
DLA8GF—SL, TH
DPRO, General Dynamics, Fort Worth, P.O. Box 371, Fort Worth, TX 76101–0371
DLA8GG—KD
DPRO, General Dynamics, Pomona, P.O. Box 2505, Pomona, CA 91769–2505
DLA8GL—VV
DPRO, General Electric Company, M/S 9–2 Automated Systems Department, Bedford Street, P.O. Box 588, Burlington, MA 01803–0949
DLA8GM—VW
DCMAO, Grand Rapids, Riverview Center Building, 678 Front Street, NW., Grand Rapids MI 49504–5352
DLA8GN—VX
DCMAO, Garden City, 605 Stewart Avenue, Garden City, NY 11530–4761
DLA8GP—YF
DPRO, General Dynamics, Lima, 1155 Buckeye Road, Lima, OH 45804–1898
DLA8GR—MO, NJ
DPRO, General Electric, Pittsfield, 100 Plastics Avenue, Pittsfield, MA 01201–3696
DLA8GW—Z2
DPRO, General Dynamics, Warren, 28251 Van Dyke Street, Warren, MI 48090–5000
DLA8HB—WA
DPRO, PEMCO Aeroplex, Inc., P.O. Box 12447, Birmingham, AL 35202–2447
DLA8HC—WB
DCMAO, Hartford, 130 Darlin Street, East Hartford, CT 06108–3234
DLA8HD—WC
DPRO, GEC/Kearfott, 164 Totowa Road, M/S 11A30, Wayne, NJ 07474–0975
DLA8HL—QT

DPRO, Hughes, Los Angeles, P.O. Box 92463, Los Angeles, CA 90009–2463
DLA8HM—WD
DPRO, Honeywell, Alliant Techsystems, Honeywell Plaza, 2701 Fourth Avenue, South, Minneapolis, MN 55408–1792
DLA8HN
DPRO, Hercules, Magna, P.O. Box 157, Magna, UT 84044–0157
DLA8HR—Z9
DCMAO San Francisco, Hawaii Residency, Federal Building, Room 4115, 300 Ala Moana Boulevard, Honolulu, HI 96813–4908
DLA8HS—XT
DPRO, Hamilton Standard, 1 Hamilton Road, Windsor Locks, CT 06096–0463
DLA8HT—SR
DPRO, Hughes, P.O. Box 11337, M/S E–4, Tucson, AZ 85734–1337
DLA8HU—XG
DPRO, Hughes, Building 600, Mail Station C107, P.O. Box 3310, Fullerton, CA 92634–3310
DLA8JJ—WG
DCMAO, Indianapolis, Building 1, Fort Benjamin Harrison, IN 46249–5701
DLA8JL—X2
DPRO, Magnavox, 1616 Directors Row, Fort Wayne, IN 46808–1286
DLA8KA—XY
DPRO, Kaman Aerospace, Old Windsor Road, P.O. Box 2, Bloomfield, CT 06002–0002
DLA8LA—WL
DCMAO, El Segundo, 222 N Sepulveda Boulevard, El Segundo, CA 90245–4320
DLA8LD—WP
DPRO, LTV Aerosapce and Defense, P.O. Box 655907, M/S 4915, Dallas, TX 75265–5907
DLA8LF—QX
DPRO, Lockheed, Sunnyvale, P.O. Box 3504, Sunnyvale, CA 94088–3504
DLA8LG—RK
DPRO, Lockheed Aeronautical, Systems Company—Georgia, 86 S. Cobb Drive, Marietta, GA 30063–0260
DLA8LT—WN
DPRO, E-Systems, Inc., P.O. Box 6379, Greenville, TX 75401–0379
DLA8MB—V1
DPRO, Harris, Melbourne, 1425 Troutman Boulevard, NE., Palm Bay, FL 32905–4102
DLA8MC—V2
DPRO, Rockwell International—TSD, P.O. Box 1357, Duluth, GA 30136–4099
DLA8MD—RE
DPRO, Martin Marietta, Denver, P.O. Box 179, Denver, CO 80201–0179
DLA8MF—QF
DCMAO, Puerto Rico, Box DLA N S G A, FPO Miami, FL 34053–0007
DLA8MH—X9
DPRO, McDonnell Douglas, Space Systems Company, 5301 Bolsa Avenue, Huntington Beach, CA 92647–2048
DLA8ML—TR
DPRO, McDonnell Douglas Helicopter, 5000 East McDowell Road, Mesa, AZ 85025–9797
DLA8MM—XL
DPRO, Martin Marietta, Orlando, P.O. Box 55837, Mail Point 49, Orlando, FL 32855–5837
DLA8MN—WQ
DCMAO, Twin Cities, 3001 Metro Drive, Bloomington, MN 55425–1573
DLA8MS—JZ
DPRO, McDonnell Douglas, St. Louis, P.O. Box 516, St. Louis, MO 63166–0516
DLA8MW—WR
DCMAO, Milwaukee, H.S. Reuss Federal Building, Suite 340, 310 West Wisconsin Avenue, Milwaukee, WI 53203–2282
DLA8NC—WV
DCMAO, Ottawa, P.O. Box 3416, Station D, Ottawa, On Canda K1P 6L4
DLA8NF—WW
DCMAO, Orlando, 3555 Maguire Boulevard, Orlando, FL 32803–3726
DLA8NH—YS
DPRO, Lockhead Sanders, Inc., Daniel Webster Highway, South, P.O. Box 868, Nashua, NH 03061–0868
DLA8NJ—WT
DCMAO, Springfield, 955 South Springfield Avenue, Springfield, NJ 07081–3170
DLA8NK—QR
DPRO, Northrop, Hawthorne, One Northrop Avenue, Hawthorne, CA 90250–3296
DLA8NM—YR
DPRO, IBM, Route 17C, Owego, NY 13827–1298
DLA8NN—YN
DPRO, Harris, 6801 Jericho Turnpike, Syosset, NY 11791–4465
DLA8NY—WU
DCMAO, New York, 201 Varick Street, New York, NY 10014–4811
DLA8PA—WY
DCMAO, Phoenix, The Monroe School, 215 N 7th Street, Phoenix, AZ 85034–1012
DLA8PE—T5
DPRO, Pratt & Whitney, East Hartford, 400 Main Street, East Hartford, CT 06108–0969
DLA8PH—XA
DCMD, Mid Atlanic, P.O. Box 7478, Philadelphia, PA 19101–7478
DLA8PL—X3
DCMAO, Philadelphia, P.O. Box 7699, Philadelphia, PA 19101–7699
DLA8PM—XB
DPRO, IBM Manassas, 9500 Godwin Drive, Manassas, VA 22110–4198
DLA8PP—XD
DCMAO, Pittsburgh, 1612 Federal Building, 1000 Liberty Avenue, Pittsburgh, PA 15222–4190
DLA8PR—X7
DPRO, GE Aerospace, Marine Highway and Borton Landing Road, Moorestown, NJ 08057–3095
DLA8PW—T2
DPRO, Pratt & Whitney, West Palm Beach, P.O. Box 109600, West Palm Beach, FL 33410–9600
DLA8RA—7H
DCMC, Residency, Annapolis, P.O. Box 1488, Annapolis, MD 21041–1488
DLA8RB—XF
DPRO, Raytheon, Spencer Laboratory, Wayside Ave., Burlington, MA 01803–0901
DLA8RC—RY
DPRO, Rockwell, Canoga Park, 6633 Canoga Avenue, Canoga Park, CA 91303–2790
DLA8RD—RB
DPRO, Rockwell, Anaheim, 3370 Miraloma Avenue M/SAB02A, Anaheim, CA 92803–3110
DLA8RP—XM
DCMAO, Reading, 45 South Front Street, Reading, PA 19602–1094
DLA8SA—XN
DCMAO, San Antonio, 615 East Houston, P.O. Box 1040, San Antonio, TX 78294–1040
DLA8SF—XR
DCMAO, San Francisco, 1250 Bayhill Drive, San Bruno, CA 94066–3070
DLA8SK—XQ
DPRO, Link Flight Simulation, Kirkwood Plant, P.O. Box 1237, Binghamton, NY 13902–1237
DLA8SL—XS
DCMAO, St. Louis, 1222 Spruce Street, St. Louis, MO 63103–2811
DLA8SN—XU
DCMAO, Syracuse, 615 Erie Boulevard, West, Syracuse, NY 13204–2408
DLA8SS—LF
DPRO, Silorsky, Stratford, CT 06497–7553
DLA8SW—XW
DCMAO, Seattle, Building 5D, Naval Station Puget Sound, Seattle, WA 98115–5010
DLA8SY—XX
DPRO, GTE Government Systems Corporation, 200 First Ave., Needham, MA 02194–9123
DLA8TB—R6
DPRO, Thiokol, P.O. Box 524, Mail Stop Z–10, Brigham City, UT 84302–0524
DLA8TE—XZ
DPRO, Texas Instruments, Inc., P.O. Box 660246, M/S 256, Dallas, TX 75266–0246
DLA8TR—S6
DPRO, TRW, Redondo Beach, One Space Park, Redondo Beach, CA 90278–1078
DLA8TW—SQ
DPRO, Textron Defense Systems, 201 Lowell Street, Wilmington, MA 01887–2941
DLA8UG—NH
DPRO, Unisys, Great Neck, Long Island, Great Neck, NY 11020–7001
DLA8VC—YC
DCMAO, Van Nuys, 6230 Van Nuys Boulevard, Van Nuys, CA 91401–2713
DLA8WB—S2
DPRO, Westinghouse Electric, Baltimore, P.O. Box 1693, M/S 1265, Baltimore, MD 21203–1693
DLA8WK—YD
DCMAO, Wichita, U.S. Courthouse, Suite B–34, 401 North Market, Wichita, KS 67202–2095
DLA8WP
Defense Contract Management Command, International Contracts Division, Wright Patterson Air Force Base, OH 45433–5000
DLA8WR—YH
DPRO, Williams International, c/o Williams International Corporation, 2280 West Maple Road, Walled Lake, MI 48088–0200
DLA8WS—YG
DPRO, Westinghouse, 401 East Hendy Avenue, P.O. Box 3499, M/S 11–7, Sunnyvale, CA 94088–3499
DLA8WT—Z8

DPRO, Grumman Aerospace Corporation, P.O. Box 9015, Stuart, FL 33495–9015
DLA8WV
DPRO, Grumman, P.O. Box 9650, Melbourne, FL 32902–9650
DLA900—UD
Defense Electronics Supply Center, 1507 Wilmington Pike, Dayton, OH 45444–5000
DLA910—U7
Defense Electronics Supply Center, Base Contracting Section, 1507 Wilmington Pike, Dayton, OH 45444–5000
DLA920—W4
Defense Electronics Supply Center, DESC–PKCC, 1507 Wilmington Pike, Dayton, OH 45444–5000

PART 7—DEFENSE INFORMATION SYSTEMS AGENCY ACTIVITY ADDRESS NUMBERS

DCA 100—VC
Defense Information Systems Agency, Contract Management Division, ATTN: PM, 701 South Courthouse Road, Arlington, VA 22204–2199 (ZD10)
DCA200—VP
Defense Commercial Communications Office, Directorate of Plans and Policy, ATTN: RP, 2300 East Drive, Scott AFB, Il 62225–5406 (ZD11)
DCA300—1F
DECCO—Pacific, ATTN: RU, 99–080 Kauhale Street, Suite 2, Aiea, HI 96701–4104 (ZD13)
DCA400—WK
DECCO—Europe, ATTN: RS, Unit 4235, Sambach Air Base, APO AE 09136 (ZD14)
DCA500—KH
DECCO—Alaska, ATTN: RT, 9864 L Street, Suite 201, Elmendorf AFB, AK 99506–2615 (ZD15)
DCA600—9T
DISA/DITPRO, Office of Acquisition, ATTN: OA, 148 Redman Street, Fort Ritchie, MD 21719–3201 (ZD16)

PART 8—DEFENSE MAPPING AGENCY ACTIVITY ADDRESS NUMBERS

DMA600—BQ
Defense Mapping Agency, SC Contracts Office, ATTN: AQC/Mail Stop J–11, 12100 Sunset Hills Road, Suite 200, Reston, VA 22090–3207 (ZD40)
DMA700—8Y
Defense Mapping Agency, AC Contracts Office, ATTN: AQC/Mail Stop L–13, 3200 South Second Street, St. Louis, MO 63118–3399 (ZD41)
DMA800—YZ
Defense Mapping Agency, HTC Contracts Office, ATTN: AQW/Mail Stop D–6, 4600 Sangamore Road, Bethesda, MD 20816–5003 (ZD42)

PART 9—DEFENSE NUCLEAR AGENCY ACTIVITY ADDRESS NUMBERS

DNA001—8Z
Defense Nuclear Agency, Headquarters, ATTN: Acquisition Management Office (AM), 6801 Telegraph Road, Alexandria, VA 22310–3398 (ZD30)
DNA002—0N
Defense Nuclear Agency, Field Command, ATTN: Acquisition Management Office (FC), 1680 Texas Street, S.E., Kirtland AFB, NM 87115–5669 (ZD31)

PART 10—MISCELLANEOUS DEFENSE ACTIVITIES ACTIVITY ADDRESS NUMBERS

MDA902
Armed Forces Radio and Television Service, ATTN: AFRTS–BC–RMK, 10888 La Tuna Canyon Road, Sun Valley, CA 91352–2098 (ZD02)
MDA904
Maryland Procurement Office, ATTN: N363, 9800 Savage Road, Fort George G. Meade, MD 20755–6000 (ZD04)
MDA905—B4
Uniformed Services University of the Health Sciences, ATTN: Directorate of Contracting, 4301 Jones Bridge Road, Bethesda, MD 20814–4799 (ZD05)
MDA906
Office for the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS), ATTN: Contract Management Division, Building 222, East Harlow Avenue, FAMC, Aurora, CO 80045–6900 (ZD06)
MDA907
Purchasing and Contracting Office, Menwith Hill Station, APO AE 09210 (ZD07)
MDA908—2X
Virginia Contracting Activity, ATTN: DPP, P.O. Box 46563, Washington, DC 20050–6563 (ZD50)
MDA911—2U
U.S. Special Operations Command, Directorate of Procurement, 7701 Tampa Point Boulevard, MacDill AFB, FL 33608–6001 (ZD22)
MDA928
Armed Forces Radiobiology Research Institute, ATTN: Acquisition Management Office, 8901 Wisconsin Avenue, Bethesda, MD 20889–5603 (ZD28)
MDA946
Procurement and Contracts Office, Washington Headquarters Services, 1155 Defense Pentagon, Washington, DC 20301–1155 (ZD46)
MDA972—WS
ARPA, Contract Management Office, 3701 North Fairfax Drive, Arlington, VA 22203 (ZD72)

PART 11—ON-SITE INSPECTION AGENCY ACTIVITY NUMBER

OSIA01
On-Site Inspection Agency, Acquisition Management, 300 West Service Road, Washington, DC 20041–0498 (ZD74)

PART 12—BALLISTIC MISSILE DEFENSE ORGANIZATION ACTIVITY NUMBER

HQ0006—SS
Ballistic Missile Defense Organization, ATTN: BMDO/DCTP, 7100 Defense Pentagon, Room 1E1019, Washington, DC 20301–7100 (ZD60)

PART 13—DEFENSE COMMISSARY AGENCY ACTIVITY ADDRESS NUMBERS

DECA01—ZG
Defense Commissary Agency, East Service Center, ATTN: DeCA/ES–AM, Building P–11200, 38th Street & E Avenue, Fort Lee, VA 23801–6390 (ZD81)
DECA02—ZT
Defense Commissary Agency, West Service Center, ATTN: DeCA/WS–AM, Building 3184, Kelly AFB, TX 78241–6290 (ZD82)
DECA03—0H
Defense Commissary Agency, North East Region, ATTN: DeCA/NE–AM, Building 2257, Fort George G. Meade, MD 20755–5220 (ZD83)
DECA04—BE
Defense Commissary Agency, Central Region, ATTN: DeCA/CE–AM, 1140 Gator Boulevard, Norfolk, VA 23521–2228 (ZD84)
DECA05—0L
Defense Commissary Agency, Southern Region, ATTN: DeCA/SO–AM, Building 835, Maxwell AFB, AL 36112–6722 (ZD85)
DECA06—0J
Defense Commissary Agency, Midwest Region, ATTN: DeCA/MW–AM, Building 3030, Kelly AFB, TX 78241–6290 (ZD86)
DECA07—0Z
Defense Commissary Agency, South West Region, ATTN: DeCA/SW–AM, Building 329, Marine Corps Air Station El Toro, Santa Ana, CA 92709–5002 (ZD87)
DECA08—0K
Defense Commissary Agency, Northwest Region, ATTN: DeCA/NW–AM, Building 9630, Fort Lewis, WA 98433–7300 (ZD88)

Appendix H to Chapter 2

117. A new DFARS Appendix H—Debarment and Suspension Procedures is added to Chapter 2 to read as follows:

Appendix H—Debarment and Suspension Procedures

Sec.
H–100 Scope.
H–101 Notification.
H–102 Nature of proceeding.
H–103 Presentation of matters in opposition.
H–104 Fact-finding.
H–105 Timing requirements.
H–106 Subsequent to fact-finding.

Authority: 41 U.S.C. 421 and FAR subpart 1.3.

H–100 Scope.

This appendix provides uniform debarment and suspension procedures to be followed by all debarring and suspending officials.

H–101 Notification.

Contractors will be notified of the proposed debarment or suspension in accordance with FAR 9.406–3 or 9.407–3. A copy of the record which formed the basis for the decision by the

debarring and suspending official will be made available to the contractor. If there is a reason to withhold from the contractor any portion of the record, the contractor will be informed of what is withheld and the reasons for such withholding.

H–102 Nature of proceeding.

There are two distinct proceedings which may be involved in the suspension or debarment process. The first is the presentation of matters in opposition to the suspension or proposed debarment by the contractor.

The second is fact-finding which occurs only in cases in which the contractor's presentation of matters in opposition raises a genuine dispute over one or more material facts. In a suspension action based upon an indictment or in a proposed debarment action based upon a conviction or civil judgment, there will be no fact-filling proceeding concerning the matters alleged in the indictment, or the facts underlying the convictions or civil judgment. However, to the extent that the proposed action stems from the contractor's affiliation with an individual or firm indicted or convicted, or the subject of a civil judgment, fact-finding is permitted if a genuine dispute of fact is raised as to the question of affiliation as defined in FAR 9.403.

H–103 Presentation of matters in opposition.

(a) In accordance with FAR 9.406–3(c) and 9.407–3(c), matters in opposition may be presented in person, in writing, or through a representative. Matters in opposition may be presented through any combination of the foregoing methods, but if a contractor desires to present matters in person or through a representative, any written material should be delivered at least 5 working days in advance of the presentation. Usually, all matters in opposition are presented in a single proceeding. A contractor who becomes aware of a pending indictment or allegations of wrongdoing that the contractor believes may lead to suspension or debarment action may contact the debarring and suspending official or designee to provide information as to the contractor's present responsibility.

(b) An in-person presentation is an informal meeting, nonadversarial in nature. The debarring and suspending official and/or other agency representatives may ask questions of the contractor or its representative making the presentation. The contractor may select the individuals who will attend the meeting on the contractor's behalf; individual respondents or principals of a business firm respondent may attend and speak for themselves.

(c) In accordance with FAR 9.406–3(c) and 9.407–3(c), the contractor may submit matters in opposition within 30 days from receipt of the notice of suspension or proposed debarment.

(d) The opportunity to present matters in opposition to debarment includes the opportunity to present matters concerning the duration of the debarment.

H–104 Fact-finding.

(a) The debarring and suspending official will determine whether the contractor's presentation has raised a genuine dispute of material fact(s). If the debarring and suspending official has decided against debarment or continued suspension, or the provisions of FAR 9.4 preclude fact-finding, no fact-finding will be conducted. If the debarring and suspending official has determined a genuine dispute of material fact(s) exists, a designated fact-finder will conduct the fact-finding proceeding. The proceeding before the fact-finder will be limited to a finding of the facts in dispute as determined by the debarring and suspending official.

(b) The designated fact-finder will establish the date for a fact-finding proceeding, normally to be held within 45 working days of the contractor's presentation of matters in opposition. An official record will be made of the fact-finding proceeding.

(c) The Government's representative and the contractor will have an opportunity to present evidence relevant to the facts at issues. The contractor may appear in person or through a representative in the fact-finding proceeding.

(d) Neither the Federal Rules of Evidence nor the Federal Rules of Civil Procedure govern fact-finding. Hearsay evidence may be presented and will be given appropriate weight by the fact-finder.

(e) Witnesses may testify in person. Witnesses will be reminded of the official nature of the proceeding and that any false testimony given is subject to criminal prosecution. Witnesses are subject to cross-examination.

H–105 Timing requirements.

All timing requirements set forth in these procedures may be extended by the debarring and suspending official for good cause.

H–106 Subsequent to fact-finding.

(a) Written findings of fact will be prepared by the fact-finder as mandated by FAR 9.406–3(d)(2)(i) and 9.407–3(d)(2)(i).

(b) The fact-finder will determine the disputed fact(s) by a preponderance of the evidence. A copy of the findings of fact will be provided to the debarring and suspending official, the Government's representative, and the contractor.

(c) The debarring and suspending official will determine whether to continue the suspension or to debar the contractor based upon the entire administrative record, including the findings of fact.

(d) Prompt written notice of the debarring and suspending official's decision will be sent to the contractor and any affiliates involved, in compliance with FAR 9.406–3(e) and 9.407–3(d)(4).

Appendix I to Chapter 2

118. A new DFARS Appendix I—Policy and Procedures for the DoD Pilot Mentor-Protege Program is added to Chapter 2 to read as follows:

APPENDIX I—POLICY AND PROCEDURES FOR THE DOD PILOT MENTOR-PROTEGE PROGRAM

Sec.

I–100 Purpose.
I–101 Definitions.
I–102 General procedures.
I–103 Program duration.
I–104 Eligibility requirements for a protege firm.
I–105 Selection of protege firms.
I–106 Approval process for companies to participate in the Program as mentor firms.
I–107 Mentor-protege agreements.
I–108 Reimbursement procedures.
I–109 Credit for unreimbursed developmental assistance costs.
I–110 Advance agreements on the treatment of developmental assistance costs.
I–111 Reporting requirements and program reviews.

Authority: 41 U.S.C. 421 and FAR subpart 1.3.

I–100 Purpose.

(a) Appendix I to 48 CFR chapter 2 implements the Pilot Mentor-Protege Program (hereinafter referred to as the "Program") established under section 831 of Pub. L. 101–510, The National Defense Authorization Act for Fiscal Year 1991, as amended. The purpose of the Program is to—

(1) Provide incentives to major DoD contractors, performing under at least one active approved subcontracting plan negotiated with DoD or other Federal agencies, to assist small disadvantaged businesses (SDBs) in enhancing their capabilities to satisfy DoD and other contract and subcontract requirements;

(2) Increase the overall participation of SDBs as subcontractors and suppliers

and DoD contracts, other Federal agency contracts and commercial contracts and;

(3) Foster the establishment of long term business relationships between SDBs and such contractors.

(b) Under the Program, eligible companies approved as mentor firms will enter into mentor-protege agreements with eligible SDBs as protege firms to provide appropriate developmental assistance to enhance the capabilities of SDBs to perform as subcontractors and suppliers. According to the law, the DoD may provide the mentor firm with either cost reimbursement, credit against SDB subcontracting goals established under contracts with DoD or other Federal agencies, or a combination of credit and reimbursement.

(c) DoD will measure the overall success of the Program by the extent to which the Program results in—

(1) An increase in the dollar value of subcontracts awarded to SDBs by mentor firms under DoD contracts;

(2) An increase in the dollar value of contract and subcontract awards to protege firms (under DoD contracts, contracts awarded by other Federal agencies and under commercial contracts) since the date of their entry into the Program;

(3) An increase in the number and dollar value of subcontracts awarded to a protege firm (or former protege firm) by its mentor firm (or former mentor firm);

(4) An improvement in the participation of SDBs in DoD, other Federal agencies, and commercial contracting opportunities that can be attributed to the development of SDBs as protege firms under the Program;

(5) An increase in subcontracting with SDB concerns in industry categories where SDBs have not traditionally participated within the mentor firm's vendor base;

(6) The involvement of emerging SDBs in the Program;

(7) An expanded relationship between mentor firms and protege firms to include non-DoD programs; and

(8) The development of protege firms that are competitive as subcontractors and suppliers to DoD or in other Federal agencies or commercial markets.

(d) This policy sets forth the procedures for participation in the Program applicable to companies that are interested in receiving—

(1) A separate contract, cooperative agreement, or other agreement entered into between DoD and the mentor firm—company is interested in reimbursement through a separate contract, cooperative agreement or other agreement with DoD or, a combination of reimbursement through such agreement with DoD and credit against SDB subcontract goals for any unreimbursed costs incurred under the Program.

(2) Program Manager funded reimbursement—company has identified a DoD program manager willing to fund the Program and the company is interested in reimbursement for technical assistance costs to a protege firm(s) through a separately priced cost reimbursement contract line item added to a DoD contract, with credit against SDB subcontracting goals for any unreimbursed costs.

(3) Indirect reimbursement and credit—company is interested in receiving reimbursement for indirect costs incurred under the Program as well as credit against SDB subcontract goals for these indirect costs.

(4) Credit only—company is interested in receiving credit only against SDB subcontracting goals for costs incurred under the Program.

I–101 Definitions.

I–101.1 Emerging SDB concern.

A small disadvantaged business whose size is no greater than 50 percent of the numerical size standard applicable to the standard industrial code for the supplies or services which the protege firm provides or would provide to the mentor firm.

I–101.2 Historically black college or university.

An institution determined by the Secretary of Education to meet the requirements of 34 CFR § 6082. The term also means any nonprofit research institution that was an integral part of such a college or university before November 14, 1986.

I–101.3 Minority institution of higher education.

An institution meeting the requirements of Section 1046(3) of the Higher Education Act of 1965 (20 U.S.C. 1135d–5(3). The term also includes Hispanic-serving institutions as defined in Section 316(b)(1) of such Act (20 U.S.C. 1059c(b)(1)).

I–102 General Procedures.

(a) At any time between October 1, 1991, and September 30, 1995, companies interested in becoming mentor firms that want to take credit only for costs incurred for providing developmental assistance to one or more protege firms, or receive credit and reimbursement of indirect costs incurred under the Program, must apply to the DoD for participation in the Program pursuant to the application process set forth at I–106(a).

(b) At any time between October 1, 1991, and September 30, 1995, companies interested in becoming mentor firms that are able to identify funding from a DoD contract program manager(s) to provide developmental assistance to one or more protege firms must apply to the DoD for participation in the Program, pursuant to the application process set forth at I–106(d).

(c) Once funding is made available by DoD, companies that are interested in becoming mentor firms that want to receive reimbursement only or a combination of reimbursement and credit for providing developmental assistance to one or more protege firms by either a separate contract, cooperative agreement or other agreement awarded for that purpose, will be solicited for participation in the Program through a program solicitation. The Program solicitation will be issued by DoD and will contain, among other things, the statement of work and the evaluation factors upon which award will be based. Companies seeking reimbursement only, or a combination of reimbursement and credit, must respond to the solicitation and will be evaluated on the quality of the proposed developmental assistance program for each protege, in accordance with the evaluation factors contained in the solicitation. Awards will be made by DoD to approved mentor firms, to provide the proposed developmental assistance to one or more identified protege firms.

I–103 Program duration.

Activities under the Program may only occur during the following periods:

(a) From October 1, 1991, until September 30, 1995, companies may apply for participation in the Program as mentor firms pursuant to I–102, General Procedures, and once approved, may enter into mentor-protege agreements, pursuant to I–107, Mentor-Protege Agreements.

(b) From October 1, 1991, until September 30, 1996, mentor firm's costs of providing developmental assistance to its protege firm may be reimbursed only if—

(1) Such costs are incurred after either a separate contact, cooperative agreement, or other agreement is entered into between DoD and the mentor firm;

(2) The funding for such costs have been identified by a DoD program manager and such costs are incurred pursuant to the execution of a separately priced contract line item added to a DoD contract(s); to

(3) Such costs are included in indirect expense pools.

(c) From October 1, 1991, until September 30, 1999, mentor firms may receive credit toward the attainment of such firm's goals for subcontract awards to SDBs for unreimbursed costs incurred in providing developmental assistance to its protege firms, only if such costs are incurred pursuant to an approved mentor-protege agreement.

I–104 Eligibility requirements for a protege firm.

(a) An entity may qualify as a protege firm if it is—

(1) An SDB concern as defined by section 8(d)(3)(C) of the Small Business Act (15 U.S.C. 637(D)(3)(C)) which is—

(i) Eligible for the award of Federal contracts; and

(ii) A small business according to the SBA size standard for the Standard Industrial Classification (SIC) code which represents the contemplated supplies or services to be provided by the protege firm to the mentor firm;

(2) A business entity that meets the criteria in (a)(1) of this section and is owned and controlled by either an Indian tribe as defined by section 8(a)(13) of the Small Business Act (15 U.S.C. 637(a)(13)) or a Native Hawaiian Organization as defined by section 8(a)(15) of the Small Business Act (15 U.S.C. 637(a)(15)); or

(3) A qualified organization employing the severely disabled as defined in Pub. L. 102–172, section 8064A.

(b) A protege firm may self-certify to a mentor firm that it meets the eligibility requirements in paragraphs I–104(a)(1), (2), or (3). Mentor firms may rely in good faith on a written representation that the entity meets the requirements of paragraphs I–104(a) (1), (2), or (3).

(c) A protege firm may have only one active mentor-protege agreement.

I–105 Selection of protege firms.

(a) Mentor firms will be solely responsible for selecting protege firms. Mentor firms are encouraged to identify and select protege firms that are defined as emerging SDB concerns.

(b) The selection of protege firms by mentor firms may not be protested, except as in I–105(c).

(c) In the event of a protest regarding the size or disadvantaged status of an entity selected to be a protege firm as defined in either paragraph I–104(a)(1) or (2), the mentor firm shall refer the protest to the Small Business Administration (SBA) to resolve in accordance with 13 CFR part 121 (with respect to size) or 13 CFR part 124 (with respect to disadvantaged status).

(d) For purposes of the Small Business Act, no determination of affiliation or control (either direct or indirect) may be found between a protege firm and its mentor firm on the basis that the mentor firm has agreed to furnish (or has furnished) to its protege firm pursuant to a mentor-protege agreement any form of developmental assistance described in paragraph I–107(f).

(e) If at any time pursuant to paragraph I–105(c), the protege firm is determined by the SBA not to be a small disadvantaged business concern, assistance furnished such business concern by the mentor firm after the date of the determination, may not be considered assistance furnished under the program.

I–106 Approval process for companies to participate in the Program as mentor firms.

(a) On or after October 1, 1991, a company that is interested in becoming a mentor firm that is seeking credit only against SDB subcontracting goals for costs incurred under the Program, or reimbursement of developmental assistance costs via inclusion of program costs in indirect expense pools and credit for such costs, must submit a request to the DoD, OUSD(A&T)SADBU to be approved as a mentor firm under the Program. The request will be evaluated on the extent to which the company's proposal addresses the items listed in paragraphs (b) and (c) of this section. To the maximum extent possible, the request should be limited to not more than 10 pages, single spaced. A company may identify more than one protege in its request for approval under the Program. The information required in paragraphs I–106(b) and (c) must be submitted to be considered for approval as a mentor firm, and may cover one or more proposed mentor-protege relationships.

(b) A company must indicate whether it is interested in participating in the Program pursuant to paragraph I–100(d), (2), (3), or (4), and submit the following information:

(1) A statement that the company is currently performing under at least one active approved subcontracting plan negotiated with DoD or another Federal agency pursuant to FAR 19.702, and that the company is currently eligible for the award of Federal contracts.

(2) The number of proposed mentor-protege relationships covered by the request for approval as a mentor firm.

(3) A summary of the company's historical and recent activities and accomplishments under their SDB program.

(4) The total dollar amount of DoD contracts and subcontracts received by the company during the two preceding fiscal years (show prime contracts and subcontracts separately per year).

(5) The total dollar amount of all other federal agency contracts and subcontracts received by the company during the two preceding fiscal years (show prime contracts and subcontracts separately per year).

(6) The total dollar amount of subcontracts awarded by the company under DoD contracts during the two preceding fiscal years.

(7) The total dollar amount of subcontracts awarded by the company under all other Federal agency contracts during the two preceding fiscal years.

(8) The total dollar amount and percentage of subcontract awards made to all SDB firms under DoD contracts and other Federal agency contracts during the two preceding fiscal years (show DoD separately). If presently required to submit a SF 295, provide copies of the two preceding years end reports.

(9) The number and total dollar amount of subcontract awards made to the identified protege firm(s) during the two preceding fiscal years (if any). Show DoD subcontract awards and other Federal agency subcontract awards separately.

(c) In addition to the information required in paragraph I–106(b), companies must submit the following information for each proposed mentor-protege relationship:

(1) Information on the company's ability to provide developmental assistance to the identified protege firm and how that assistance will potentially increase subcontracting opportunities in industry categories where SDBs are not dominant in the company's vendor base.

(2) A letter of intent indicating that both the mentor firm and the protege firm will negotiate a mentor-protege agreement. The letter of intent must be signed by both parties and contain the following information:

(i) The name, address, and telephone number of both parties.

(ii) The protege firm's business classification, based upon the SIC code(s) which represents the contemplated supplies or services to be provided by the protege firm to the mentor firm.

(iii) A statement that the protege firm meets the eligibility criteria in either paragraph I–104(a)(1), (2) or (3).

(iv) A preliminary assessment of the developmental needs of the protege firm and the proposed developmental assistance the mentor firm envisions providing the protege firm to address

those needs and enhance the protege firm's ability to perform successfully under contracts or subcontracts with DoD, other federal agencies and commercial contracts.

(v) An estimate of the dollar amount and type of subcontracts that will be awarded by the mentor firm to the protege firm, and the period of time over which they will be awarded.

(vi) Information as to whether the protege firm's development will be concentrated on a single major system, a service or supply program, research and development programs, initial production, mature systems, or in the mentor firm's overall contract base.

(3) An estimate of the cost of the developmental assistance program and the period of time over which the assistance will be provided.

(d) A company that has identified Program funds to be made available through a DoD program manager must provide: the information in paragraphs I–106(b) and (c) to the appropriate program manager and to the OUSD(A&T)SADBU, with a letter signed by the appropriate program manager indicating the amount of funding that has been identified for the developmental assistance program.

(e) Companies seeking credit only for the cost of developmental assistance, reimbursement of program costs via their inclusion in indirect expense pools and credit for such costs, or reimbursement with funds made available by a DoD program manager, shall submit four copies of the information specified in paragraphs I–106(b) and (c) to: DoD, OUSD(A&T)SADBU, 3061 Defense Pentagon, Washington, DC. 20301–3061, Attn: Pilot Mentor-Protege Program Manager. Upon receipt of this information, OUSD(A&T)SADBU will review and evaluate each request and, to the maximum extent possible, within 30 days advise each applicant of approval or rejection of its request to become a mentor firm.

(f) Companies interested in reimbursement of costs of a developmental assistance program through either a separate contract, cooperative agreement, or other agreement awarded for that purpose will be solicited to provide the information in paragraphs I–106(b) and (c) as well as any other information specified in the program solicitation.

(g) A company approved as a mentor firm for credit only, for reimbursement through funds made available by a DoD program manager, or for reimbursement via inclusion of program costs in indirect expense pools and credit for such costs, may proceed with the negotiation of the mentor-protege agreement with the identified protege firm(s).

(h) Companies that apply for participation in the program pursuant to paragraph I–106(e) and are not approved, will be provided the reasons and an opportunity to submit additional information for reconsideration.

(i) A company may not be approved for participation in the Program as a mentor firm if at the time of requesting participation in the Program it is currently debarred or suspended from contracting with the Federal government pursuant to FAR subpart 9.4.

(j) If the mentor firm is suspended or debarred while performing under an approved mentor-protege agreement, the mentor firm—

(1) May continue to provide assistance to its protege firms pursuant to approved mentor-protege agreements entered into prior to the imposition of such suspension or debarment;

(2) May not be reimbursed or take credit for any costs of providing developmental assistance to its protege firm, incurred more than 30 days after the imposition of such suspension or debarment; and

(3) Shall promptly give notice of its suspension or debarment to its protege firm and OUSD(A&T)SADBU.

I–107 Mentor-protege agreements.

(a) A signed mentor-protege agreement for each mentor-protege relationship identified under I–106(b)(2) must be submitted to OUSD(A&T)SADBU and approved before developmental assistance costs may be incurred. To the maximum extent possible, such mentor-protege agreements will be approved within five business days of receipt.

(b) Each signed mentor-protege agreement submitted for approval under the Program shall include—

(1) The name, address and telephone number of the mentor firm and the protege firm and a point of contact within the mentor firm who will administer the developmental assistance program;

(2) The SIC code which represents the contemplated supplies or services to be provided by the protege firm to the mentor firm and a statement that at the time the agreement is submitted for approval, the protege firm, if an SDB concern, does not exceed the size standard for the appropriate SIC code.

(3) A developmental program for the protege firm specifying the type of assistance identified in paragraph I–107(f) that will be provided. The developmental program shall also include—

(i) Factors to assess the protege firm's developmental progress under the Program including milestones for providing the identified assistance; and

(ii) The anticipated number, dollar value, and type of subcontracts to be awarded the protege firm consistent with the extent and nature of mentor firm's business, and the period of time over which they will be awarded.

(iii) The dollar value of the technical assistance program broken out per year.

(4) A program participation term for the protege firm which shall not exceed nine years.

(5) Procedures for the mentor firm to notify the protege firm in writing at least 30 days in advance of the mentor firm's intent to voluntarily withdraw its participation in the Program. Mentor firms may only voluntarily terminate the mentor-protege agreement(s) if they no longer want to be a participant in the Program as a mentor firm. Otherwise, a mentor firm must terminate a mentor-protege agreement for cause.

(6) Procedures for a protege firm to notify the mentor firm in writing at least 30 days in advance of the protege firm's intent to voluntarily terminate the mentor-protege agreement.

(7) Procedures for the mentor firm to terminate the mentor-protege agreement for cause which provide—

(i) The protege firm shall be furnished a written notice of the proposed termination, stating the specific reasons for such action, at least 30 days in advance of the effective date of such proposed termination.

(ii) The protege firm shall have 30 days to respond to such notice of proposed termination, and may rebut any findings believed to be erroneous and offer a remedial program.

(iii) Upon prompt consideration of the protege firm's response, the mentor firm shall either withdraw the notice of proposed termination and continue the protege firm's participation, or issue the notice of termination.

(iv) The decision of the mentor firm regarding termination for cause, conforming with the requirements of this section, shall be final and is not reviewable by DoD.

(8) Additional terms and conditions as may be agreed upon by both parties.

(c) Mentor firms shall send a copy of any termination notices to the DoD, OUSD(A&T)SADBU, and where funding is made available through a DoD program manager, also provide a copy to the program manager and to the appropriate PCO of ACO.

(d) Termination of a mentor-protege agreement shall not impair the

obligations of the mentor firm to perform pursuant to its contractual obligations under Government contracts and subcontracts. Termination of all or part of the mentor-protege agreement shall not impair the obligations of the protege firm to perform pursuant to its contractual obligations under any contract awarded to the protege firm by the mentor firm.

(e) Only developmental assistance provided after the DoD approval of the mentor-protege agreement may be reimbursed.

(f) The mentor-protege agreement may provide for the mentor firm to furnish any or all of the types of developmental assistance as follows:

(1) Assistance by mentor firm personnel in—

(i) General business management, including organizational management, financial management, and personnel management, marketing, business development, and overall business planning;

(ii) Engineering and technical matters such as production inventory control, quality assurance; and

(iii) Any other assistance designed to develop the capabilities of the protege firm under the development program.

(2) Award of subcontracts under DoD contracts or other contracts on a non-competitive basis.

(3) Payment of progress payments for the performance of subcontracts by a protege firm in amounts as provided for in the subcontract; but in no event may any such progress payment exceed 100 percent of the costs incurred by the protege firm for the performance of the subcontract. Provision of progress payments by a mentor firm to a protege firm at a rate other than the customary rate for small disadvantaged businesses shall be implemented in accordance with FAR 32.504(c).

(4) Advance payments under such subcontracts. Advance payments must be administered by the mentor firm in accordance with FAR subpart 32.4.

(5) Loans.

(6) Investment(s) in the protege firm in exchange for an ownership interest in the protege firm, not to exceed 10 percent of the total ownership interest. Investments may include but not be limited to cash, stock, contributions in kind, etc.

(7) Assistance obtained by the mentor firm for the protege firm from one or more of the following:

(i) Small Business Development Centers (SBDC) established pursuant to section 21 of the Small Business Act (15 U.S.C. 648).

(ii) Entities providing procurement technical assistance pursuant to chapter 142 of Title 10 U.S.C. (Procurement Technical Assistance Centers.)

(iii) Historically Black Colleges and Universities.

(iv) Minority institutions of higher education.

(g) A mentor firm may not require an SDB concern to enter into a mentor-protege agreement as a condition for being awarded a contract by the mentor firm including a subcontract under a DoD contract awarded to the mentor firm.

I–108 Reimbursement procedures.

(a) A mentor firm may be reimbursed only for the cost of developmental assistance incurred by the mentor firm and provided to a protege firm under I–107(f) (1) and (7), and pursuant to an approved mentor-protege agreement. Reimbursement shall be made only through either a separate contract, cooperative agreement, or other agreement entered into between the DoD and the mentor firm awarded for the purpose of providing developmental assistance to one or more protege firms; a separately priced contract line item in a DoD contract; or inclusion of program costs in indirect expense pools. No other means for the reimbursement of the costs of developmental assistance provided under I–107(f) (1) and (7) are authorized under the Program.

(b) Costs reimbursed via inclusion in indirect expense pools may be reimbursed only to the extent that they are otherwise reasonable, allocable, and allowable.

(c) Assistance provided in the form of progress payments in excess of the customary progress payment rate for SDBs, shall be reimbursed only if implemented in accordance with FAR 32.504(c).

(d) Assistance provided in the form of advance payments shall be reimbursed only if they have been provided to a protege firm under subcontract terms and conditions similar to FAR 52.232–12. Reimbursement of any advance payments shall be made pursuant to the inclusion of DFARS 252.232–7008, Reimbursement of Advance Payments—DoD Pilot Mentor-Protege Program, in appropriate contracts. In requesting reimbursement, the mentor firm agrees that the risk of any financial loss due to the failure or inability of a protege firm to repay any unliquidated advance payments shall be the sole responsibility of the mentor firm.

(e) No other forms of developmental assistance are authorized for reimbursement under the Program.

I–109 Credit for unreimbursed developmental assistance costs.

(a) Developmental assistance costs incurred by a mentor firm for providing assistance to a protege firm pursuant to an approved mentor protege agreement, which have not been reimbursed through either a separate contract, cooperative agreement, or other agreement entered into between DoD and the mentor firm, or through a separately priced contract line item added to a DoD contract, may be credited as if it were a subcontract award for determining the performance of such mentor firm in attaining an SDB subcontracting goal(s) established under any contract containing a subcontracting plan pursuant to FAR 52.219–9.

(b) For crediting purposes only, costs that have been reimbursed via inclusion in indirect expense pools may also be credited as subcontract awards for determining the performance of such mentor firm in attaining an SDB subcontracting goal(s) established under any contract containing a subcontracting plan pursuant to FAR 52.219–9. However, costs that have not been reimbursed because they are not reasonable, allocable, or allowable under I–108(b), shall not be recognized for crediting purposes.

(c) Other costs that are not eligible for reimbursement pursuant to I–108(a) may be recognized for credit only if requested, identified, and incorporated in an approved mentor-protege agreement. Such costs are not eligible for reimbursement.

(d) The amount of credit a mentor firm may receive for any such unreimbursed developmental assistance costs shall be equal to—

(1) Four times the total amount of such costs attributable to assistance provided by small business development centers (SBDC), historically black colleges and universities (HBCU), minority institutions (MI), and procurement technical assistance centers (PTAC).

(2) Three times the total amount of such costs attributable to assistance furnished by the mentor's employees.

(3) Two times the total amount of other such costs incurred by the mentor in carrying out the developmental assistance program.

(e) A mentor firm may receive credit toward the attainment of an SDB subcontracting goal(s) for each subcontract awarded for a product or a service by the mentor firm to an entity that qualifies as a protege firm pursuant to I–104(a). With respect to a former SDB protege (firm(s), a mentor may take credit for awards to such concern(s) that, except for its size would be a small

business concern owned and controlled by socially and economically disadvantaged individuals, but only if—

(1) The size of such business concern is not more than two times the appropriate size standard;

(2) The business concern formerly had a mentor-protege agreement with such mentor firm that was not terminated for cause; and

(3) The credit is taken not later than October 1, 1999.

(f) Amounts credited toward the SDB goal(s) for unreimbursed costs under the Program shall be separately identified from the amounts credited toward the goal resulting from the award of actual subcontracts to protege firms. The combination of the two shall equal the mentor firm's overall accomplishment toward the SDB goal(s).

(g) Adjustments may be made to the amount of credit claimed under paragraphs I–109(a) and (b) if the DoD Director of Small and Disadvantaged Business Utilization determines that—

(1) A mentor firm's performance in the attainment of its SDB subcontracting goals through actual subcontract awards declined from the prior fiscal year without justifiable cause.

(2) Imposition of such a limitation on credit appears to be warranted to prevent abuse of this incentive for mentor firm's participation in the Program.

(h) The mentor firm shall be afforded the opportunity to explain the decline in SDB participation before imposition of any such limitation on credit. In making the final decision to impose a limitation on credit, the DoD Director shall consider—

(1) The mentor firm's overall SDB participation rates (in terms of percentages of subcontract awards and dollars awarded) as compared to the participation rates existing during the two fiscal years prior to the firm's admission to the Program;

(2) The mentor firm's aggregate prime contract awards during the prior two fiscal years and the total amount of subcontract awards under such contracts; and

(3) Such other information the mentor firm may wish to submit.

(i) The decision of the Director regarding the imposition of a limitation on credit shall be final.

(j) Any prospective limitation on credit imposed by the Director shall be expressed as a percentage of otherwise eligible credit and shall apply beginning on a specific date in the future and continue until a date certain during the current fiscal year.

(k) Any retroactive limitation on credit imposed by the Director shall reflect the actual costs incurred for developmental assistance (not exceeding the maximum amount reimbursed).

(l) For purposes of calculating any incentives to be paid to a mentor firm for exceeding an SDB subcontracting goal pursuant to 252.219–7009, incentives shall be paid only if an SDB subcontracting goal has been exceeded as a result of actual subcontract awards to SDBs (excluding credit under paragraphs I–109 (a), (b) and (c)).

(m) Developmental assistance costs that are incurred pursuant to an approved mentor-protege agreement, and have been charged to, but not reimbursed through a separate contract, cooperative agreement, or other agreement entered into between the DoD and the mentor firm, or through a separately priced contract line item added to a DoD contract, shall not be otherwise reimbursed, either as a direct or indirect cost, under any other DoD contract, irrespective of whether the costs have been recognized for credit against SDB subcontracting goals.

(n) Developmental assistance provided under an approved mentor-protege agreement is distinct from, and shall not duplicate, any effort that is the normal and expected product of the award and administration of the mentor firm's subcontract. Costs associated with the latter shall be accumulated and charged in accordance with the contractor's approved accounting practices; they are not considered developmental assistance costs eligible for either credit or reimbursement under the Program.

I–110 Advance agreements on the treatment of developmental assistance costs.

Pursuant to FAR 31.109, approved mentor firms seeking reimbursement, credit, or a combination thereof, are strongly encouraged to enter into an advance agreement with the contracting officer responsible for determining final indirect cost rates under FAR 42.705. The purpose of the advance agreement is to establish the accounting treatment of the costs of the development assistance pursuant to the mentor-protege agreement prior to the incurring of any costs by the mentor firm. An advance agreement is an attempt by both the Government and the mentor firm to avoid possible subsequent dispute based on questions related to reasonableness, allocability, or allowability of the costs of developmental assistance under the Program. Absent an advance agreement, mentor firms are advised to establish the accounting treatment of such costs and address the need for any changes to their cost accounting practices that may result from the implementation of a mentor-protege agreement, prior to incurring any costs, and irrespective of whether costs will be reimbursed, credited or a combination thereof.

I–111 Reporting requirements and program reviews.

(a) Mentor firms shall report on the progress made under active mentor-protege agreements semiannually by attaching to their SF 295—

(1) A statement which includes—

(i) The number of active mentor-protege agreements in effect; and

(ii) The progress in achieving the developmental assistance objectives under each mentor-protege agreement, including whether the objectives of the Program set forth in I–100(c) were met, any problem areas encountered, and any other appropriate information.

(2) A copy of the SF 294 for each contract where developmental assistance was credited, with a statement in Block 18 identifying—

(i) The amount of dollars credited to the SDB subcontract goal as a result of developmental assistance provided to protege firms under the Program;

(ii) An explanation as to the relationship between the developmental assistance provided the protege firm(s) under the Program and the activities under the contract covered by the SF 294(s); and

(iii) The number and dollar value of subcontracts awarded to the protege firm(s), broken out per protege.

(b) For commercial companies and companies participating in the DoD "Test Program for Negotiation of Comprehensive Small Business Subcontracting Plans," indicate in Block 16 of the SF 295—

(1) The total dollars credited to the SDB goal as a result of developmental assistance provided to a protege firm(s) under the Program.

(2) The total dollar amount of subcontracts awarded to the protege firm(s) broken our per protege.

(c) The OUSD(A&T)SADBU will conduct periodic performance reviews of the progress and accomplishments realized under approved mentor-protege agreements.

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Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412, 413, 482, 485 and 489
Medicare; Hospital Inpatient Prospective Payment Systems and Fiscal Year 1995 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 482, 485, and 489

[BPD–802–P]

RIN 0938–AG46

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1995 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In addition, in the addendum to this proposed rule, we are describing proposed changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 1994. We are also setting proposed rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems.

DATES: Comments will be considered received at the appropriate address, as provided below, no later than 5 p.m. on July 26, 1994.

ADDRESSES: Mail written comments (an original and 3 copies) to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–802–P, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (an original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, MD 21207.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–802–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to: Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, 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) 783–3238 or by faxing to (202) 275–6802. The cost for each copy is $6.00. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

To obtain data used in deriving the standardized amounts and DRG relative weights, see section VIII.B. of the **SUPPLEMENTARY INFORMATION** section of this preamble, Requests for Data From the Public.

FOR FURTHER INFORMATION CONTACT: Lana Price, (410) 966–4529.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), a system of payment for the operating costs of acute hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively-set rates was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment for hospital inpatient operating costs is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. On September 1, 1993, we published a final rule with comment period (58 FR 46270) to implement changes to the prospective payment system for hospital operating costs beginning with Federal fiscal year (FY) 1994.

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 (Public Law 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. 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. (See subpart M of 42 CFR part 412, and the August 30, 1991, final rule (56 FR 43358) for a complete discussion of the prospective payment system for hospital inpatient capital-related costs.)

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs. This proposed rule would be effective for discharges occurring on or after October 1, 1994. Following is a summary of the major changes that we are proposing to make:

1. Changes to the DRG Classification and Relative Weights

As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and relative weights at least annually. Our proposed changes for FY 1995 are set forth in section II of this preamble.

2. Changes to the Hospital Wage Index

In section III of this preamble, we discuss revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section include:

- FY 1995 wage index update.

- Changes in the reporting of hospital wage index data.
- Revisions to the wage index based on hospital redesignations.
- Impact of the revised hospital wage index.
- Occupational mix adjustment.
- Research on refinements to labor market areas.
- State labor market options.

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

In section IV of this preamble, we discuss several provisions of the regulations in 42 CFR parts 412, 413, 485, and 489 and set forth certain proposed changes concerning the following:

- Definition of and payment for transfer cases.
- Review of DRG assignments.
- National average standardized amounts for FY 1995.
- Outliers.
- Rural referral centers.
- Determination of number of beds in determining the indirect medical education adjustment.
- Disproportionate share adjustment.
- Changes affecting essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs).
- Clarification of payments to rural referral center/EACH hospitals.
- Direct graduate medical education payment.
- Other technical changes.

4. Changes and Clarifications to the Prospective Payment System for Capital-Related Costs

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

- Evaluation of provisions relating to obligated capital for hospitals subject to lengthy certificate-of-need (CON) process.
- Specific adjustment for taxes to the capital prospective payment system federal rate.
- Revision of provision relating to exceptions payments.
- Extraordinary circumstances exceptions payments.
- Funding of depreciation.

5. Changes for Hospitals Excluded from the Prospective Payment System

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

- New requirements for certain long-term care hospitals excluded from the prospective payment systems.
- Removal of the 1986 malpractice rule.
- Related technical changes.

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

In the addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1995 prospective payment rates for operating costs and capital-related costs. We are also proposing new update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 1995 for hospitals and hospital units excluded from the prospective payment system.

7. Impact Analysis

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

8. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 1995 capital acquisition model and budget neutrality adjustment.

9. Report to Congress on the Update Factor for Prospective Payment Hospitals and Hospitals Excluded from the Prospective Payment System

Section 1886(e)(3)(B) of the Act requires that the Secretary report to Congress no later than March 1, 1994 on our initial estimate of an update factor for FY 1995 for both prospective payment hospitals and hospitals excluded from the prospective payment system. This report is included as Appendix C to this proposed rule.

10. Proposed Recommendation of Update Factor for Hospital Inpatient Operating Costs

As required by sections 1886 (e)(4) and (e)(5) of the Act, Appendix D provides our recommendation of the appropriate percentage change for FY 1995 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.

11. Framework for Capital Update

In Appendix E, we are setting forth a preliminary framework for developing the annual update factor for inpatient hospital capital-related costs.

12. Discussion of Prospective Payment Assessment Commission Recommendations

The Prospective Payment Assessment Commission (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. 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. Under section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2) (A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We are printing ProPAC's March 1, 1994 report, which includes its recommendations, as Appendix F of this document. The recommendations, and the actions we are proposing to take with regard to them (when an action is recommended), are discussed in detail in the appropriate sections of this preamble, the addendum, or the appendices to this proposed rule. See section VII of this preamble for specific information concerning where individual recommendations are addressed. For a brief summary of the ProPAC recommendations, we refer the reader to the beginning of the ProPAC report as set forth in Appendix F of this proposed rule. ProPAC also produced technical appendices in its March 1, 1994 report that provide background material and detailed analyses used in preparation of the ProPAC recommendations. For further information relating specifically to the ProPAC report or to obtain a copy of the technical appendices, contact ProPAC at (202) 401–8986.

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1994 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. 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 Medicare fiscal 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. The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.

Currently, cases are assigned to one of 491 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

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

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (hereafter CC).

Generally, GROUPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

The changes we are proposing to make to the DRG classification system for FY 1995 are set forth below.

2. MDC 2 (Diseases and Disorders of the Eye)

When a case is coded with a principal diagnosis of subcorneal pustular dermatosis (diagnosis code 694.1), it is classified to MDC 2 (Diseases and Disorders of the Eye), where it is assigned to DRGs 46, 47, and 48 (Other Disorders of the Eye).[1] We recently received a suggestion from the public that we should review the DRG classification of subcorneal pustular dermatosis because it is a dermatological condition and is not a disease or disorder of the eye.

Since this issue involves a possible medical misclassification of a diagnosis, we asked our medical consultants to evaluate the condition. They determined that subcorneal pustular dermatosis is indeed a dermatological condition and not an eye condition. Based on their determination and recommendations, we propose to remove diagnosis code 694.1 from its current classification in MDC 2 and assign it to MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast).

In order to determine the appropriate DRG assignment in MDC 9, we first made a clinical evaluation of the medical DRGs. Based on the current MDC 9 configuration, the only possible DRGs appear to be DRGs 272 and 273 (Major Skin Disorders) or DRGs 283 and 284 (Minor Skin Disorders). After reviewing the average standardized charges and the types of costs assigned to DRGs 272 and 273, we believe the best assignment for 694.1 is DRGs 283 and 284. We note that the proposed FY 1995 relative weights of DRGs 46, 47, and 48 (0.7573, 0.4330, and 0.4182, respectively) are approximately equal to those of DRGs 283 and 284 (0.7142 and 0.4358, respectively). Therefore, we propose to move diagnosis code 694.1 to DRGs 283 and 284.

3. MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)

In the September 1, 1993 final rule (58 FR 46283), we stated that we would be evaluating the newborn and neonate DRG classifications and relative weights for possible improvements. Because of the low volume of cases in these DRGs in the MedPAR file, we stated that we intended to rely on data bases outside the Medicare claims file to supplement our data. We expect that any major reclassification changes to MDC 15 will be based on an evaluation of actual neonate case data, including charges and clinical information.

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[1] 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 is split on age >17 and age 0–17.

As we have not yet completed this evaluation, we will not be proposing our MDC 15 revisions for FY 1995. However, since publication of the September 1, 1993 final rule, we have received several suggestions from the public concerning improvements for the neonate DRG classifications. Some commenters suggested that we reevaluate the diagnoses that are currently considered significant problems in determining the assignment of a neonate case to DRG 390 (Neonate with Other Significant Problems) rather than DRG 391 (Normal Newborn). These commenters believe that many of the diagnoses currently assigned to DRG 390 are not truly significant clinically and in terms of resource use. These commenters also identified specific diagnoses within this group that are problematic. Even though we are not ready to proceed with a comprehensive proposal for revising MDC 15, we did ask our medical specialists to evaluate the specific conditions that were identified as problematic in the assignment of newborns to DRG 390.

Currently, cases of otherwise normal newborns with one of the following diagnoses are assigned to DRG 390 rather than DRG 391:

752.5—Undescended testicle
795.4—Other nonspecific abnormal histological findings
V05.3—Need for prophylactic vaccination against viral hepatitis
V05.4—Need for prophylactic vaccination against Varicella
V20.1—Other healthy infant or child receiving care

All of these diagnoses were identified by the commenters as nonsignificant conditions that are either not problems or require only minimal diagnostic work-up, no treatment, and result in the consumption of minimal or no additional resources. For these reasons, the commenters believe that these diagnoses should be added to the list of conditions that may be found as secondary diagnoses for DRG 391.

Specifically, a healthy newborn with undescended testicles requires only a minimal diagnostic work-up and no treatment at the time of birth. In addition, the conditions that are assigned to diagnosis code 795.4 (Other nonspecific abnormal histological findings) are nonsignificant problems and require no additional resources to treat.

Commenters also pointed out that it has become standard practice to inoculate newborns against viral hepatitis, and that a prophylactic vaccination against Varicella is normal and routine and does not indicate a problem with the newborn. Diagnosis code V20.1 is generally used to identify a healthy infant that remains in the hospital for an extended period of time because of maternal illness, and should not be considered a significant problem.

All of the conditions listed above were reevaluated on a clinical basis by our medical specialists, who determined that these diagnoses are not significant problems in neonates. Therefore, we are proposing to add them to the list of secondary diagnoses that would assign an otherwise normal newborn to DRG 391.

Based on comments received, we also reevaluated perinatal jaundice (diagnosis codes 774.0 through 774.7) and its DRG assignments. Currently, all of these diagnosis codes except 774.6 (unspecified fetal and neonatal jaundice) are considered major problems and are assigned to DRGs 387 (Prematurity with Major Problems) and 389 (Full Term Neonate with Major Problems). Diagnosis code 774.6 is not considered a significant problem and is assigned to DRG 388 (Prematurity without Major Problems) and DRG 391. Some commenters did not believe that 774.6 should be assigned to DRG 391 when all the other perinatal jaundice codes are considered major problems. Other commenters believe that some of the perinatal jaundice diagnoses that are currently considered major are really not that resource intensive.

Our medical specialists reevaluated these perinatal jaundice conditions, and, based on their determinations, we are proposing several revisions to the neonatal DRG assignments. First, the following diagnosis codes would be removed from the major problems list in DRGs 387 and 389 and would be added to the significant problems list:

774.0—Perinatal jaundice from hereditary hemolytic anemias
774.1—Perinatal jaundice from other excessive hemolysis
774.2—Neonatal jaundice associated with preterm delivery

Thus, a premature newborn with one of these codes would be assigned to DRG 388 and a full-term newborn with one of these codes would be assigned to DRG 390.

The following diagnosis codes would be removed from the major problems list in DRGs 387 and 389 and would not be added to the significant problems list:

774.30—Neonatal jaundice due to delayed conjugation, cause unspecified
774.31—Neonatal jaundice due to delayed conjugation in diseases classified elsewhere
774.39—Other neonatal jaundice due to delayed conjugation from other causes
774.5—Perinatal jaundice from other causes

Therefore, a premature newborn with one of these conditions would be assigned to DRG 388 and a full-term newborn with one of these conditions would be assigned to DRG 391.

The following diagnosis codes would remain on the major problems list and continue to result in assignment to DRGs 387 and 389:

774.4—Perinatal jaundice due to hepatocellular damage
774.7—Kernicterus not due to isoimmunization

Finally, diagnosis codes 774.6 (Unspecified fetal and neonatal jaundice) would continue to be considered a nonsignificant condition and result in assignment to DRGs 388 and 391.

We note again that these proposals are based only on clinical considerations and respond to specific requests made by the public. We will continue our work on a more comprehensive evaluation of the MDC 15 DRGs and will announce our proposal when that evaluation is completed.

4. 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 would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of "other OR procedures" as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for the procedure in the most resource-intensive surgical class, which may sometimes occur in cases involving multiple procedures, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when 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 relative weight 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 relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

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

At this time, we would revise the surgical hierarchy for MDC 2 (Diseases and Disorders of the Eye) and MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat).

- In MDC 2, we would reorder Extraocular Procedures Except Orbit (DRGs 40 and 41) above Intraocular Procedures Except Retina, Iris and Lens (DRG 42).
- In MDC 3, we would reorder Rhinoplasty (DRG 56) above Salivary Gland Procedures Except Sialoadenectomy (DRG 51).

5. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications or comorbidities (CCs). We developed this list using 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 1 day for at least 75 percent of the patients.

In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. For FY 1995, we are not proposing to make any changes to the current CC list.

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

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

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

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

rule for the revision made for discharges occurring in FY 1990 (54 FR 36552), the September 4, 1990 final rule for the revision made for discharges occurring in FY 1991 (55 FR 36126), the August 30, 1991 final rule for the revision made for discharges occurring in FY 1992 (56 FR 43209), the September 1, 1992 final rule for the revisions made for discharges occurring in FY 1993 (57 FR 39753), and the September 1, 1993 final rule for the revisions made for discharges occurring in FY 1994 (58 FR 46278).)

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1994. (See section II.B.7, below, for a discussion of these changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

In addition, upon review of our current CC Exclusions List, we found that there are some diagnosis codes that do not exclude themselves as CCs. In the September 1, 1987 final notice, we noted that a very few codes were not excluded from themselves because they may signify the bilateral occurrence of a particular condition (for example, diagnosis code 730.02 (acute osteomyelitis of upper arm)) (52 FR 33154). However, we found some diagnosis codes that do not meet this criterion. Therefore, we are proposing to add the following diagnosis codes to the CC Exclusions List as excluding themselves when they are secondary diagnoses:

710.0—Systemic lupus erythematous
710.1—Systemic sclerosis
710.3—Sicca syndrome
710.4—Dermatomyositis
710.8—Other specified diffuse diseases of connective tissue

Based on a comment we received, we are also proposing to exclude diagnosis code 707.1 (Ulcer of lower limb, except decubitus) as a CC when the principal diagnosis is 440.23 (atherosclerosis of the extremities with ulceration). The commenter believes that this exclusion is similar to the current exclusion of 785.4 (Gangrene) when the principal diagnosis is 440.24 (Atherosclerosis of the extremities with gangrene), and we agree with the commenter's assessment.

Finally, it was brought to our attention by another commenter that when a patient's principal diagnosis is complication of a transplant condition (diagnosis codes 996.71 and 996.8x), the diagnosis codes used to denote transplant status (V42.x) should not be considered CCs. Thus, for the following principal diagnoses, we are proposing to delete the indicated status code:

- For code 996.71 (Complications due to heart valve prosthesis) delete code V42.2 (Heart valve transplant influencing health status) as a CC.
- For code 996.80 (Complications of unspecified organ transplant) delete codes V42.0 (Kidney transplant influencing health status), V42.1 (Heart transplant influencing health status), V42.6 (Lung transplant influencing health status), V42.7 (Liver transplant influencing health status), and V42.8 (Other specified organ or tissue transplant influencing health status) as CCs.
- For code 996.81 (Complications of kidney transplant) delete code V42.0 (Kidney transplant influencing health status) as a CC.
- For code 996.82 (Complications of liver transplant) delete code V42.7 (Liver transplant influencing health status)
- For code 996.83 (Complications of heart transplant) delete code V42.1 (Heart transplant influencing health status) as a CC.
- For code 996.84 (Complications of lung transplant) delete code V42.6 (Lung transplant influencing health status) as a CC.
- For code 996.86 (Complications of pancreas transplant) delete code V42.8 (Other specified organ or tissue transplant influencing health status) as a CC.
- For code 996.89 (Complications of other specified organ transplant) V42.8 (Other specified organ or tissue transplant influencing health status) as a CC.

All of the changes discussed above have been added to Table 6f, Additions to the CC Exclusions List, in section V of the addendum to this proposed rule.

Tables 6f and 6g in section V of the addendum to this proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1994. 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 6f—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1994, 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 6g—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1994, 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 $84.00 and on microfiche for $20.50, plus $3.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number, (PB) 88–133970) should be made to the following address: National Technical Information Service; United States Department of Commerce; 5285 Port Royal Road, Springfield, Virginia 22161; or by calling (703) 487–4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, and 1994) and those in Tables 6f and 6g 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, 1994.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 11.0, is available for $195.00, which includes $15.00 for shipping and handling. Version 12.0 of this manual, which will include the changes proposed in this document as finalized in response to public comment, will be available in September 1994 for $195.00. These manuals may be obtained by writing 3M/HIS at: 100 Barnes Road; Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

6. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic OR procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) in order to determine whether procedures are properly assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the OR procedures performed is related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

60.0—Incision of prostate
60.12—Open biopsy of prostate
60.15—Biopsy of periprostatic tissue
60.18—Other diagnostic procedures on prostate and periprostatic tissue
60.2—Transurethral prostatectomy
60.61—Local excision of lesion of prostate
60.69—Prostatectomy NEC
60.81—Incision of periprostatic tissue
60.82—Excision of periprostatic tissue
60.93—Repair of prostate
60.94—Control of (postoperative) hemorrhage of prostate
60.95—Transurethral balloon dilation of the prostratic urethra
60.99—Other operations on prostate

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 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 part of the final rules published on September 4, 1990, August 30, 1991, September 1, 1992, and September 1, 1993, we moved several other procedures from DRG 468 to 477. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, and 58 FR 46279, respectively.)

a. Adding Procedure Codes to MDCs. 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. On the basis of this review, we are proposing the following DRG classification changes in order to reduce unnecessary assignment of cases to DRG 468 or 477.

• MDC 1 (Diseases and Disorders of the Nervous System)

We have observed that surgical pacemaker procedures are being performed with increasing frequency for anatomical nerve problems associated with heart block. These diagnoses, diagnosis codes 337.0 (Idiopathic peripheral autonomic neuropathy), 742.8 (Other specified anomalies of nervous system), and 742.9 (Unspecified anomaly of brain, spinal cord, and nervous system), are assigned to MDC 1, but the surgical pacemaker procedures are not. Consequently, when a pacemaker procedure is performed on a patient with one of these diagnoses, the case is assigned to DRG 468. Therefore, we propose to add the following procedure codes to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures):

37.74—Insertion or replacement of epicardial lead (electrode) into epicardium
37.75—Revision of lead (electrode)
37.76—Replacement of transvenous atrial and/or ventricular lead(s) (electrode)
37.77—Removal of lead(s) (electrode) without replacement
37.79—Revision or relocation of pacemaker pocket
37.80—Insertion of permanent pacemaker, initial or replacement, type of device not specified
37.85—Replacement of any type pacemaker device with single-chamber device, not specified as rate responsive
37.86—Replacement of any type pacemaker device with single-chamber device, rate responsive
37.87—Replacement of any type pacemaker device with dual-chamber device
37.89—Revision or removal of pacemaker device

In addition, during our review of DRG 468 cases, we found that there are several hundred cases of lower limb amputation procedures with a principal diagnosis from MDC 1. Patients with diabetes often develop complications that require the performance of a lower limb amputation. Although the majority of the diagnosis codes for diabetes are assigned to MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), cases with a principal diagnosis of diabetes with neurological manifestations (diagnosis codes 250.60, 250.61, 250.62 and 250.63) are assigned to MDC 1. Therefore, we are proposing to move the following procedures to DRGs 7 and 8:

84.11—Amputation of toe
84.12—Amputation through foot
84.13—Disarticulation of ankle
84.14—Amputation of ankle through malleoli of tibia and fibula
84.15—Other amputation below knee
84.16—Disarticulation of knee
84.17—Amputation above knee

• MDC 5 (Diseases and Disorders of the Circulatory System)

Closed endoscopic biopsy of lung (procedure code 33.27) and open biopsy of lung (procedure code 33.28), diagnostic tools for vascular tumors, are often performed on patients with a principal diagnosis of 228.00 (Hemangioma of unspecified site) or 228.09 (Hemangioma of other sites). Although these principal diagnoses are assigned to MDC 5, the diagnostic procedures are not. Thus, if they are included together on the same claim, the case will be assigned to DRG 468. Therefore, we are proposing to assign procedure codes 33.27 and 33.28 to DRG 120 (Other Circulatory System OR Procedures) in MDC 5.

In addition, we identified the following nonextensive OR procedures (that is, procedures assigned to DRG 477) as appropriate to move to MDC 5:

40.11—Biopsy of lymph structure
40.19—Other diagnostic procedures on lymphatic structures
40.21—Excision of deep cervical lymph node
40.23—Excision of axillary lymph node
40.24—Excision of inguinal lymph node
40.29—Simple excision of other lymphatic structure
40.3—Regional lymph node excision

These procedures are commonly performed with a variety of diagnoses found in MDC 5 such as disorders of the peripheral vascular system (diagnosis codes 747.60 and 747.69) and peripheral angiopathy (diagnosis code 443.81), as well as a number of heart conditions including malignant neoplasm of the heart (diagnosis code 164.1), and coxsackie carditis, coxsackie pericarditis, coxsackie endocarditis, and coxsackie myocarditis (diagnosis codes 074.20, 074.21, 074.22, 074.23, respectively). We note that these commonly performed diagnostic procedures are assigned to virtually every other MDC because they are associated with many diagnoses. Therefore, we propose to move these procedures to DRG 120.

We also note that hemangioma and anomalies of the peripheral vascular system may require open rectal biopsy (procedure code 48.25) or excision of the rectal lesion (procedure code 48.35) as part of their treatment. At the present time, neither of these procedure codes classify to MDC 5. Thus, we are proposing to move procedure codes 48.25 and 48.35 to DRG 120.

• MDC 6 (Diseases and Disorders of the Digestive System)

A total splenectomy (procedure code 41.5) may be performed on patients with

a principal diagnosis of secondary malignant neoplasm of other digestive organs and spleen (diagnosis code 197.8). This diagnosis is included in MDC 6, but the procedure is not, resulting in the assignment of cases to DRG 468. Thus, we propose to add procedure code 41.5 to DRG 170 and 171 (Other Digestive System OR Procedures) in MDC 6.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. We also reviewed the list of procedures that produce assignments to each of DRG 468, 476, and 477 to ascertain if any of those procedures should be moved to one of the other DRGs based on average charges and length of stay. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are proposing to move a limited number of procedures.

In reviewing the list of OR procedures that produce DRG 468 assignments, we analyzed the average charge and length of stay data for cases assigned to that DRG to identify those procedures that are more similar to the discharges that currently group to either DRG 476 or 477. We identified three procedures that are significantly less resource intensive than the other procedures assigned to DRG 468. Therefore, we are proposing to move the following procedures to the list of procedures that result in assignment to DRG 477:

24.5—Alveoloplasty
53.61—Incisional hernia repair with prosthesis
53.69—Repair of other hernia of anterior abdominal wall with prosthesis

We conducted a similar analysis of the procedures that assign cases to DRG 477 to determine if any of those procedures might more appropriately be classified to DRG 468. Again, we analyzed charge and length of stay data to identify procedures that were more similar to discharges assigned to DRG 468 than to those classified in DRG 477. We did not identify any procedures in DRG 477 that should be assigned to DRG 468.

All of the proposed reassignments of procedures in DRGs 468 and 477 would be effective with discharges beginning on or after October 1, 1994.

7. 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. That mission includes approving coding changes, and 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 health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding fields, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, 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 6, August 5, and December 2, 1993, and finalized the coding changes after consideration of comments received at the meetings and in writing within 30 days following the December 1993 meeting. The initial meeting for consideration of coding issues for implementation in FY 1996 will be held on May 5, 1994. Copies of the minutes of these meetings may be obtained by writing to one of the co-chairpersons representing NCHS and HCFA. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Sue Meads, 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, 1994. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section IV of the addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classification.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6c (Invalid Diagnosis Codes). The invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 1994. The corresponding new or expanded codes are included in Tables 6a and 6b. The committee did not delete any procedure codes effective for October 1, 1994. Revisions to diagnosis and procedure code titles are in Tables 6d (Revised Diagnosis Code Titles) and 6e (Revised Procedure Code Titles), which also include the proposed DRG assignments for these revised codes.

8. DRG Refinements

For several years, we have been analyzing major refinements to the DRG classification system to compensate hospitals more equitably for treating severely ill Medicare patients. These refinements, generally referred to as severity of illness adjustments, would create DRGs specifically for hospital discharges involving very ill patients who consume far more resources than do other patients classified to the same DRGs in the current system. This approach has been taken by various

other groups in refining the DRG system, most notably the research done for Yale, the changes incorporated by the State of New York into its all patient (AP) DRG system, and the all-patient refined (APR) DRGs, which are a joint effort of 3M/HIS and the National Association of Children's Hospitals and Related Institutions.

Our preliminary work on these refinements is finished, and we have prepared a paper available to the public for comment that describes our proposed severity DRG classification system as well as the analysis upon which our proposal was formulated. Briefly, our approach was to develop a list of secondary diagnoses that have a major effect on the resources used by hospitals in treating patients across DRGs and to evaluate the need to create DRGs for major CCs on a DRG-by-DRG basis. The following is a description of our methodology:

- Our first step, similar to the process used by Yale, was to collapse the current paired DRG groupings (DRGs with and without CCs). We also evaluated the current DRGs to determine if any of them could be combined. Based on this analysis, we eliminated 24 DRGs.
- Our next step was to evaluate individual diagnosis codes to determine if the presence of the diagnosis as a secondary condition resulted in increased resource use for hospitals across all DRGs. We analyzed how the presence of the secondary diagnosis affected resource use compared to other secondary diagnoses that have been classified as non-CC, CC, or major CC.
- Although our final decisions of the CC designation of a secondary diagnosis were primarily data driven, we did make some designations based on other factors. Specifically, regardless of the data, we did not designate a diagnosis as major if it is indicative of poor quality of care or is prone to hospital upcoding.
- After finalizing the classification of secondary diagnoses, we evaluated which collapsed DRGs should be split on the basis of the presence of a major CC, other CCs, or both. We developed criteria for this evaluation that allow a DRG to split only if the volume and difference in resource use is significantly different from the remainder of the cases in the DRG and there is a significant reduction in variance. The collapsed DRGs can be split into three variations:

—DRG With CC or Major CC
—DRG Without CC
- DRG With Major CC
—DRG Without Major CC
—DRG With Major CC
—DRG With CC
—DRG Without CC

There are 120 DRGs that do not split at all. This final step resulted in the creation of 652 DRGs compared to the 491 DRGs we currently use.

The paper we have prepared includes a listing of the revised DRGs as well as the relative weights that would have been assigned to the DRGs using the FY 1992 MedPAR data and a list of every diagnosis code in effect in FY 1993 with its current and proposed CC assignment (non-CC, CC, or major CC). In order to begin consultation with the hospital industry and other interested organizations before formally proposing our revised system, we will be distributing the paper to many hospital-related associations and organizations for their comment. In addition, requests for the DRG severity refinement paper may be made to the following address: Division of Hospital Payment Policy, 1–H–1 East Low Rise, 6325 Security Boulevard, Baltimore, Maryland 21207, Attn: Nancy Edwards; or by calling (410) 966–4532. Comments are due to HCFA by September 30, 1994.

Similar to our usual practice for proposed DRG changes to the prospective payment system, we are making available to the public an FY 1992 Expanded Modified MedPAR File for Severity that contains the discharge records we used to calculate the severity DRG relative weights. Requests for this file can be made by following the instructions set forth in section VIII.B of this preamble (Requests for Data from the Public). Also available are Severity versions of the HCFA Medicare Case-Mix Index File, Table 5 DRG, and the AOR/BOR File.

Our plan is to incorporate comments and suggestions we receive and to consider proposing the complete revised DRG system as part of the FY 1996 prospective payment system proposed rule, which will be published in the spring of 1995. However, as the final rule published on September 1, 1992 (57 FR 39761) indicates, we would not propose to make significant changes to the DRG classification system unless we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG 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.

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. Our goal is to refine our methodology so that we can fulfill, in the most appropriate manner, both the statutory requirement to make appropriate DRG classification changes and to recalibrate DRG relative weights (as mandated by section 1886(d)(4)(C) of the Act) as well as to make DRG changes in a budget neutral manner.

One approach to this problem would be to maintain 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 relative 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 the case-mix index from accumulating in the DRG weights.

In addition to the severity changes, we also intend to improve the classification and relative weights of the DRGs that apply to newborns, children, and maternity patients. The Medicare population does not include many of these individuals. The original DRG classification system was developed from analysis of claims data representative of the total inpatient population. When we calculated the original Medicare weights for the DRGs to which newborn, children and maternity patients are classified, we used non-MedPAR discharge records from Maryland and Michigan hospitals because there were either no MedPAR cases or too few cases assigned to these DRGs to provide a reasonably precise estimate of the average cost of care. (See the September 1, 1983 prospective payment final rule with comment period (48 FR 39768).) Since that time, because of the lack of MedPAR data, these low-volume DRGs have not been analyzed and refined, and the relative weights assigned to them may no longer be entirely reflective of the resources needed to treat the patients. We again intend to rely on data bases outside the MedPAR file to supplement our data.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 1995 recalibration as we did for FY 1994. (See the September 1, 1993 final rule (58 FR 46290).) That is, we would recalibrate

the weights based on charge data for Medicare discharges. However, we would use the most current charge information available, the FY 1993 MedPAR file, rather than the FY 1992 MedPAR file. The MedPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights are constructed from FY 1993 MedPAR data, received by HCFA through December 1993, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1993 MedPAR file includes data for approximately 10.5 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1993 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed above in section II.B of this preamble. As noted in section II.B.4, due to the unavailability of revised GROUPER software, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification. However, there are some changes that cannot be modeled.
- 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 relative weight.
- We established the relative weight for heart transplants (DRG 103) in a manner consistent with the methodology for all other DRGs except that the heart transplant cases that were used to establish the weight were limited to those Medicare-approved heart transplant centers that have cases in the FY 1993 MedPAR file. Similarly, we limited the liver transplant cases that were used to establish the weight for DRG 480 (Liver Transplant) to those hospitals that are Medicare-approved liver transplant centers.
- Acquisition costs for kidney, heart, and liver transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); and DRG 480 (Liver Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before 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. We propose to use that same case threshold in recalibrating the DRG weights for FY 1995. Using the FY 1993 MedPAR data set, there are 35 DRGs that contain fewer than 10 cases. We computed the weight for the 35 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 proposed DRG classification changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight before 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 beginning with FY 1991, reclassification and recalibration changes 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. 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 because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this proposed rule, we are proposing to make a budget neutrality adjustment to assure the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

III. Proposed Changes to the Hospital Wage Index and Possible Refinements to Labor Market Areas

A. Background

Under the Medicare prospective payment system, different payment rates are calculated for hospitals located in rural, urban, and large urban areas. For purposes of the standardized payment amount, section 1886(d)(2)(D) of the Social Security Act requires that we use Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB) to determine whether hospitals are located in rural, urban or large urban areas (areas with a population over 1 million). However, section 1886(d)(3)(A) of the Act provides for the elimination of separate urban and rural standardized payment amounts beginning in FY 1995. This change is discussed below in section IV.C. of this proposed rule.

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary shall adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." In accordance with the broad discretion conferred by this provision, we currently define hospital labor market areas based on the definitions of MSAs issued by OMB. Additionally, as discussed below, we adjust the wage index to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

Section 1886(d)(3)(E) of the Act also requires that the wage index be updated annually beginning October 1, 1993. This section further provides that the Secretary base the update on a survey of wages and wage-related costs of short-term acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category and must exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing services.

For determining prospective payments to hospitals in FY 1994, the wage index is based on the data collected from the Medicare cost reports

submitted by short-term acute care hospitals for cost reporting periods beginning in FY 1990 (that is, cost reporting periods beginning on or after October 1, 1989 and before October 1, 1990). The current wage index includes wages and salaries paid by a hospital, home office salaries, fringe benefits, and certain contract labor costs and hours. The current computation for the wage index excludes salaries and wages associated with non-hospital type services, such as skilled nursing facility services, home health agency services, or other subprovider components that are not subject to the prospective payment system.

As discussed in detail below, we are proposing to use updated wage data to construct the wage index as required by section 1886(d)(3)(E) of the Act. The FY 1995 wage index would be based on data for hospital cost reporting periods beginning on or after October 1, 1990 and before October 1, 1991 (FY 1991).

B. FY 1995 Wage Index Update

We propose to base the FY 1995 wage index, effective for hospital discharges occurring on or after October 1, 1994 and before October 1, 1995, upon the data collected from the Medicare cost report (Worksheet S–3, Part II) submitted by hospitals for cost reporting periods beginning in FY 1991.

We propose to use all of the categories of data collected from Worksheet S–3, Part II. Therefore, the proposed FY 1995 wage index reflects the following:

- Total short-term acute care hospital salaries and hours.
- Home office costs and hours.
- Fringe benefits associated with hospital and home office salaries.
- Direct patient care related contract labor cost and hours.
- The exclusion of salaries and hours for non-hospital type services such as skilled nursing facility services, home health services, or other sub-provider components that are not subject to the prospective payment system.

1. Verification of Wage Data from the Medicare Cost Report

The data for the proposed FY 1995 wage index was obtained from Worksheet S–3, Part II, of the HCFA–2552 submitted by short-term acute care hospitals for cost reporting periods beginning during FY 1991. The wage data are reported electronically to HCFA through the Hospital Cost Report Information System (HCRIS). Because of substantial deficiencies in the initial data reported by hospitals on the cost report (including missing data items such as excluded hours and total paid hours), we initiated an intensive review of the wage data and made numerous edits to ensure quality and accuracy. Medicare intermediaries were instructed to transmit any revisions through HCRIS by early January 1994.

We subjected the revised cost report data to several edit checks. Of the 5,294 providers in the data base, over 1,400 providers had data elements that failed an edit; 53 of these involved mathematical errors and have been resolved.

The other edits involved data that appeared unusual and had to be verified by the intermediary. Only 74 providers had data elements that were unresolved as of March 14, 1994. Most of the unresolved data elements fall outside established edit parameters and require verification by the intermediary. None of the unresolved data elements failed critical edits (that is, edits indicating serious data errors that affect the wage index computation).

The wage file used to construct the proposed wage index includes data obtained in late January 1994 from the HCRIS database and subsequent changes we received from intermediaries through March 14, 1994. We have instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data, via HCRIS, no later than June 15, 1994. We expect that all outstanding data elements will be resolved by that date and that we will be able to reflect the corrected data in the final rule.

In the past, the hospital wage index data file was not available to the public until mid-May. However, to allow hospitals more time to evaluate the wage data used to construct the proposed hospital wage index, on March 16, 1994, we made available to the public a diskette containing the raw hospital wage data that were used to construct the proposed FY 1995 wage index. We advised State and national hospital groups of the availability of the data. We also instructed all fiscal intermediaries to inform the prospective payment hospitals they service that we would not be sending out hospital-specific wage data as we had for the proposed FY 1994 wage index, but that we would make the FY 1991 data available on a diskette. The fiscal intermediaries were instructed to advise hospitals of the availability of the data either through their representative hospital organizations or directly from HCFA using order forms provided to them. Additional details on the cost and ordering of this file will be found below in section VIII. B. of this proposed rule, Requests for Data from the Public.

In addition, we note that Table 3c in the Addendum to this proposed rule contains each hospital's inflated average hourly wage used to construct the wage index values. By backing out the applicable inflation factors (set forth below in section III.B.3.), a hospital can determine its uninflated average hourly wage as reflected in the proposed wage index. This table will also be included in the final rule. If a hospital believes, based on its review of the data contained in Table 3c, that its average hourly wage is inconsistent with the data submitted on Worksheet S–3, the hospital should contact its intermediary.

2. Requests for Wage Data Corrections

As noted above we will use cost report data from FY 1991 (that is, cost reporting periods beginning on or after October 1, 1990 and before October 1, 1991) for the update to the wage index. As such, we believe hospitals have had ample time to ensure the accuracy of their FY 1991 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. However, if a hospital believes that its FY 1991 wage data have been incorrectly reported, the hospital must submit corrections along with complete supporting documentation to its intermediary in time to allow for review, verification and transmission of the data before the development of the final wage index. To allow sufficient time to process any changes, a hospital must submit requests for corrections to its fiscal intermediary by May 15, 1994. The request should include all documentation necessary to support the requested change. To be reflected in the final wage index, any wage data corrections must be reviewed by the intermediary and transmitted to HCFA via HCRIS on or before June 15, 1994.

This deadline is necessary to allow sufficient time to download and edit the data so that the final wage index calculation can be completed for development of the final prospective payment rates to be published by September 1, 1994. We cannot guarantee that corrections transmitted to HCFA after June 15, 1994, will be reflected in the final wage index. Therefore, we suggest that hospitals wishing to submit corrected data do so as soon as possible and follow up with their intermediaries to ensure inclusion of the corrected data in the final FY 1995 wage index.

After reviewing requested changes submitted by hospitals, intermediaries will transmit any revised cost reports to HCRIS and will forward to the hospitals a copy of the revised Worksheet S–3.

Part II. If requested changes are not accepted, fiscal intermediaries will notify hospitals in writing of reasons why the changes were not accepted. This procedure will ensure that hospitals have an opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, in the event that a hospital disagrees with the intermediary's resolution of a requested change, the hospital may contact HCFA to attempt to resolve the dispute.

We have created the above-described process to resolve all substantive wage data correction disputes before we finalize the raw wage data for the FY 1995 payment rates. Accordingly, hospitals that do not meet the procedural deadlines described above will not be afforded a later opportunity to submit wage corrections or to dispute the intermediary's decision with respect to requested changes. We note that we intend to make a diskette available in mid-August that will contain the finalized raw wage data that will be used to construct the wage index values in the final rule. As with the diskette made available in March 1994, HCFA will make the August diskette available to hospital associations and the public. This August diskette, however, is being made available only for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the finalized wage data, not for the initiation of new wage data correction requests. Hospitals are encouraged to review their hospital wage data promptly after the release of the second diskette.

If after reviewing the August diskette, a hospital believes that its wage data is incorrect due to a fiscal intermediary or HCFA error, it should send a letter to both its fiscal intermediary and HCFA. The letters to the intermediary and HCFA should outline why the hospital believes an error exists. These requests must be *received* by HCFA no later than September 23. Requests should be sent to: Charles R. Booth, Director; Office of Payment Policy; 181 East High Rise; 6325 Security Boulevard; Baltimore, Maryland 21207. The intermediary will review requests upon receipt and, if it is determined that an intermediary or HCFA error exists, the fiscal intermediary will notify HCFA immediately.

As indicated above, after mid-August, we will make changes to the hospital wage data only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the August diskette. Specifically, neither the intermediary nor HCFA will accept the following types of requests in conjunction with this mid-August process: requests for wage data correction that were submitted too late to be included in the data transmitted to the HCRIS system on or before June 15, 1994, requests for correction of errors made by the hospital not identified during the hospital's review of the March 1994 data, or requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process. Verified corrections to the wage index made as a result of an intermediary or HCFA error received timely (that is, by September 23, 1994) will be effective October 1, 1994.

We continue to believe, as outlined in the final rule published September 1, 1992 (57 FR 39765), that midyear corrections should not be made in most cases. We believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors made during the preparation of Worksheet S–3 to the intermediary's attention. Moreover, because hospitals will have access to the raw wage data in mid-August, they will have the opportunity to detect any ministerial data tabulation errors made by the intermediary or HCFA before the implementation of the prospective payment rates on October 1. We believe that if hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be free of such errors. Nevertheless, in the unlikely event that such errors should occur, we do not believe a hospital should be disadvantaged because actions taken by its intermediary or HCFA in the tabulation of its data resulted in an error of which the hospital could not have been aware. Since the current regulations do not provide for midyear corrections in these situations, we are proposing to revise the regulations to specify that the Secretary retains the right to make midyear changes to the wage index under very limited circumstances. Again, we believe that it is appropriate to reserve the right to make midyear changes to the wage index in those limited circumstances where the hospital can show that an error was made, and the hospital could not have known about, or sought to correct, the error by September 23, 1994.

Specifically, we propose to revise § 412.63(s)(2) to provide that the Secretary may make midyear corrections to the wage index only in those limited circumstances where a hospital can show: (1) That the intermediary or HCFA made an error in tabulating its data, and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, by September 23, 1994. As indicated earlier, since a hospital will have the opportunity to verify its data and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be made prospectively from the date the correction is made. If midyear corrections are made, we will evaluate their impact to determine if a budget neutrality adjustment to the program payments should be made at the beginning of the following fiscal year in accordance with § 412.63(s)(4).

3. Computation of the Wage Index

As noted above, we are proposing to base the FY 1995 wage index on wage data reported on the FY 1991 cost report. The wage index would be based on data from 5,294 hospitals paid under the prospective payment system and short-term acute care hospitals in waiver States. The method used to compute the proposed wage index is as follows:

Step 1—We gathered data from each of the non-Federal short-term acute care hospitals for which data were reported on the Worksheet S–3, Part II of the Medicare cost report for the hospital's cost reporting periods beginning on or after October 1, 1990, and before October 1, 1991. Each hospital was assigned to its appropriate urban or rural area prior to any reclassifications under sections 1886(d)(8) or 1886(d)(10) of the Act. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1990 and had reported a cost reporting period exceeding 52 weeks. The data were included because no other data from these hospitals would be available for the cost reporting period described above, and particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe this wage data as FY 1991 data.

Step 2—For each hospital, we subtracted the excluded salaries (that is, direct salaries attributable to skilled nursing facility services, home health services, and other sub-provider components not subject to the prospective payment system) from gross

hospital salaries to determine net hospital salaries. To the net hospital salaries, we added hospital contract labor costs, hospital fringe benefits, and any home office salaries and fringe benefits reported by the hospital to determine total salaries plus fringe benefits.

Step 3—For each hospital, we inflated or deflated, as appropriate, the total salaries plus fringe benefits resulting from Step 2 to a common period to determine total adjusted salaries. To make the wage inflation adjustment, we used the percentage change in average hourly earnings for each 30-day increment from October 14, 1990 through September 15, 1992, for hospital industry workers from S.I.C. 806, Bureau of Labor Statistics Employment and Earnings Bulletin. The annual inflation rates used were 5.6 percent for FY 1990 and FY 1991 and 4.8 percent for FY 1992. The inflation factors used to inflate the hospital's data were based on the midpoint of the cost reporting period as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/90	11/15/90	1.071953
11/14/90	12/15/90	1.067097
12/14/90	01/15/91	1.062262
01/14/91	02/15/91	1.057450
02/14/91	03/15/91	1.052659
03/14/91	04/15/91	1.047890
04/14/91	05/15/91	1.043143
05/14/91	06/15/91	1.038417
06/14/91	07/15/91	1.033713
07/14/91	08/15/91	1.029030
08/14/91	09/15/91	1.024368
09/14/91	10/15/91	1.019727
10/14/91	11/15/91	1.015751
11/14/91	12/15/91	1.011790
12/14/91	01/15/92	1.007845
01/14/92	02/15/92	1.003915
02/14/92	03/15/92	1.000000
03/14/92	04/15/92	0.996101
04/14/92	05/15/92	0.992217
05/14/92	06/15/92	0.988348
06/14/92	07/15/92	0.984494
07/14/92	08/15/92	0.980655
08/14/92	09/15/92	0.976831

For example, the midpoint of a cost reporting period beginning January 1, 1991 and ending December 31, 1991 is June 30, 1991. An inflation adjustment factor of 1.033713 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1991 and covers a period of less than 360 days or greater than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 4—For each hospital, we subtracted the reported excluded hours from the gross hospital hours to determine net hospital hours. We increased the net hours by the addition of any reported contract labor hours and home office hours to determine total hours.

Step 5—As part of our editing process, we deleted data for 69 hospitals that are no longer participating in the Medicare program or that are in bankruptcy status, and for which we lacked sufficient documentation to verify data that failed edits. We retained the data for other hospitals that are no longer participating in the Medicare program because these hospitals contributed to the relative wage levels in their labor market areas during their FY 1991 cost reporting period.

Step 6—Within each urban or rural labor market area we added the total adjusted salaries plus fringe benefits obtained in Step 3 for all hospitals in that area to determine the total adjusted salaries plus fringe benefits for the labor market area.

Step 7—We divided the total adjusted salaries plus fringe benefits obtained in Step 6 by the sum of the total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus fringe benefits obtained in Step 3 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $18.1808.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

C. Changes In the Reporting of Hospital Wage Index Data

Currently, the data used to develop the wage index are submitted by hospitals on the Worksheet S–3, Part II of the Medicare cost report. We developed this worksheet as part of the FY 1990 cost reports, and we used the worksheet to calculate the wage index for FY 1994. The worksheet has been evaluated by HCFA and industry representatives to ensure that this data collection mechanism captures relative wage costs as accurately as possible and to determine whether any refinements are appropriate. The Medicare Technical Advisory Group (MTAG) established a task force to study and recommend changes to the cost reporting form used to collect wage index data. The task force was comprised of hospital, intermediary, and HCFA representatives. The MTAG task force recommended, and we are proposing, three major changes to the Worksheet S–3, Part II; the provider cost report questionnaire (HCFA 339); and accompanying instructions as discussed below. We note that the proposed changes outlined below are effective for cost reporting periods beginning on or after October 1, 1994. Therefore the proposed changes will not affect the proposed FY 1995 wage index, which is based on FY 1991 wage data.

1. The Elimination of Part A Physicians' and CRNA Salaries

Currently, a hospital that directly employs and pays the salary of a physician can include the Part A portion of the physician's salary in total salaries reported on Worksheet S–3, Part II. (The Part B portion of physician salaries has always been excluded from the wage index.) However, if a hospital contracts for physician services, it is not permitted to include the Part A physician services as contract labor because we consider Part A physician services to be administrative, not direct patient-care related (to be included in the computation of the wage index, contract labor must be directly related to patient care).

Not all hospitals directly employ physicians. There are currently five States in which State laws specifically restrict hospitals from directly hiring physicians. Hospitals in these States are forced to contract out for physicians. The inability of those hospitals that contract for physician services to include the Part A portion of the services as contract labor has been perceived as inequitable. In States where hospitals may directly employ physicians, the hospitals may include some of these characteristically high wages in the wage data, while in States where hospitals must contract for their physician services, these contract wages cannot be included in their wage data.

We agree with the MTAG task force recommendation and are proposing to exclude all Part A physician costs on the Worksheet S–3, Part II, regardless of whether the physician is a hospital employee or contractor. For purposes of this exclusion, physician's salaries are defined as salaries applicable to positions that require a licensed physician, such as a medical director of a department. Salaries for physicians employed in other positions, such as hospital administrator, that do not

require a physician would not be excluded.

Since this change would apply equally to hospitals that are permitted to employ physicians and to those that must contract for physician services, we believe this proposal will promote payment equity and provide more uniformity in the wage data across areas. This action should not require any additional reporting burden since these Part A physician salaries already are reported on the cost report (Worksheet A–8–2).

We believe that this proposal to eliminate Part A physicians' salaries is more appropriate than the alternative of allowing all Part A physician costs (whether salaried or under contract) for three reasons. First, physician costs are not driven by normal labor market situations and, in many cases, hospitals must hire physicians from outside of their recruiting areas. Second, many hospitals have indicated difficulty in accurately determining the hours for the physicians attributable to Part A services, especially for those under contract.

Third, we have found that some hospitals that employ physicians are not appropriately eliminating Part B physician salaries from the total salaries reported for the wage index as required in the cost reporting instructions. Accordingly, we are proposing that hospitals exclude all physicians' salaries (both Part A and Part B related) from the wage data reported on the Medicare cost report. In addition, we are proposing that the salaries for teaching physicians also be excluded, since payment for these services does not fall under the prospective payment system.

Regarding Part A CRNA (certified registered nurse anesthetist) costs, we propose to require hospitals to exclude these salaries from the wage data reported on the cost report. These Part A services are currently paid on a "pass-through" basis, outside the prospective payment system. Therefore, we believe it is appropriate to exclude these costs from the wage index. Moreover, this Part A pass-through provision is applicable to a limited number of hospitals (small rural hospitals). All other hospitals are paid for CRNA services under Part B of the Medicare program. Therefore, in order to ensure consistency across areas, we believe that no CRNA costs should be reflected in the wage index computation. CRNA services are generally excluded from the wage index as Part B services. Since the Part A portion was granted as a pass through for certain rural hospitals, it is currently included in wage index.

We note that these changes are effective for cost reporting periods beginning on or after October 1, 1994 and will not affect the current reporting of physicians and CRNA salaries.

2. Management Contracts

The second major proposed change concerns the inclusion of certain management contracts in the hospital wage index data. Before FY 1994, the wage index did not include any costs associated with contract services. However, many hospitals indicated that they were inappropriately disadvantaged because they were forced to contract out for nurses and technicians due to shortages of these services in their areas. To alleviate this problem, we revised the cost report to collect the data associated with any direct patient care service contract (that is, nursing, therapeutic, etc.). We specifically excluded any Part B services, Part A physician services, management contracts, or any contract for services not directly involved with patient care.

The hospital industry has expressed concern that we do not currently recognize the cost of certain contract management services. In particular, many rural hospitals that are either unable to recruit or cannot afford top managers such as hospital administrators must contract for the services of these individuals. Therefore, we believe it is appropriate to include the costs of certain management contracts in the wage index. We propose to expand the definition of contract services reported on the Worksheet S–3 to include the personnel cost associated with contracts for any personnel hired in the top four positions within the hospital. Allowable contract management services would be limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of the Chief Executive Officer (CEO)/Hospital Administrator, Chief Operating Officer (COO), Chief Financial Officer (CFO), or Nursing Administrator. The exact titles assigned to individuals may vary but the individuals should be performing essentially the same duties as customarily assigned these management positions.

The hospitals (via HCFA–339 form) would be required to provide the fiscal intermediary with complete details on all direct patient care related contracts and the description and aggregate totals for all management contracts. Because of the difficulty in accurately determining hours and isolating wage related costs for the other types of contract services, the wage data would continue to exclude all other non-patient care contract services except those limited management contracts discussed above.

Since the current cost report does not provide for the collection of management contract data, this revised definition would not be effective until cost reporting periods beginning on or after October 1, 1994. To provide consistent reporting of data, hospitals must continue to exclude all management contracts until the FY 1995 data is reported.

3. Reporting of Wage-Related Costs

Since we began including fringe benefits in the wage index, we have been concerned with the inconsistent reporting of fringe benefits, whether because of a lack of provider proficiency in identifying fringe benefit costs or varying interpretations across fiscal intermediaries of the definition for fringe benefits in PRM–I, § 2144.1. Although we have attempted to promote consistent reporting of fringe benefits by providing fiscal intermediaries with general guidelines to be used in determining allowable fringe benefit costs, the intermediaries must necessarily make judgments as to whether certain costs qualify as a fringe benefit, and inconsistencies persist.

Last summer, HCFA conducted a survey to determine what costs the health care industry thought should be recognized as fringe benefit costs. The survey consisted of a questionnaire with a yes/no response column and a column for comments. We received 238 responses from hospitals, fiscal intermediaries, state hospital associations, national hospital associations, state agencies, and bureaus and offices within HCFA. The results of those surveys were examined closely by the MTAG task force.

Based on the recommendations of the task force, we are proposing several changes that we believe will promote more equitable and consistent reporting of wage-related costs for all hospitals. Where the term "fringe benefit" has been used in the past, we will now refer to these costs as "wage- related costs" for wage index purposes. We believe that this change in terminology will eliminate the confusion regarding those wage-related costs that we will allow to be incorporated in the wage index versus the definition of fringe benefits required by Medicare principles for cost reimbursement purposes. Accordingly, we are proposing to revise the Worksheet S–3, Part II to capture wage-related costs in three parts.

a. Wage-Related Costs (Core). For most hospitals, the wage-related costs

used to develop the wage index would be limited to "core" wage-related costs. The list of "core" wage-related costs includes all commonly recognized costs (which are similar to fringe benefits used for cost reimbursement purposes) that contribute significantly to the wage costs of a hospital and that are readily identifiable on the hospital records. These costs will also be listed on the revised HCFA–339 form, and hospitals will be required to provide the intermediary with a detailed description of the wage-related costs in Exhibit 7. This description will allow the intermediary to review the appropriateness of each wage-related cost. We believe that this core list includes virtually all significant wage-related costs, including those costs that are required by statute.

To develop the list of core wage-related costs, the MTAG task force established a number of specific criteria. To be considered a core wage-related cost, one or more of the following criteria must be met:

- The wage-related cost is provided at a significant financial cost to the employer.
- The wage-related cost is of a type and nature that would generally be offered as a fringe benefit by most employers.
- The perceived value of this wage-related cost is of such importance that it would influence an individual's employment decisions.
- The wage-related cost is a mandatory requirement under Federal or State law (for example FICA, Federal and State unemployment, etc.).
- Fees paid to external organizations that are directly associated with the core wage-related costs may be included as part of the wage-related cost (for example, actuarial fees, claim administration fees, IRS form preparation fees, etc.).

The following is the proposed list of core wage-related costs:

(1) Retirement Costs:
401(k) employer contributions
Tax sheltered annuity (TSA) employer contributions
Qualified and non-qualified pension plan cost
Prior year pension service cost
(2) Plan Administration Costs (Paid to external organization):
401(k)/TSA plan administration fees
Legal/accounting/management fees—pension plan
Employee managed care program administration fees
(3) Health and Insurance Costs:
Health insurance (purchased or self-funded)
Prescription drug plan
Dental, hearing, vision plans
Life insurance (if employee is owner or beneficiary)
Accident insurance (if employee is owner or beneficiary)
Disability insurance (if employee is owner or beneficiary)
Long-term care insurance (if employee is owner or beneficiary)
Workmen's compensation insurance
Retiree health care cost (only current year, not the extraordinary accrual required by FASB 106 (that is, the non-cumulative portion))
(4) Taxes:
FICA—employers portion only
Medicare taxes—employers portion only
Unemployment insurance
State or Federal unemployment taxes
(5) Other:
Executive deferred compensation
Day care cost and allowances
Tuition reimbursement

b. Other Wage-Related Costs. A hospital may be able to report an additional wage-related cost that does not appear on the core list if it meets the following criteria:

- The wage-related cost is provided at a significant financial cost to the employer. To meet this test the individual wage-related cost must be greater than 1 percent of total salaries after the direct excluded salaries are removed (Column 3, line 3 on Worksheet S–3, Part II).
- Any wage-related cost that would be a fringe benefit if reported to the IRS as a fringe benefit.
- The wage-related cost has not been furnished for the convenience of the provider.

We note that those wage-related costs that are required to be reported to the IRS as salary (for example, loan forgiveness and sick pay accruals) would not be included as other wage-related costs, since the costs associated with these items are considered salaries and would already be included in the total salaries reported on line 1.01 of the Worksheet S–3, Part II.

c. Wage-Related Costs (Excluded Area). Wage-related costs associated with employees in areas of the hospital that are excluded from the data used to calculate the wage index (such as a hospital-based SNF) should be removed from the total wage-related costs. This is not a new policy; however, to ensure that hospitals are removing these costs, we have added a new line on the Worksheet S–3, Part II.

In addition to the above changes, we are proposing that, beginning on or after October 1, 1994, hospitals use Generally Accepted Accounting Principles (GAAP) in developing the wage-related costs contained in the Worksheet S–3, Part II, for purposes of the hospital wage index. For all other purposes, however, Medicare principles will continue to apply in determining the allowability of fringe benefit costs. The MTAG task force recommended application of GAAP for purposes of developing wage-related costs used to construct the hospital wage index. We believe it is appropriate to apply GAAP for these purposes because the function of the wage index is to measure *relative* hospital labor costs across areas. This function is distinct from that of cost reimbursement, in which applicable Medicare principles (which may differ from GAAP) measure the actual costs incurred by individual hospitals. We believe the application of GAAP for purposes of compiling data on wage-related costs used to construct the wage index will more accurately reflect relative labor costs, because certain wage-related costs (such as pension costs) as recorded under GAAP tend to be more static from year to year. Application of Medicare principles, on the other hand, could create large swings in these costs from year to year, particularly in years when there are large over- or under-funded pension estimates; such application might lead to a wage index that does not accurately reflect relative labor costs. Again, we emphasize that under this proposal, GAAP will apply *only* for purposes of developing wage-related costs on Worksheet S–3 Part II. Our policy requiring the use of applicable Medicare principles for determining fringe benefits for all other purposes remains unchanged.

The revised cost report and the HCFA–339 forms are currently being evaluated by the Office of Management and Budget. Once these forms are approved, we propose to implement the form to collect wage data for any cost report beginning on or after October 1, 1994. However, we will issue subsequent revisions to the forms and instructions to reflect any changes incorporated in the final rule based on public comments.

D. Revisions to the Wage Index Based on Hospital Redesignation

Under section 1886(d)(8)(B) of the Act, 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 methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, pursuant to section 1886(d)(8)(c) of the Act, 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 determined exclusive of the wage data for the redesignated hospitals applies to 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 (the "combined" wage index value). 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 value increases 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, geographic reclassification may not reduce the wage index for an urban area below the Statewide rural average, provided the wage index prior to reclassification was greater than the Statewide rural wage index value.
- Section 13501(b) of Public Law 103–66 amended section 1886(d)(8)(C) of the Act to provide that a change in classification of hospitals from one area to another may not result in the reduction in the wage index for any urban area whose wage index is below the rural wage index for the State. This provision also applies to any urban area that encompasses an entire State.

We note that, except for those rural areas where redesignation would reduce the rural wage index value, and in the situation described above that was addressed by section 13501(b) of Public Law 103–66, 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, several MSAs listed in Table 4a have no hospitals remaining in the MSA. This is because all the hospitals originally in these MSAs have been reclassified to another area by the MGCRB. For those areas, we have listed the Statewide rural wage index value.

The proposed revised wage index values effective for discharges occurring on or after October 1, 1994 are shown in Tables 4a, 4b, and 4c of the addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. For some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one State are included in the group of redesignated hospitals, and one State has a higher Statewide rural wage index value than the wage index value otherwise applicable to the redesignated hospitals. Tables 4d and 4e list the average hourly wage for each labor market area based on the FY 1991 wage data. In addition, we have expanded Table 3c (Hospital Case-Mix Indexes for Discharges) to include the average hourly wage for each hospital based on the FY 1991 data. The average hourly wage published in the final rule will be used by the MGCRB to evaluate if a hospital meets the reclassification criteria. Hospitals that choose to apply before publication of the final rule can use the proposed wage data in applying to the MGCRB for wage index reclassifications that would be effective for FY 1996. We note that in adjudicating these wage reclassification requests during FY 1995, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 1995 wage index.

The proposed FY 1995 wage index values incorporate all reclassification decisions made by the MGCRB for FY 1995. At the time this proposed wage index was constructed, the MGCRB had completed its review. There were 429 hospitals redesignated for purposes of the wage index (including hospitals redesignated under both sections 1886(d)(8)(B) and 1886(d)(10) of the Act). This number does not include MGCRB decisions that are still under review by the Administrator.

Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule. The changes may affect not only the wage index value for specific geographic areas, but also whether redesignated hospitals receive the wage index value for 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 value for the area from which the hospitals are redesignated may be affected.

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this **Federal Register** document. The request for withdrawal of an application for reclassification that would be effective in FY 1995 must be received by the MGCRB by [OFR: Insert date 45 days after date of publication]. A hospital that requests to withdraw its application may not request that the MGCRB decision be reinstated after publication of the final wage index values.

E. Impact of the Revised Hospital Wage Index

Section 1886(d)(3)(E) of the Act requires that the wage index be updated annually beginning October 1, 1993. In addition, this section requires that updates to the hospital wage index be budget neutral. The FY 1995 wage index will represent the second annual update to the wage data. We will use the wage data from the FY 1991 Medicare cost report to calculate the updated wage index. For FY 1995, the wage index will continue to include salaries, fringe benefits, home office salaries, and certain contract labor salaries. In the past, updates to the wage data have resulted in significant payment shifts among hospitals. Since the wage index is now updated annually and there are no changes to the types of costs included in the wage index data, we expect these payment fluctuations will be minimized. Based on the proposed wage index calculation (after reclassifications under sections 1886(d)(8)(B) and 1886(d)(10) of the Act), there is a significant drop, compared with previous years, in the

number of labor markets that experience major increases or decreases in wage index values. We reviewed the data for any area that experienced a wage index change of 10 percent or more to determine the reason for the fluctuation. When necessary, we contacted the intermediaries to determine the validity of the data, or to obtain an explanation for the change. Our review indicated that most of the significant changes were attributable to improved reporting by hospitals.

The following chart compares the shifts in wage index values (after reclassifications) for labor markets for FY 1995 with those experienced as a result of last year's wage index update.

Percentage change in area wage index values	Number of labor market areas	
	FY 1995	FY 1994
Increase more than 10 percent	6	13
Increase between 5 and 10 percent	18	24
Decrease between 5 and 10 percent	17	58
Decrease more than 10 percent	11	14

Under the proposed FY 1995 wage index, 86.4 percent of all prospective payment hospitals (4,778 hospitals) would experience a change in their wage index value of less than 5.0 percent. Approximately 5.2 percent (283 hospitals) would experience a change of between 5 and 10 percent, and 8.4 percent (469 hospitals) would experience a change of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals. (The totals in this chart exceed the number of hospitals in our database, as our projection includes new hospitals and hospitals that for other reasons are not included in our wage file.)

Percentage change in area wage index values	Number of hospitals	
	Rural	Urban
Decrease more than 10 percent	188	196
Decrease between 5 and 10 percent	26	94
Change between −5 and +5 percent	2,099	2,679
Increase between 5 and 10 percent	44	119
Increase more than 10 percent	67	18

F. Occupational Mix Adjustment

In its March 1, 1994 report, ProPAC recommended that the Secretary develop methods to collect more timely hospital wage data by occupational categories and to adjust the HCFA wage index for occupational mix (Recommendation 15).

The HCFA wage index reflects variations in the cost of labor; that is, it includes the effects of variations in the mix of occupations as well as the price of labor. ProPAC believes that the wage index should reflect only variations in the price of labor, which are beyond the hospital's control and are not otherwise accounted for by adjustments in the prospective payment system.

Previous ProPAC studies on the effect of adjusting the wage index for occupational mix using data collected from California hospitals found that a wage index adjusted for occupational mix would redistribute funds from urban to rural hospitals. Within urban areas, the occupational mix adjustment would redistribute funds from large to small hospitals. Within rural areas, the occupational mix adjustment would increase the wage index values of all bed-size groups. ProPAC also reanalyzed the California data to examine the impact of an occupational mix adjustment on wage index values based on hospital-specific labor market areas. ProPAC currently believes that the implementation of revised labor areas, including nearest neighbor labor markets, would substantially improve payment equity among hospitals if an occupational adjustment was developed.

We are not convinced that an occupational mix adjustment would improve the accuracy of the wage index, as we have discussed most recently in the August 30, 1991 final rule (56 FR 43222). Currently, the wage index measures the overall costs of labor. If the wage index were to measure the price of labor, then a set of occupational weights would have to be developed to determine a standard occupational mix. Hospitals would not be compensated for a mix of employees above the standard, while hospitals with a mix of employees below the standard would be overcompensated, relative to their cost of labor. If we were to adopt hospital-specific labor market areas in conjunction with an occupational mix adjustment, one concern would be the application of occupational weights to every prospective payment hospital in the country. Application of one set of occupational weights to every prospective payment hospital would conflict with the intended purpose of hospital-specific labor markets, which is to make the wage index more responsive to local conditions. We cannot envision a single set of occupational weights that could be applied to all prospective payment hospitals in an equitable manner.

Last year, ProPAC suggested that we convene a working group made up of representatives from HCFA and the hospital industry to try to improve the timeliness and accuracy of the wage data. HCFA assembled such a discussion work group and presented ProPAC comments concerning the equity of adopting a method to collect data to assist in the development of an occupational mix. The discussion workgroup's consensus was that the data required to implement the proposal is not currently available and the likelihood of obtaining such data would be minimal. There seems to be little support among hospital industry representatives for developing a system that in their opinion clearly creates additional reporting burdens with an unproven or minimal impact on the distribution of payments. Therefore, at this time we are not proposing any changes to the collection of data to be used in developing an occupational mix adjustment.

G. Research on Refinements to Labor Market Areas

1. Background

Almost from the beginning of the prospective payment system, we have received comments from hospitals and ProPAC objecting to the use of MSA-based labor market areas to construct the wage index. Common concerns have been that the Statewide rural areas are too large to distinguish differences in labor market conditions, and that the MSA-based wage index does not reflect the fact that hospitals in the center cities (the "urban core") pay higher wages than suburban hospitals. Some commenters have argued that rural labor market areas should be subdivided into two smaller groups based on county populations and that MSA-based labor market areas should be divided into urban core and suburban ring labor markets to distinguish the differences in labor market conditions.

In light of these concerns, we have continued to examine a variety of options for revising wage index labor market areas. In this proposed rule, we discuss in detail issues raised by commenters concerning ProPAC's "nearest neighbor" recommendation, our research and analysis on alternative labor market areas, and the possibility of allowing all hospitals in a State to opt out of the current labor market system.

2. Discussion of Comments Concerning ProPAC's Nearest Neighbor Recommendation

In its March 1, 1993 report, ProPAC recommended that the Secretary substantially revise the hospital wage index under the prospective payment system for FY 1994. In its March 1, 1994 report, ProPAC made the same recommendation (Recommendation 16). Specifically, ProPAC recommends that we develop hospital-specific labor market areas based on geographic proximity, using each hospital's "nearest neighbors" for purposes of a revised wage index. As in 1993, ProPAC has also recommended that Congress repeal the current statutory provisions relating to geographic reclassification for the wage index.

In ProPAC's 1993 report, the Commission discussed establishing each hospital's labor market area based on its 10 nearest neighbors within a 50-mile radius. In its 1994 report, ProPAC examined defining labor markets for each hospital by including the nearest 15 hospitals within a 20-mile radius, and extending the radius up to 30 or 35 miles when needed in order to include a total of at least 3 hospitals.

In our May 26, 1993 proposed rule (58 FR 30242), we stated that we believed, and ProPAC agreed, that legislation would be required before we could use hospital-specific labor market areas in constructing the wage index due to the statutory requirements regarding hospital reclassifications for wage index purposes. We also stated that in addition to the statutory constraints, we did not believe that it would be feasible or advisable to attempt to implement ProPAC's recommendation in FY 1994. Although we acknowledged that ProPAC's recommendation might have promise, we indicated that careful analysis of the impact of such a proposal on hospitals was necessary before proposing to adopt such a significant change. In addition, we stated there were also a number of administrative issues that must be carefully considered before ProPAC's proposal could be implemented, including the possible development of an exceptions or appeals process to resolve disputes concerning the labor market areas. We agreed with ProPAC that if we adopted hospital-specific labor market areas using its methodology, the MGCRB as it is currently constituted might no longer be necessary. We also stated that we would not recommend that Congress repeal the MGCRB provisions of the Act until we had analyzed fully the implications of adopting hospital-specific labor market areas or some other revisions to labor market areas. We noted that after our analysis was complete, we would decide whether to recommend that the mission of the MGCRB be altered to make it responsible for resolving disputes concerning hospital-specific labor market areas.

To facilitate a thorough analysis of ProPAC's proposal, we published in the FY 1994 proposed rule hospital-specific wage index values using ProPAC's data on hospital locations and the new FY 1990 hospital wage data (58 FR 30457). The tables indicated what each hospital's wage index value would be if the wage index were based on the wage data for the hospital and its 10 nearest neighbors up to a radius of 50 air miles. The tables also showed which hospitals were in each hospital's labor market area based on ProPAC's data base. Subsequently, we discovered a technical error in the wage index values and republished a revised wage index value for each hospital in a correction notice (June 29, 1993, 58 FR 34742).

We solicited public comments on ProPAC's proposal and suggestions concerning the development of an exceptions or appeals process, if appropriate, for possible implementation in FY 1995. We also solicited comments on a number of other issues such as the feasibility of using road miles instead of air miles, a process to verify hospital locations, and what the process should be to establish a wage index for new hospitals. We stated that we planned to continue our analysis of alternatives based on the current MSA based system that have appeared promising in the past, and that we planned to evaluate all potential labor market revisions using the same basic criteria. Comments on these issues were due to HCFA by August 31, 1993.

In both the proposed and final rules for FY 1994, we stated our intention to analyze the comments we received as well as to conduct the research we outlined. We also stated that we would continue to consult with ProPAC and study any additional information they developed. We stated our intention to publish a proposal for formal public comment in the FY 1995 proposed rule if hospital-specific labor market areas based on the nearest neighbor concept proved promising. We indicated that we would include information describing all aspects of our proposal, and consider all comments, before issuing a final rule for implementation.

In response to the May 26, 1993 proposed rule, we received a total of 266 comments on the nearest neighbor wage index proposal, including 28 from national, State, and local organizations representing hospitals. In all, 33 commenters were in favor of the nearest neighbors proposal, 128 were opposed and 105 were in support if changes were made to satisfy their concerns. The areas of major concern raised by the commenters were the redistribution of Medicare payments that would occur if hospital-specific labor market areas were adopted, how the boundaries should be drawn around hospitals to define labor market areas, and the nature and extent of an exceptions process. Several commenters also had reservations about whether a hospital's nearest neighbors were reflective of its labor market area. We discuss these and other issues below.

- *Redistribution of Medicare Payments*—Many commenters were concerned about whether instituting hospital-specific labor market areas would lead to major shifts in Medicare payments at the same time that hospitals face an uncertain financial future because of the impact of health care reform. One state hospital association noted that adoption of the nearest neighbors proposal would cause a major redistribution of payments among rural hospitals, and that many hospitals that would be adversely affected were already in precarious financial condition. Another state association commented that the effects of the proposal on the hospitals in its State would vary greatly, with substantially increased payments to some hospitals and decreased payments to others. Many commenters suggested that if we were to adopt the nearest neighbors proposal, some type of phase-in over several years would be essential.

- *Definition of Labor Market Areas*—Several commenters stated that hospital characteristics such as size, services offered, and case mix are a more reliable determinant of who a hospital competes with for labor than who its nearest neighbors are. One state association stated that its analysis of the wage index computed under the nearest neighbors proposal demonstrates that geographic proximity does not provide an accurate measure of the amount a hospital must pay to compete for labor. Since there are a wide range of options for defining hospital-specific labor market areas, many of the commenters suggested variations depending on their perception of what new labor market areas should achieve. Some favored changing the size of labor market areas so as to increase payment to a particular hospital or type of hospital, while others favored defining labor markets in a way that would decrease the payment shifts that would occur under the options.

In order to minimize the payment changes that would result from the wage index, some groups supported including a larger number of hospitals in each labor market, while others supported limiting the size of labor market areas. One state association asserted that both nearest neighbor and fixed boundary labor market alternatives are problematic because neither method allows a sufficient amount of flexibility for determining labor market areas. The association believes that it would be more accurate if the direction and distance of worker commuting patterns were incorporated into the determination of a hospital's nearest neighbors. Another association stated that it may be difficult to identify a uniform approach that is equitable for all areas of the country, and urged HCFA to consider using different methodologies in different regions as appropriate. A national association stated that while the nearest neighbors proposal has conceptual appeal, whether the association would support a nearest neighbor proposal ultimately would depend on where HCFA draws the line around hospitals.

• *Exceptions Process*—Most of the commenters agreed that some type of exceptions process would be needed regardless of which system for defining hospital labor market areas is developed. Several commenters stressed the need for an exceptions process to address geographic anomalies; cases in which air miles are not equivalent to road miles; and cases in which a hospital is grouped with unlike hospitals, such as a rural referral center (RRC) grouped with much smaller primary care hospitals or a tertiary care hospital in a single hospital MSA that is grouped with much smaller rural hospitals. Another commenter supported giving a hospital the right to appeal to add or delete hospitals from its labor market area if the target hospital can demonstrate substantial labor market competition (or a lack of it) with a specific hospital. Some commenters supported special exception criteria for RRCs. One group believes that the nearest neighbors proposal should be modified to accommodate RRCs that otherwise would have been reclassified, that have only other rural hospitals in their nearest neighbors group, or that would be significantly harmed by the proposal. Another group believes that RRCs should be excluded from a nearest neighbors wage index and that they should be allowed to use either their own hospital-specific wage index or be allowed to reclassify into the nearest MSA using the existing MGCRB rules.

• *Multi-campus hospitals*—We received a wide range of comments concerning multi-campus hospitals. Some commenters suggested that the hospital's location should be its main address listed on the cost report. Other commenters suggested that the facility with the largest concentration of employees be defined as the hospital's location, or that a hospital should be allowed to pick which campus would be considered its location for labor market area purposes.

• *Hospital Location Verification*—Some commenters suggested that we publish each hospital's longitude and latitude and require them to submit documentation to verify any requests for corrections to this data. Others suggested that we use the Global Positioning System to verify location. Some commenters suggested that the hospital's emergency room entrance should be used as the hospital's location, others suggested the main employee entrance, and still others suggested that a hospital be allowed to designate any point on its campus as its location.

• *State Boundaries*—Some commenters stated that labor market areas should not be constructed across State lines because cost of living and labor costs can vary greatly from State to State due to differences in State tax structures, costs of health insurance and other employee benefit programs dependent on State law.

• *Blend/Floor*—Some commenters suggested that a nearest neighbors wage index should not be adopted unless a hospital's own wage data were weighted more heavily than those of its neighbors. Other commenters suggested that we institute a floor below which a hospital's wage index could not fall or that we blend the current wage index with any index based on revised labor market definitions.

3. Analysis of Alternative Labor Market Areas

We agree with commenters, and with ProPAC, that improvements to the current labor market system should be explored. Below, we discuss the feasibility of several alternative methodologies for establishing labor markets, including revised versions of the current MSA-based system, various hospital-specific methodologies, as well as an alternative that combines the hospital-specific and MSA-based methodologies. In evaluating each of the alternatives presented, we considered the major issues raised by commenters, ProPAC's recommendations, as well as our own internal research and analysis. ProPAC's data on air-mile distances between hospitals were used to develop wage indexes based on hospital-specific systems.

We note that in our May 26, 1993 proposed rule (58 FR 30244), we indicated that we would hold a meeting with a working group consisting of hospital industry representatives to review potential revisions to labor market areas, and other issues related to the wage index. On November 19, 1993, HCFA staff met with 17 representatives of State and national hospital associations to discuss options for redefining hospital labor market areas and other issues related to the current wage index. A ProPAC representative also attended and presented information on the status of the Commission's current research. HCFA staff presented information on each of the options under consideration.

The group expressed no preference for any of the hospital-specific or MSA-based options with the possible exception of a hospital-specific wage index based in large part on the hospital's own wages. The group was extremely concerned about the redistribution of dollars that would occur if nearest neighbors labor market areas were adopted in the current budgetary climate. It was also concerned about how an exceptions process would function under any revised labor market scheme, fearing that it would be too subjective and that it would be impossible to predict how many hospitals would be reclassified.

a. MSA-based and Hospital-Specific Alternatives. In our labor market research, we reviewed a large number of options: nine hospital-specific wage indexes based on the nearest neighbor and fixed radius approaches and seven MSA-based indexes involving ways of subdividing MSAs or statewide rural areas. Following is a description of the options we reviewed. We have assigned each option a name to facilitate discussion and for use in tables that follow later in this section.

Hospital-Specific Alternatives

10 Nearest Neighbors—A wage index based on each hospital's own wage data and that of its 10 nearest neighbors, or all hospitals within a distance of 50 miles, if there are fewer than 10 other hospitals within 50 miles. One hundred ninety-five hospitals had no neighbor within 50 miles. These hospitals were assigned their own relative wage level, which is computed by comparing its own wages to the national average hourly wage. The same 195 hospitals also were assigned their "own wage

index" for the 15 Nearest Neighbors and 20 Nearest Neighbors wage indexes.

10 Nearest Neighbors/Minimum of 2—A wage index based on each hospital's own wage data and that of its 10 nearest neighbors within 20 miles (with a minimum of at least 2 nearest neighbors within 20 miles or all hospitals within 35 miles).

15 Nearest Neighbors—A wage index based on each hospital's own wage data and that of its 15 nearest neighbors, or all hospitals within a distance of 50 miles if there are fewer than 15 other hospitals within 50 miles.

15 Nearest Neighbors/Minimum of 2—A wage index based on each hospital's own wage data and that of its 15 nearest neighbors within 20 miles (with a minimum of at least 2 nearest neighbors within 20 miles or all hospitals within 35 miles).

20 Nearest Neighbors—A wage index based on each hospital's own wage data and that of its 20 nearest neighbors, or all hospitals within 50 miles if there are fewer than 20 other hospitals within 50 miles.

20-Mile Radius—A wage index based on each hospital's own wage data and that of all its neighbors within a 20-mile radius. The 887 hospitals having no neighbor within 20 miles were assigned their own relative wage level.

25-Mile Radius—A wage index based on each hospital's own wage data and that of all its neighbors within a 25-mile radius. The 522 hospitals having no neighbor within 25 miles were assigned their own relative wage level.

30-Mile Radius—A wage index based on each hospital's own wage data and that of all its neighbors within a 30-mile radius. The 391 hospitals having no neighbor within 30 miles were assigned their own relative wage level.

35-Mile Radius—A wage index based on each hospital's own wage data and that of all its neighbors within a 35-mile radius. The 301 hospitals having no neighbor within 35 miles were assigned their own relative wage level.

MSA-Based Alternatives

These alternatives represent various subdivisions (by counties) of the current MSA/rural labor market area definitions. As such, all counties in each subdivided category need not be contiguous.

Central-Outlying—A wage index in which each MSA is divided into 2 areas based on its central and outlying counties.

Rural-Population—A wage index in which each Statewide rural area is divided into 2 distinct labor market areas, one including all counties with populations greater than 25,000 and one made up of counties with populations less than 25,000.

Rural-Density—A wage index in which each Statewide rural area is divided into 2 areas if it contains counties with population densities greater and less than 35 persons per square mile.

Rural-Population/Density—A wage index in which each Statewide rural area is divided into as many as 4 areas depending on whether populations are greater or less than 25,000 person and population densities are greater or less than 35 persons per square mile.

Rural-Adjacent—A wage index in which each Statewide rural area is divided into 2 areas, one including all counties adjacent to an MSA and the other made up of counties not adjacent to an MSA.

Rural-Population/Adjacent—A wage index in which each Statewide rural area is divided into as many as 4 areas depending on the adjacent/non-adjacent status of its non-MSA counties and whether county populations are greater or less than 25,000 persons.

Rural-Density/Adjacent—A wage index in which each Statewide rural area is divided into as many as 4 areas depending on the adjacent/non-adjacent status of its non-MSA counties and whether county population densities are greater or less than 35 persons per square mile.

As a basis of comparison for these alternatives, we also reviewed three variations of the current MSA-based wage index.

Current MSA-based Indexes

Geographic—The FY 1994 hospital wage index without the effects of geographic reclassification.

Reclassification—The actual FY 1994 hospital wage index after reclassification.

Estimated FY 1995—The FY 1994 hospital wage index revised to include an estimate of the effects of geographic reclassification in FY 1995 (based on FY 1990 data).

We used three basic criteria to analyze each of the alternatives:

(1) *Wage Conformity Within Labor Markets.* This criterion assesses the extent to which a wage index conforms to a hospital's own relative wage level. It also evaluates the extent to which a hospital's wages are aberrant for its labor market area (that is, are more than one standard deviation above the labor market wage index);

(2) *Wage Index Conformity Across Labor Markets (Boundary Problems).* This criterion measures the extent to which the new labor market areas reflect uniform labor market conditions as indicated by the degree of similarity in the hospital wage rates across labor market areas. The boundaries should minimize inequitable treatment, that is, cases in which hospitals facing similar labor costs are grouped into different labor markets.

(3) *Distributional Equity Improvement.* This criterion examines the impact of a labor market option to determine its effects on the distribution of hospital payments, and the extent to which the hospitals that would gain and lose under various proposals are already doing well or poorly under the current system. Redistribution of payments should fairly compensate both high-wage hospitals and low-wage hospitals.

None of the options we initially reviewed were a significant improvement over the current reclassified wage index in terms of wage conformity within labor markets, wage conformity across labor markets, or distributional equity improvement. The following tables summarize our major results:

Wage Conformity Within Labor Markets

Table A displays the number of hospitals for which the difference between the area wage index value for a given alternative and the hospital's own relative wage index value (determined by dividing the hospital's average hourly wage by the national average hourly wage) is greater than .08 either positive or negative. A .08 difference in the wage index was selected as it represents approximately a $200 difference in payments per case. For each wage index option, the Lose and Gain columns show the number of hospitals for whom the difference represents a given decrease or increase in wage index value.

Table B displays the number of hospitals whose wage index values are more than 108 percent above their labor market wage index value (that is, one standard deviation greater).

TABLE A.—NUMBER OF HOSPITALS LOSING OR GAINING MORE THAN .08 RELATIVE TO OWN WAGE LEVEL, FOR SELECTED WAGE INDEXES BY TYPE OF GEOGRAPHIC AREA

Wage index	All hospitals n=5,230		Large urban n=1,612		Other urban n=1,307		Rural n=2,311	
	Lose >.08	Gain >.08	Lose >.08	Gain >.08	Lose >.08	Gain >.08	Lose >.08	Gain >.08
Existing System:								
Geographic FY 94	682	1,708	263	531	137	321	282	856
Estimate FY 95	590	1,672	289	493	141	317	160	862
Hospital-Specific:								
Nearest 10	627	1,674	268	452	178	302	181	920
Nearest 10/Min 2	597	1,204	260	421	140	259	197	524
Nearest 15/Min 2	592	1,224	255	439	140	261	197	524
20 Mile Radius	549	1,014	264	438	141	244	144	332
MSA-Based:								
Central-Outlying	676	1,576	264	474	134	233	278	869
Rural-Adjacent	682	1,690	263	530	137	321	282	839
Rural-Density	706	1,540	262	530	137	321	307	689

TABLE B.—NUMBER OF HOSPITALS WHOSE WAGES ARE MORE THAN 108 PERCENT ABOVE THEIR LABOR MARKET AREA

Wage index	Number of hospitals with wages greater than 108 percent			
	All hospitals n=5230	Large urban n=1612	Other urban n=1307	Rural n=2311
Existing System:				
Geographic FY 94	746	235	144	367
Estimate FY 95	559	232	137	190
Hosp.-Specific:				
Nearest 10	620	217	181	222
Nearest 10/Min 2	650	224	135	291
Nearest 15/Min 2	653	228	134	291
20 Mile Radius	594	229	139	226
MSA-based:				
Central-Outlying	758	243	148	367
Rural-Adjacent	756	235	144	377
Rural-Density	798	235	144	419

Wage Conformity Across Labor Markets

Table C presents the assessment of wage conformity across labor markets. We determined that a "boundary problem" existed for a target hospital (that is, the hospital whose wage index value is being calculated) if—

- Among nearby hospitals, one or more other hospitals' wage index value is at least .04 greater than that of the target hospital, corresponding to approximately a $100 difference in payments per case, and
- The hospital with the lower wage index value pays higher wages than the hospital with the higher wage index value.

"Nearby hospitals" were defined as the 20 nearest hospitals or if a hospital does not have 20 other hospitals within a 35 mile radius, all hospitals within a 35 mile radius. Table C shows the number of hospitals with one or more boundary problems and the average size of the wage index difference for those boundary problems. An average wage index difference of .12 corresponds to a payment difference of about $300 per case.

Table D shows the effects that different labor market alternatives would have when compared to the current FY 1994 pre-reclassified wage index.

TABLE C.—NUMBER OF HOSPITALS SUBJECT TO "BOUNDARY PROBLEM" AND AVERAGE SIZE OF "BOUNDARY PROBLEM" BY TYPE OF GEOGRAPHIC AREA

Wage index	All hospitals n=5230		Large Urban n=1612		Other urban n=1307		Rural n=2311	
	Number hospitals	Average difference	Number hospitals	Average difference	Number hospitals	Average difference	Number hospitals	Average difference
Existing System:								
Geographic FY 94	760	0.113	49	0.099	240	0.103	471	0.125
Estimate FY 95	662	0.110	51	0.105	215	0.101	396	0.120
Hospital—Specific:								
Nearest 10	1223	0.077	387	0.074	224	0.074	612	0.086
Nearest 10/Min 2	1343	0.084	405	0.079	263	0.079	675	0.091
Nearest 15/Min 2	1240	0.085	305	0.080	260	0.079	676	0.091
20 Mile Radius	1041	0.083	169	0.079	264	0.080	608	0.089
MSA–Based:								
Central-Outlying	712	0.101	106	0.107	232	0.094	374	0.107

TABLE C.—NUMBER OF HOSPITALS SUBJECT TO "BOUNDARY PROBLEM" AND AVERAGE SIZE OF "BOUNDARY PROBLEM", BY TYPE OF GEOGRAPHIC AREA—Continued

Wage index	All hospitals n=5230		Large Urban n=1612		Other urban n=1307		Rural n=2311	
	Number hospitals	Average difference	Number hospitals	Average difference	Number hospitals	Average difference	Number hospitals	Average difference
Rural-Adjacent	838	0.106	49	0.098	241	0.102	548	0.113
Rural-Density	884	0.109	49	0.098	241	0.103	594	0.120

TABLE D.—LABOR MARKET ALTERNATIVES: PERCENT CHANGE FROM CURRENT MSA VALUES

[Pre-Reclassification]

All hospitals	N	Greater than 10 percent	5–10 percent	0–5 percent	0	–5 to 0 percent	–10 to –5 percent	Less than –10 percent
Estimate FY 95	5,230	210	64	1,114	3,556	235	48	3
Nearest 10	5,230	614	665	1,629	0	1,514	490	318
Nearest 10/Min 2	5,230	366	480	1,692	0	1,353	590	749
Nearest 15/Min 2	5,230	356	452	1,761	0	1,359	553	749
20 Mile Radius	5,230	356	333	1,775	0	1,381	491	894
Central-Outlying	5,230	10	3	1,380	3,389	150	108	190
Rural-Adjacent	5,230	9	5	1,441	2,936	685	126	28
Rural-Density	5,230	7	163	775	3,149	506	432	198

As demonstrated by the above tables, our analyses showed that none of the MSA-based options consistently outperformed the current estimated FY 1995 post-reclassified wage index in terms of wage conformity within labor market areas and wage conformity across labor market areas.

With respect to wage conformity within labor market areas, the results in Table A demonstrate that the 20-mile radius hospital-specific option, with 549 losing hospitals, best reduces the number of hospitals with wage index values more than .08 below their own wage level. The FY 1995 post-reclassified wage index was second best, with 590 hospitals with wage index values more than .08 below their own wage level. The 20-mile radius approach also produced the fewest number of hospitals (1014) with wage index values more than .08 above their own wage levels. However, as demonstrated in Table B, the estimated FY 1995 post-reclassified wage index outperformed the other labor market options, with only 559 hospitals whose own average hourly wages were 108 percent or more of their respective labor market area's average hourly wage. Therefore, the 20-mile radius and the estimated FY 1995 post-reclassified wage indexes demonstrated somewhat better outcomes for wage conformity within labor market areas than any of the other options we studied.

With respect to wage conformity across labor market areas ("boundary problems"), as indicated in Table C, the estimated FY 1995 post-reclassified wage index generated the fewest hospitals having boundary problems (662), with the central-outlying MSA option having the second lowest number of such hospitals (712). All of the nearest neighbor options, including the 20-mile radius option (with 1,041 hospitals), had the effect of significantly increasing the number of boundary problems that would occur, although the problems were of a smaller magnitude.

Overall, none of the MSA-based options or the nearest neighbor options consistently outperformed the current estimated FY 1995 post-reclassification wage index. While the 20-mile radius option performed well in terms of wage conformity within labor market areas, it performed significantly worse than the current system with respect to wage conformity across labor market areas. Additionally, with respect to the distributional effects of all the options, none demonstrated any measurable improvement in payment equity across hospital groups. Therefore, we are not presenting any tables concerning the distributional effect in this discussion. We have decided not to propose changes to labor market areas for FY 1995 because we believe that neither revisions to the current MSA-based system or the nearest neighbors labor market options that we studied constitute a clearly demonstrable improvement over the current system.

b. Options for Future Wage Index Refinements Using Combined MSA/Hospital-Specific Approach. While none of the alternative labor market areas that we studied, whether based on current MSA definitions or the "nearest neighbor" approach, provided a distinct improvement over the current reclassification wage index, we believe a classification system that uses a combination of both approaches has considerable potential for improving the wage index. Discussed below are some options for further study that we believe may offer a viable alternative to the current system by taking into consideration all of the varying factors that affect a hospital's labor market. Each of these options is based on a weighted average of each hospital's own average hourly wages and the average hourly wages of a group of other hospitals. The following concepts and assumptions underlie the wage index options that we are now analyzing:

- Empirically defining labor market areas in a highly accurate, definitive manner is extremely difficult, if not impossible. MSAs and statewide rural areas may be reasonably accurate in many cases, but in other cases, these areas may be larger than a hospital's "true" labor market area. None of the methodologies we studied for subdividing MSAs and/or statewide rural areas or for designing nearest neighbor labor market areas proved to have been demonstrably more accurate than the current system.
- Both a hospital's own wage data and that of other hospitals in its vicinity may contain relevant information about the level of wages in the hospital's true labor market. In particular, a hospital's own data may reflect specific circumstances of the hospital's labor market that we have yet to discover in our analysis of the data, but that reflect

geographic variation that Medicare would want to capture in the wage index.

• No matter how we determine labor market areas, both a hospital's own wage data and that of other hospitals assigned to its labor market area may contain any number of spurious sources of variation, including data errors, that should not be captured in the wage index. The larger the number of hospitals whose data are averaged, the more the effects of spurious factors are reduced.

To address all of these considerations, we have designed for comment and future study an approach that uses the current MSA system but generally gives a hospital's own wages a higher weight than under the current system. (We have assigned each hospital's own wages a weight sufficient to ensure that in no case would the weight of a hospital's own wages be reduced below its current level.) We believe that a hospital's own wages, to some degree, reflect its specific labor market conditions. Hence, a hospital's wage index would be more representative of these labor market conditions if a higher weight was assigned to its own wages than typically occurs in large MSA or statewide rural area labor markets. If this approach results in situations in which a hospital's wage level continues to be significantly higher than the combined average hourly wage used to construct its wage index, we would provide an exceptions mechanism whereby a hospital's wage index would be derived entirely or in part from its "nearest neighbor" labor market area.

We are considering two alternative wage indexes based on this approach. The first of two wage indexes we considered places a 25 percent (.25) weight on each hospital's own average hourly wage and a 75 percent weight (.75) on the average hourly wage of the other hospitals in each hospital's MSA or statewide rural area. However, if a hospital's data represent more than 25 percent of the hours in the MSA or statewide rural area in which it is located, then, in calculating the hospital's wage index, that higher percent was used instead of the 25 percent weight. The resulting weighted average hourly wage is divided by the national average hourly wage to obtain each hospital's wage index value. For purposes of discussion, this wage index is denoted as "Minimum 25" or "M25".

The second wage index differs from the first alternative only in that a minimum weight of .50 is given the hospital's own average hourly wage, instead of a minimum 25 percent. This wage index is denoted as "Minimum 50" or "M50".

However, we recognize that in some cases a hospital's immediate labor market area as defined under a "nearest neighbor" approach may be more representative of its true labor market area than an MSA-based labor market area. To address such situations, we have developed a mechanism that would essentially provide a hospital with an alternative wage index derived entirely or in part from its nearest neighbors labor market. Currently, we are examining two methods for reclassification, a "simple" method and a "refined" method. Both methods utilize the two wage indexes just introduced, and like the current MGCRB reclassification system, also require a hospital's own wages to exceed certain thresholds to meet eligibility. These thresholds are as follows:

•The first threshold would be used to identify hospitals whose own wage levels are still aberrant when using the Minimum 25 or Minimum 50 wage indexes. We set this threshold at the mean plus 1.0 standard deviation of the ratio of each hospital's own average hourly wage to the weighted sum of its own average hourly wage plus the average hourly wage of the other hospitals in the MSA or Statewide rural area in which the hospital is located. For the M25 wage index, the threshold would be 1.07. That is, a hospital's average hourly wage would have to equal at least 107 percent of the weighted average hourly wage used to develop its wage index in order to qualify for reclassification. For the M50 wage index, the threshold would be 1.05.

• The second threshold, which would be used to identify hospitals whose wages are comparable to the hospitals in the immediate (that is, nearest neighbor) labor market area, was set at 83 percent, which equals the mean minus 1 standard deviation of the ratio of each hospital's average hourly wage to the average hourly wage of its nearest 10 neighbors.

Under the "simple" reclassification methodology, there would be only a single adjustment available to a hospital that demonstrates that its wages are aberrant within its labor market area (that is, it meets both thresholds discussed above). The basis for the adjustment is evidence that the average hourly wage of the other hospitals in its MSA or statewide rural area is not representative of the average hourly wage in the hospital's actual labor market. A common reason that the MSA's average hourly wage may not be representative of a particular hospital's actual wage costs is that the MSA is too large and comprises multiple labor markets.

To qualify for reclassification under this method, a hospital would have to meet a third criterion. The average hourly wage of a hospital's nearest 10 neighbors (with a minimum of at least 2 neighbor hospitals within 20 miles or all hospitals within 35 miles) would have to exceed the average hourly wage of the other hospitals in its MSA or statewide rural area. If this is the case, then the average hourly wage of the hospital's nearest 10 neighbors would be substituted for the MSA or statewide rural average hourly wage in calculating the numerator of the hospital's wage index. Under this reclassification scheme a hospital's own wages would be given the same weight as in the MSA-based alternative wage index (M25 or M50).

The "refined" reclassification methodology would add a second basis for adjusting a reclassified hospital's wage index. This was developed to assist hospitals whose situation warrants a different nearest neighbor approach. For example, it is possible that a hospital's data could represent more than 25 percent, or even 50 percent, of the total hours when combined with its 10 nearest neighbors. However, the same hospital's data very likely might represent a much lower percentage of the total hours in the MSA or statewide rural area in which it is located. This refined method would allow a hospital to use not only the average hourly wage of its 10 nearest neighbors, but also its hours weight when combined with its 10 nearest neighbors. So, in addition to the test of the representativeness of the other hospitals' average hourly wage described above, there would be a test of the appropriateness of substituting its hours weight from the hospital's immediate labor market for the weight that would otherwise be used (.25, .50, or its MSA/statewide rural hours weight). A reclassified hospital's hour weight reflected in the wage index would be adjusted under this method if two criteria are met. First, a hospital's share of the total hours in its nearest 10 neighbors "labor market" would have to exceed its hour weight in its MSA/statewide rural labor market. Second, the use of the nearest neighbors' hours weight would have to increase the average hourly wage that comprises the numerator of its wage index value. If both criteria were met, then the nearest neighbors' weight would be substituted for the hours weight that would have been used were the hospital not reclassified.

This refined reclassification methodology would allow for three different types of reclassification groups under which a hospital's wage index would be calculated by using one of the following: (1) The nearest neighbors' average hourly wage and the MSA hour weight; (2) the nearest neighbors' hours weight and the MSA-based average hourly wage; or (3) both the nearest neighbors' weight and average hourly wage. The following tables summarize our findings under each of the options we examined in comparison with the current labor market system.

Table E displays the number of hospitals for which the difference between the area wage index value for a given alternative and the hospital's own relative wage index value (determined by dividing the hospital's average hourly wage by the national average hourly wage) is greater than .08, either positive or negative. For each wage index option, the Lose and Gain columns show the number of hospitals for whom the difference represents a given decrease or increase in wage index value.

Table F presents the assessment of wage conformity across labor markets. We determined that a "boundary problem" existed for a target hospital (that is, the hospital whose wage index value is being calculated) if—

- Among nearby hospitals, one or more other hospitals' wage index value is at least .04 greater than that of the target hospital, and
- The hospital with the lower wage index value pays higher wages than the hospital with the higher wage index value.

"Nearby hospitals" were defined as the 20 nearest hospitals or if a hospital does not have 20 other hospitals within a 35 mile radius, all hospitals within a 35 mile radius. Table F shows the number of hospitals with one or more boundary problems and the average size of the wage index difference for those boundary problems. An average wage index difference of .12 corresponds to a payment difference of about $300 per case.

TABLE E.—NUMBER OF HOSPITALS LOSING OR GAINING MORE THAN .08 RELATIVE TO THEIR OWN WAGE LEVEL FOR SELECTED WAGE INDEXES BY TYPE OF GEOGRAPHIC AREA

Wage index	All hospitals		Large urban		Other urban		Rural	
	Lose >.08	Gain >.08	Lose >.08	Gain >.08	Lose >.08	Gain >.08	Lose >.08	Gain >.08
FY94 Pre-Reclass WI	684	1,708	263	530	137	321	281	857
Est. 95 Post-Reclass WI	590	1,672	289	493	141	317	160	862
M25 Simple	385	1,305	161	412	101	269	123	624
M25 Refined	352	1,284	165	408	104	266	83	610
M50 Simple	195	698	90	235	48	153	57	310
M50 Refined	187	693	91	234	48	151	48	308

TABLE F.—NUMBER OF HOSPITALS SUBJECT TO AND AVERAGE SIZE OF "BOUNDARY PROBLEM" BY TYPE OF GEOGRAPHIC AREA

Wage Index	All hospitals		Large urban		Other urban		Rural	
	Number hospitals	Average difference	Number hospitals	Average difference	Number hospitals	Average difference	Number hospitals	Average difference
FY94 Pre-Reclass WI	760	0.113	49	0.099	240	0.103	471	0.126
Est. 95 Post-Reclass WI	662	0.110	51	0.105	215	0.101	396	0.120
M25 Simple	532	0.087	26	0.081	161	0.083	345	0.090
M25 Refined	515	0.085	26	0.081	161	0.082	329	0.089
M50 Simple	273	0.067	8	0.089	86	0.060	179	0.071
M50 Refined	268	0.067	8	0.089	85	0.060	175	0.071

Table G shows the effects of the two possible reclassification schemes as compared to the current reclassification system. Table H shows the effects the different labor market alternatives would have when compared to the current FY 1994 pre-reclassified wage index.

TABLE G.—NUMBER OF HOSPITALS QUALIFYING FOR SIMPLE AND REFINED RECLASSIFICATION USING THE MINIMUM 25 (M25) AND THE MINIMUM 50 (M50) WAGE INDEXES, COMPARED TO THE NUMBER OF HOSPITALS ESTIMATED TO RECLASS FOR THE WAGE INDEX IN FY 1995

Reclassification alternatives	All hospitals	Large urban	Other urban	Rural
Estimated FY 1995 Reclasses	362	60	81	221
Hospitals Eligible for Reclass under 1.07 Criterion for M25	660	197	141	322
Simple Reclass:				
N10 AHW/MSA Hrs	411	121	84	206
No Adjustment	249	76	57	116
Refined Reclass:				
N10 AHW/MSA Hrs	250	111	61	78
N10 AHW/N10 Hrs	161	10	23	128
MSA AHW/N10 Hrs	110	7	13	90
No Adjustment	139	69	44	26
Hospitals for Reclass under 1.05 Criterion for M50	610	178	140	292

TABLE G.—NUMBER OF HOSPITALS QUALIFYING FOR SIMPLE AND REFINED RECLASSIFICATION USING THE MINIMUM 25 (M25) AND THE MINIMUM 50 (M50) WAGE INDEXES, COMPARED TO THE NUMBER OF HOSPITALS ESTIMATED TO RECLASS FOR THE WAGE INDEX IN FY 1995—Continued

Reclassification alternatives	All hospitals	Large urban	Other urban	Rural
Simple Reclass:				
N10 AHW/MSA Hrs	378	102	85	191
No Adjustment	232	76	55	101
Refined Reclass:				
N10 AHW/MSA Hrs	300	98	75	127
N10 AHW/N10 Hrs	78	4	10	64
MSA AHW/N10 Hrs	54	1	4	49
No Adjustment	178	75	51	52

TABLE H—LABOR MARKET ALTERNATIVES—PERCENT CHANGE FROM CURRENT MSA VALUES

[Pre-Reclassification]

	Greater than 10 percent	5–10 percent	0–5 percent	0	0 to −5 percent	−5 to −10 percent	Less than −10 percent
Est. 95 Post-Reclass WI	210	64	1,114	3,556	235	48	3
M25 Simple	180	201	2,155	0	2,302	379	13
M25 Refined	222	230	1,982	0	2,387	396	13
M50 Simple	318	332	1,662	0	1,528	925	465
M50 Refined	343	301	1,643	0	1,546	927	470

As demonstrated in the above tables, we believe these options for refining the wage index show promising results. All four of the wage index options significantly reduce the number of boundary problems, as seen in Table F. Not only would the number of boundary problems be reduced, but the boundary problems that do remain would be smaller, especially for the M50 wage indexes where the average difference is 0.067 for both the simple and refined reclassification methods. As indicated in Table E, these wage index options produce wage index values that would more closely resemble a hospital's own wage level, as was expected. Table G demonstrates that the new reclassification methods would likely affect a larger number of hospitals than the current system. Whereas in the current system, we estimated that only 362 hospitals qualify for the wage index reclassification, under the M25 wage index the simpler reclassification method would lead to 411 hospitals being adjusted to their nearest neighbors' average hourly wage. The refined reclassification method under the M25 wage index would make it possible for 250 hospitals to use the nearest neighbors' average hourly wage, 161 hospitals to use both the nearest neighbors' average hourly wage and hours weight, and 110 hospitals to use just the nearest neighbors' hours weight. We show the effects the four new options would have when compared to the estimated 1995 post-reclassified system against the current 1994 pre-reclassified values in Table H.

We plan to continue our evaluation of these new wage index options in the coming months and are soliciting public comment. We will continue to accept comments on these wage index refinements until August 31, 1994. We will respond to these comments in the FY 1996 prospective payment system proposed rule. Comments on this issue should be sent to: Lana Price, Director; Division of Hospital Payment Policy; 1–H–1 East Low Rise; 6325 Security Boulevard; Baltimore, Maryland 21207.

While we believe the alternatives discussed above offer much promise with respect to refining the hospital wage index, we do not believe that sections 1886(d)(2), (3) and (8) of the Act authorize a hospital-specific wage index scheme that combines each hospital's own wages and the wages of other hospitals in its MSA or Statewide rural area using different hour weights. Moreover, the MGCRB provisions under section 1886(d)(10) of the Act contemplate wage index reclassifications from one area to another that cannot be reasonably implemented consistent with these alternatives. Therefore, before we could implement these alternatives, legislative changes would be necessary to allow the Secretary greater flexibility in refining the hospital wage index. Again, we invite public comments on these issues by August 31, 1994, so that we may consider them in our continuing evaluation of wage index refinements.

H. State Labor Market Option

In addition to the alternatives discussed above, we are also considering a State labor market option (SLMO) under which hospitals would be able to voluntarily design labor market areas within their own State boundaries. Although we are not formally proposing the SLMO at this time, we welcome comments on this option. Under the SLMO, an application to design labor market areas could be submitted by a group of hospitals or any entity that represents hospitals that would be affected under the SLMO (for example, a state hospital association, the Office of the Governor, etc.). The application would have to include a statement signed by each hospital's chief executive or chief financial officer supporting participation in the SLMO.

The SLMO is being considered on the premise that hospitals within a State may, in some circumstances, have better information than HCFA concerning local labor market competition between hospitals. Accordingly, we are considering the SLMO along with the alternatives discussed above, which we believe would require legislative changes. Absent changes to the statute, we believe that the SLMO would offer opportunities for hospitals to design labor market areas that are more reflective of local wage conditions than the current system.

1. Criteria for Participating in a SLMO

Below we describe some of the criteria we would apply to determine whether labor market areas under the SLMO could be approved. (We have not fully designed or specified the limitations for creating labor market areas under the SLMO, and we are interested in any comments from the public for developing criteria under which a SLMO would be approved.) However, we envision that hospitals participating in a SLMO could design labor market areas under the following restrictions:

• We are considering limiting approval of labor market areas under the SLMO to cases in which there is unanimous support among hospitals. (We may also consider use of "overwhelming support" as a criterion rather than unanimous support. We likely would specify a percentage of participating hospitals that must support the SLMO labor market areas (for example, 75 percent). Such a criterion may also specify that to be approved, the SLMO labor market area must be supported by each hospital that would lose more than 5 percent of payments relative to the current system.)

• Aggregate payments to hospitals participating in the SLMO could be no higher than they otherwise would have been in the absence of the SLMO.

• All hospitals that participate in the SLMO must sign an application for it to become effective. Although the application could come from a group of hospitals or its representatives, each participating hospital must sign the application and agree to its provisions. In addition, each participating hospital must indicate in the application (or a separate agreement) that:

The participating hospital waives its rights to any wage index it would otherwise receive absent the SLMO, including a wage index it might receive through geographic reclassification.

The hospital understands how its participation in the SLMO would affect its prospective payments, including an understanding that the hospital's wage index could be higher or lower under the SLMO in comparison to its wage index under labor market areas in the absence of the SLMO. (The SLMO application would only have to specify that the hospital understands the effect of HCFA regulations regarding SLMOs and that there may be a reduction of their wage index as a result of participation. The hospital would not have to indicate the precise level of its wage index in the SLMO application.)

Labor market areas under the SLMO would be automatically renewed each year for the purpose of calculating the wage index until one or more participating hospitals withdraws its support for the SLMO.

• Labor market areas under the SLMO generally would be prohibited from crossing State boundaries. The only exception would be that hospitals from a bordering State may be included in a SLMO labor market area if they are currently located in an MSA that crosses a State boundary. In this case, the wage index would be calculated as if hospitals in the bordering State were included under the SLMO labor market area. For hospitals in the bordering State, the wage index would continue to be calculated as it is under the current system.

Section 1886(d)(3)(E) of the Act requires that the Secretary establish the wage index for the purposes of adjusting payment rates for hospital inpatient services to reflect wages in a geographic area relative to the national average. For this reason, we are considering establishing a criterion that labor market areas under the SLMO must include all hospitals within a contiguous area or must have defined geographic boundaries or distance parameters. However, we are concerned that such a requirement may prevent hospitals in noncontiguous areas within a State that share similar demographic features from being grouped in one labor market area under the SLMO. We are also concerned that hospitals may be able to meet the contiguity requirement but design an area with an illogical configuration that may not represent a labor market area. For example, we do not believe it would be appropriate to approve an application for a new labor market area that groups 2 hospitals 100 miles apart but excludes the hospitals located in between. We are also concerned about approving a SLMO application under which the wage index would be based only on hospital-specific wages. Such an application would not reflect local market conditions based on contiguous geographic areas. Because of these concerns, we are soliciting public comments regarding appropriate criteria for approving labor market areas under the SLMO.

2. Calculation of Budget Neutrality

As noted above, we would require payments to hospitals under the SLMO to be budget neutral in relation to payments in the absence of the SLMO. We are considering alternatives for applying a budget neutrality adjustment. Because the budget neutrality calculation for the SLMO labor market areas would be made after the effects of reclassification, we expect that hospitals under a SLMO will continue to apply for reclassification as they do under the current system. Such reclassifications would be recognized both for purposes of computing the budget neutrality adjustment and computing the wage index values applicable to reclassified hospitals. We envision two options for applying the budget neutrality adjustment:

• *Adjusting the wage index for the SLMO labor market areas.* Under this option, there would be a single adjustment to the wage index that would affect all hospitals participating in the SLMO in equal proportions.

• *Adjusting the wage index for selected hospitals within the SLMO labor market areas.* Under this option, the application to create labor market areas under SLMO would specify how the budget neutrality adjustment would be applied. For example, it could be applied equally to all SLMO hospitals or it could be limited to selected hospitals.

If the SLMO application does not specify how to apply the budget neutrality adjustment, the adjustment to the wage index would have a proportional effect on payments to all hospitals participating in a SLMO labor market area. (As indicated above, reclassification granted to hospitals participating in a SLMO would be recognized in computing the wage index values applicable to non-SLMO reclassified hospitals under section 1886(d)(8)(C) of the Act.)

3. Effect on Hospitals Not Participating in the SLMO

Hospitals that are not part of labor market areas under the SLMO would continue to have their wage index calculated under the current labor market areas—including the effects of reclassification. The wage index for these hospitals would continue to reflect the average hourly wage in their current labor market area relative to the national average. If a non-SLMO hospital were reclassified to an MSA that includes hospitals that are part of a SLMO labor market area, the wage index for the non-SLMO hospital would be calculated as if the SLMO did not exist.

We note that hospitals in SLMO States that are not part of a redesigned labor market area would not necessarily have to be part of the budget neutrality adjustment and their support for the SLMO would not be needed. However, if they chose to be part of the budget neutrality adjustment, their support for the SLMO would be needed even if they

were not included in a redesigned labor market areas.

4. Process for Submitting a SLMO Proposal

We are considering establishing the process described below for establishing labor market areas under the SLMO. Given that hospitals may apply both for geographic reclassification by the MGCRB and for a revised labor market area under the SLMO in the same year, our time frames for SLMO decisions may parallel the time frames used for reclassification decisions by the MGCRB. However, we expect that approval or rejection of SLMO applications would be made by HCFA's Bureau of Policy Development. The potential process would consist of the following:

(1) The initial SLMO application would be made to HCFA and would include a statement from each participating hospital attesting to their support for labor market areas under the SLMO.

(2) We envision providing notification to applicants of approval of the SLMO labor market areas before publication of our annual prospective payment system proposed rule (usually published in the Federal Register by May of each year). For hospitals whose SLMO application has been denied, we are considering providing an opportunity to submit additional information in support of a SLMO application. This information would be used by HCFA in reconsidering a denial before publication of the proposed rule.

(3) Approval of SLMO labor market areas and the resulting proposed wage indices would be announced in the proposed rule. The proposed rule would include the wage index under the current labor market areas (including the effects of reclassification) and under the SLMO labor market areas.

(4) Hospitals participating in the SLMO would be able to withdraw support for the SLMO during the 60-day comment period following publication of the proposed rule. If one or more hospitals withdraws support for a labor market area under the SLMO, the SLMO would not go into effect in the following fiscal year. To withdraw from the SLMO, the participating hospital would submit a letter to HCFA referencing the appropriate proposed rule and stating its participation in the SLMO labor market area is being withdrawn.

(5) Absent any withdrawal of support for labor market areas under the SLMO, HCFA would announce labor market areas and wage indices under the SLMO in the prospective payment system final rule (published by September 1 of each year).

(6) The labor market areas under the SLMO would be in effect for at least 1 Federal fiscal year following approval by HCFA. The SLMO labor market areas would be automatically renewed for following years unless a participating hospital informed HCFA in writing of its decision to withdraw.

5. Special Issues Affecting the SLMO

We are considering the following policies that would address the effects of special situations on the SLMO concept.

• *New Hospitals*—If a new hospital is established in a SLMO labor market area after its approval, the wage index for the new hospital would be determined as it is under the current system for the remainder of the fiscal year. In order for the SLMO labor market area to be renewed for the following fiscal year, the new hospital would have to inform HCFA in writing of its support for the SLMO labor market area.

• *Ownership Changes and Hospital Mergers*—If there is an ownership change or hospital merger during the period that the SLMO labor market area is in effect, the SLMO would remain in effect for the remainder of the fiscal year. In order for the SLMO labor market area to be renewed for the following fiscal year, the new ownership would have to inform HCFA in writing of its support for the SLMO labor market area.

We will accept comments on the SLMO until August 31, 1994. These comments should be sent directly to: Lana Price, Director; Division of Hospital Payment Policy; 1–H–1 East Low Rise; 6325 Security Boulevard; Baltimore, Maryland 21207. Responses to these comments will appear in the FY 1996 prospective payment system proposed rule.

I. Conclusion

Since the inception of the prospective payment system, we have repeatedly solicited comments concerning how labor market areas used to construct the wage index should be defined. In recent years, we have also solicited comments concerning specific proposals to modify or replace our current use of MSAs. For example, we have offered for public comment the reclassification criteria used by the MGCRB and alternatives to the MSA-based system such as ProPAC's nearest neighbor proposal and the options outlined in the present rule. In essence, therefore, we have been engaged in a continuing dialogue with the public concerning whether it is appropriate to use MSAs to define labor market areas to construct the wage index.

On June 30, 1993, the Office of Management and Budget announced the revised definitions for Metropolitan Areas (MA) to reflect the MA standards published on March 30, 1990, and the demographic data drawn from the 1990 Decennial Census. In that bulletin, OMB stated that in cases where an agency is publishing for comment a proposed regulation that would use the MA definitions for a nonstatistical purpose, the agency should seek public comment on the proposed use of the MA definitions. As indicated above, we are not proposing the options outlined in sections III G and H at this time. However, consistent with OMB's bulletin and as part of our continuing review of the definitions used to define labor market areas for wage index purposes, we are soliciting comments on the use of MSA definitions as incorporated in the options described in this document.

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

A. Definition of and Payment for Transfer Cases (§ 412.4)

The prospective payment system distinguishes between "discharges", situations in which a patient leaves an acute-care hospital after receiving complete treatment, and "transfers", situations 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. Therefore, the regulations at § 412.4(d) provide that, in a transfer situation, 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.

Currently, the per diem rate paid to a transferring hospital is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the geometric mean 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 established for all other cases (nontransfer and transfer cases alike)

classified to the DRG. They are not, however, 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 instead receive the full DRG payment.

1. Definition of a Transfer Case

Under current policy, cases that are transferred from an acute-care area paid under the prospective payment system to a hospital or unit excluded from the prospective payment system are considered to be discharges (as opposed to transfers) from the acute-care hospital. As a discharge, payment for the case is the full DRG amount.

The rationale for this policy was set forth in the initial hospital inpatient prospective payment interim final rule with comment period, which was published on September 1, 1983. In that document, we stated that: "* * * Hospitals and units excluded from the prospective payment system are organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities would not be the same services obtained in transferring hospitals (that is, paid under the prospective payment system), and payment to both facilities would be appropriate." (See 48 FR 39759.) Thus, since the prospective payment hospital was assumed to be providing a full course of acute inpatient care before transfer to the excluded hospital or unit for additional care and treatment, we believed it was appropriate to pay the prospective payment hospital the full DRG amount.

For the most part, inpatient hospital services furnished by hospitals and hospital units excluded from the prospective payment system are paid on a reasonable cost basis, subject to a cost per discharge limit. This payment does not vary by source of admission or discharge destination. Under §§ 412.22 through 412.29, the following types of facilities are identified as being excluded from the prospective payment system: psychiatric hospitals and distinct part units; rehabilitation hospitals and distinct part units; long-term care hospitals; cancer hospitals; children's hospitals; hospitals outside the 50 States, the District of Columbia, or Puerto Rico; Veterans Administration and other Federal hospitals; and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries. Also listed in § 412.22(c)(2) and (3) are hospitals paid under approved State cost control systems and hospitals reimbursed in accordance with authorized demonstration projects. Under § 412.4(b)(3)(i), patients moving from an acute-care hospital paid under the prospective payment system to hospitals within either of these categories are currently considered transfers, and therefore they are not referred to in the following discussion.

Since implementation of the prospective payment system over 10 years ago the distinctions between the types of services provided in acute-care hospitals and excluded hospitals and hospital units have become less clear. Acute-care hospitals may have an incentive to reduce patient lengths of stay, and thus patient costs, in order to maximize profits since payment is no longer linked to actual costs. This has led to a steady increase in the numbers of excluded hospitals and units, as well as postacute-care facilities, as acute-care hospitals look to discharge patients whom heretofore they were treating until the patients were ready to be discharged to their homes. (See Langenbruner et al., *Health Care Financing Review*, Spring 1989.)

As part of a study of Medicare transfer cases funded by HCFA ("Transfers of Medicare Hospital Patients under the Prospective Payment System", PM–191–HCFA, January 1994), RAND examined trends in transfer episodes from FY 1987 to FY 1991. RAND's analysis found that, from 1987 to 1991, while transfers from one prospective payment system setting to another increased 4.1 percent, transfers from a prospective payment system setting to excluded rehabilitation units and excluded psychiatric units increased 16.9 percent and 7.0 percent, respectively. We believe that this growth in transfers to excluded hospital units is an indication that the distinction in the types of services provided in short-term acute-care settings and excluded settings is not as significant as it was in 1983.

In addition, in section VI.A. of this preamble, we are proposing revised criteria for determining whether an entity qualifies for exclusion from the prospective payment system as a separate long-term care hospital. This proposed change is in response to situations where hospitals are manipulating the process for recognition as a separate Medicare provider in order to circumvent the prospective payment system exclusion rules. For example, some hospitals have begun to organize themselves under what they themselves refer to as the "hospital within a hospital" model. The effect of such a reorganization is to grant an exclusion to what is, for all practical purposes, a long-term care hospital unit, even though section 1886(d)(1)(B) of the Act limits the exclusion from the prospective payment system for hospital units to rehabilitation and psychiatric units.

We believe that the motivation for such arrangements is primarily financial and may lead to inappropriate transfers that are not necessarily in the best interests of patients' health and well-being. We strongly believe that patients should be treated in settings that are best suited to provide the levels of care the patients need. Decisions regarding the most appropriate setting should be based on clinical criteria. To help ensure that this occurs, to the greatest extent practicable, financial incentives should be neutral regarding the setting wherein a patient is treated. This means matching payments as nearly as possible to the resources required to treat the patient. We believe our current definition of transfer cases provides financial incentives on the acute-care side to transfer patients to excluded hospitals and units in order to reduce lengths of stay and at the same time receive payment at the full DRG amount. These incentives exist whether the acute-care hospital is transferring patients to its hospital-based excluded units or to other excluded hospitals.

For these reasons, we are proposing to change our definition of a transfer case by adding new § 412.4(b)(4) to include cases transferred from an acute-care setting paid under the prospective payment system to an excluded hospital or unit. We believe that this policy would more appropriately pay those prospective payment hospitals that are transferring patients to an excluded hospital or unit before completion of a course of treatment. This policy would extend to cases transferred to all excluded hospitals and units, Veterans Administration hospitals, other Federal hospitals, and hospitals not participating in Medicare. Discharges to non-hospital settings, such as skilled nursing facilities and intermediate care facilities, would still be paid as discharges.

2. Payment for Transfer Cases

Since the inception of the prospective payment system, there has been concern that a flat per diem payment rate for transfer cases fails to account for the likelihood that the beginning of a patient's hospitalization is the most resource intensive portion of the stay. Comments received in response to the September 1, 1983 interim final rule recommended that the transferring

hospital should receive either the full DRG amount or should be paid on a sliding scale to reflect the higher costs of the first few days of a patient's stay. Our response at that time was that little or no data were provided in support of this position (49 FR 245, January 3, 1984).

Last year, in the May 26, 1993 proposed rule, we responded to a ProPAC recommendation concerning payment of transfer cases and described the preliminary results of the analysis undertaken by RAND to evaluate the adequacy of our transfer payment policy (58 FR 30245). RAND found that among cases transferred prior to reaching the mean length-of-stay, 1-day stays cost 2.096 times the per diem payment amount for cases in nonsurgical DRGs (based on the geometric mean length of stay) and 2.576 times the per diem for surgical DRGs. Among nonsurgical transfer cases, the costs of 2-day stays are about 1.215 times the per diem payment amount, and cases transferred after 2 days cost about 10 percent more than the applicable per diem amount. Among surgical cases, the costs of stays of 2 or more days are actually about 7 percent below the applicable per diem amount.

To evaluate the impact of replacing the flat per diem methodology with one designed to reflect the observed relationship between costs and the first few days of hospitalization, RAND simulated a transfer payment methodology that multiplies the per diem amounts by the coefficients referred to above. The improvement in payment-to-cost ratios for per diem transfer cases was significant, from 0.7224 under current policy to 0.9722 using the scaled per diem.

We did not propose a change to the transfer payment policy last year, however, due to concerns over the specification of the transfer payment formula. First, the coefficients used to graduate the per diem amount are dependent on the specification of the model and the data employed. Ensuring the continued validity of the per diem weighting factors would require frequent reestimation as other payment parameters change and more recent data become available.

Second, we were concerned that weighting the per diem amounts by the coefficients directly from the regression may overstate the precision of the estimates of costs per day prior to transfer. Because available data do not attribute charges or costs to a particular day, the estimated costs for each additional day reflect the incrementally higher costs per case compared to transfers occurring 1 day earlier. If, in transfers occurring after 3 or more days, for example, costs per day were more evenly distributed than the graduated per diem payments, the coefficients in the regression might not reflect the costs of additional days.

This leads to a third concern, that the graduation of the scaled per diem amounts may generate inappropriate incentives to transfer patients as soon as possible, that is, before the point at which costs equal payments. This incentive could arise, for example, for cases in which payments early in a patient's stay are greater than costs (that is, cases with more even costs throughout the stay rather than high costs in the first day or two). In such cases, the longer the patient stays in the hospital, the more likely that total costs will approach total payments. Under this scenario, a hospital seeking to maximize its profit could do so by transferring the patient as soon as possible.

In order to address these concerns and to pay hospitals more appropriately for the treatment they furnish to patients before transfer, we are proposing at § 412.4(d)(1) to pay transfers twice the per diem amount for the first day of any transfer stay plus the per diem amount for each of the remaining days prior to transfer, up to the full DRG amount. We believe this method will improve the payment equity for transfer cases in a straightforward way while alleviating our concerns about a steeply graduated per diem based directly on regression coefficients. We are proposing that this change be applied uniformly for both medical and surgical transfer cases; although surgical transfer cases appear to be more costly, on average, the first day, they are relatively less costly for the second day and beyond.

Using the graduated per diem methodology we are proposing, RAND estimated the payment-to-cost ratio of transfer cases that were transferred prior to reaching the geometric mean length of stay would be 0.9321. While this is somewhat less than the payment-to-cost ratio for nontransfer cases (0.9645), it represents a significant improvement over the current ratio for these cases (0.7224).

Since publication of the September 1, 1993 final rule, RAND has completed the second and final phase of its study. This phase of the study focused on the receiving hospitals and how they fare under our current transfer payment policy. Their findings in this regard were more ambiguous than in the case of sending hospitals. RAND performed regressions on transfer cases in receiving hospitals to determine whether these cases were more expensive than nontransfer cases within the same DRGs. They found no consistent relationship.

Over 60 percent of all transfer cases were assigned DRGs from MDC 5 (Diseases and Disorders of the Circulatory System). According to RAND, "* * * for the surgical DRGs in MDC 5 (DRGs 104 through 116), the costs of transfer cases relative to nontransfer cases at the same hospital range from almost the same (in DRG 106, coefficient = 0.007) to about 11 percent greater (DRG 105, coefficient = 0.105). In the medical DRGs in MDC 5, the range is even wider, with transfers received into DRG 121 and 122 actually costing less than other cases in the same DRG at the same hospital and transfers received in DRG 127 costing 37 percent more." (See RAND page 40.)

Based on these results, RAND did not recommend and we are not proposing any change in the payments for the receiving hospital in a transfer episode. That is, if the receiving hospital is also the final discharging hospital, they will be paid the full DRG amount plus any outlier payments they are eligible to receive (under either the day or cost outlier thresholds). If the patient is transferred again prior to discharge, then, under the change we are proposing, the sending hospital in this second transfer episode would be paid using the graduated per diem methodology, rather than the flat per diem rate they currently receive.

B. Review of DRG Assignments (§ 412.60)

Under the provisions of § 412.60(d), a hospital has 60 days from the date of the notice of the initial DRG assignment of a claim to request review of that assignment. The hospital may submit additional information as part of its request. The intermediary reviews the request and any additional information and decides if a change in the assignment is appropriate. Any change by the intermediary to a higher-weighted DRG must be reviewed by the hospital's Peer Review Organization (PRO) to determine if the request and the change are appropriate.

Under the first PRO contract cycle, this review was conducted on a postpayment basis. However, the second PRO contract, effective July 1, 1986, required that this review be conducted on a prepayment basis. Therefore, § 412.60(d)(2) currently provides that the intermediary must request that the PRO review any change in assignment to a higher-weighted DRG.

Under the fourth contract cycle, the PROs are no longer required to review these cases on a prepayment basis.

Rather, the cases are flagged and the PRO conducts a 100 percent review after payment. Therefore, we are proposing to revise § 412.60(d)(2) to conform the regulations to current practice. At the same time, we would revise an incorrect cross-reference to the regulations that govern the PROs' review of these DRG reassignments. The correct cross-reference is § 466.71(c)(2).

C. National Average Standardized Amounts for FY 1995 (§ 412.63)

Section 1886(d)(3)(A) of the Act directs the Secretary to compute national average standardized amounts for use in determining payments for inpatient operating services, updated annually by the applicable percentage increase set forth under section 1886(b)(3)(B) of the Act. Under section 1886(d)(3)(A)(ii) of the Act, for FYs 1988 through 1994, the Secretary has computed separate national average standardized amounts for large urban, other urban and rural areas. However, section 1886(d)(3)(A)(iii) of the Act requires that, for discharges occurring after October 1, 1994, the average standardized amounts for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an other urban area. We note that hospitals located in a rural area will continue to be considered rural for all other payment purposes, such as the disproportionate share adjustment.

The Secretary has been applying updates to the average standardized amounts for each fiscal year as provided under section 1886(b)(3)(B) of the Act. For FY 1995, section 1886(b)(3)(B)(i)(X) of the Act directs the Secretary to update the rural national average standardized amount by the amount necessary to make it equal to the other urban national average standardized amount.

Current § 412.63(m) already reflects the requirement that, for discharges occurring after October 1, 1994, we will pay for inpatient hospital services based on national average standardized amounts for large urban and other areas. Thus, there will no longer be separate national average standardized amounts for other urban and rural areas. However, we are proposing to make several technical changes to § 412.63(m) and (r), concerning computation of Federal rates, to eliminate now obsolete references to the rural and other urban standardized amounts and replace them with references to the standardized amounts for other areas. In the addendum to this proposed rule, we provide a description of the updates being proposed for FY 1995 under the requirements of sections 1886(b)(3)(B)(i)(X) and 1886(d)(3)(A)(iv) of the Act.

D. Outliers (§§ 412.80, 412.82 and 412.84)

Section 1886(d)(5)(A) of the Act provides 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. Under section 1886(d)(3)(B) of the Act, the Secretary has been required to separately reduce the urban and rural national standardized amount by the proportion of estimated total DRG payments attributable to outliers in each respective area. Beginning with FY 1995, section 1886(d)(3)(B) of the Act, as amended by section 4002(c)(2)(B)(iii) of Public Law 101–508, requires the Secretary to reduce the large urban and other national standardized amounts by the same factor to account for the proportion of total DRG payments made to outlier cases. (As explained in section IV.C. of this preamble, section 1886(d)(3)(A)(iii) of the Act specifies that beginning in FY 1995, the standardized amount for other urban and rural areas will be equal, with the result that there will be only two standardized amounts, one for large urban areas and one for all other areas.) Section 1886(d)(9)(B)(iv) of the Act requires that the urban and other standardized amounts applicable to hospitals in Puerto Rico be reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act directs that outlier payments in any year may not be less than 5 percent nor more than 6 percent of total payments projected or estimated to be made based on the prospective payment rates.

Section 13501(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) amended section 1886(d)(5)(A) of the Act with respect to outliers beginning in FY 1995. With regard to cost outliers, section 13501(c) of Public Law 103–66 requires that the Secretary modify the methodology for determining the cost outlier threshold. Formerly, section 1886(d)(5)(A)(ii) of the Act specified that a hospital can receive payment for a cost outlier if the adjusted costs for a discharge exceed the greater of a fixed dollar amount or a fixed multiple the DRG payment for the case. As amended by section 13501(c)(2) of Public Law 103–66, section 1886(d)(5)(A)(ii) of the Act now specifies that, for discharges on or after October 1, 1994, a hospital may receive payment for a cost outlier if adjusted costs exceed the DRG prospective payment rate plus a fixed dollar amount determined by the Secretary. We will refer to this revised cost outlier threshold as "fixed loss." A further discussion of the methodology for determining the fixed loss is provided below.

Section 13501(c) of Public Law 103–66 also amended section 1886(d)(5)(A) of the Act with respect to day outliers. Beginning with FY 1995, section 1886(d)(5)(A) of the Act requires the Secretary to reduce the proportion of total outlier payments paid under the day outlier methodology. Under the requirements of section 1886(d)(5)(A)(v) of the Act, the proportion of outlier payments paid under the day outlier methodology, relative to the proportion of outlier payments in FY 1994, shall be 75 percent in FY 1995, 50 percent in FY 1996 and 25 percent in FY 1997. Under the provisions of section 1886(d)(5)(A)(i) of the Act, the Secretary will no longer pay for day outliers after September 30, 1997. As indicated in the table published in our September 1, 1993 final rule (58 FR 46348), we estimated that 18 percent of FY 1994 outlier payments would be for outliers meeting the day outlier threshold only, while 13 percent would meet the day and cost outlier thresholds and be paid under the day outlier methodology. Thus, a total of 31.3 percent of total outlier payments in FY 1994 would be paid as day outlier cases. Pursuant to section 1886(d)(5)(A) of the Act, we propose setting the day outlier thresholds for FY 1995 through FY 1998 so that day outlier payments approximate the following proportion of total outlier payments:

- FY 1995—24 percent (75 percent of 31.3 percent).
- FY 1996—16 percent (50 percent of 31.3 percent).
- FY 1997—8 percent (25 percent of 31.3 percent).

As payments to day outliers are reduced, there will be a corresponding increase in payments to cost outliers.

1. FY 1995 Outlier Thresholds

For FY 1994, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 23 days or 3.0 standard deviations. The marginal cost factor (or the percent of Medicare's average per diem payment paid for each outlier day) for day outliers is equal to 55 percent in FY 1994. The cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or $36,000 ($33,000 for hospitals that have not yet entered the prospective payment system for inpatient capital-related costs). The marginal cost factor (or the percent of costs paid after costs for the

case exceed the threshold) for cost outliers is 75 percent.

For FY 1995, we propose to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 22 days or 3.0 standard deviations. Section 13501(c)(3) of Public Law 103-66 provides that the additional payments for outlier cases may be different than the hospital's marginal cost of care during the transition period phasing out payments to day outliers. We are proposing to revise § 412.80 to reflect this provision. We also propose to revise § 412.82(c), so that it does not specify a marginal cost factor of 55 percent. HCFA will specify the level of the marginal cost factor during the day outlier phase-out in the annual prospective payment system rulemaking process.

Our proposed policy would reduce the proportion of outlier payments paid to day outliers as required by section 1886(d)(5)(A) of the Act. We are proposing to accomplish the required reduction in payments to day outliers for FY 1995 solely through a reduction in the marginal cost factor rather than through an increase in the threshold. To determine the marginal cost factor necessary to achieve the mandated reduction in outlier payments, we simulated both the current and proposed outlier policies. Based on these simulations, we determined that a reduction in the marginal cost factor to 49 percent is necessary to achieve the required 25 percent reduction in the proportion of payments paid under the day outlier methodology. Therefore, we are proposing to reduce the marginal cost factor from 55 percent in FY 1994 to 49 percent in FY 1995.

We are also proposing a fixed loss cost outlier threshold in FY 1995 equal to the prospective payment rate for the DRG plus $23,300 ($21,400 for hospitals that have not yet entered the prospective payment system for capital-related costs). The fixed loss threshold would replace the current threshold, which is equal to the greater of 2.0 multiplied by the DRG payment for the case or $36,000. We are proposing the fixed loss threshold under the requirements of section 1886(d)(5)(A) of the Act. We believe the fixed loss threshold is an improvement over current policy because it focuses Medicare's outlier payments on the most costly cases. Under current policy, it is possible that cases in certain high-weight DRGs can incur losses significantly greater than $36,000 before Medicare will make an outlier payment. (We note that the fixed loss threshold is adjusted by the wage index, similar to the current cost outlier threshold. Thus, hospitals that are paid based on a wage index value of less than 1.0 will have this threshold reduced while other hospitals will be paid based on a higher threshold.)

To further focus Medicare's cost outlier payments on the costliest cases, we are proposing to increase the marginal cost factor from 75 percent to 80 percent. We note that raising the marginal cost factor to 80 percent is consistent with a recommendation made by ProPAC in its March 1, 1994 annual report. While we are raising the marginal cost factor for cost outlier cases to 80 percent, we are continuing to set the cost and day outlier thresholds in order to maintain the estimated 5.1 percent proportion of total DRG payments paid as outliers.

The thresholds we would propose if we were not implementing the change in the day and cost outlier payment methodology required by section 1886(d)(5)(A)(v) of the Act and discussed above would be:

- Day outliers—The geometric mean length of stay for each DRG plus the lesser of 21 days or 3 standard deviations.
- Cost outliers—The greater of 2.0 times the prospective payment rate for the DRG or $31,000.

We estimate that the proposed FY 1995 outlier thresholds would result in 76 percent of outlier cases paid using the cost outlier methodology and 24 percent paid using the day outlier methodology. Cases that meet the day outlier threshold but that would be paid using the cost outlier methodology, because it yields the higher payment, would represent 20 percent of all outlier cases. Our simulation of FY 1995 outlier payments based on FY 1993 MedPAR data indicates that the percentage of outlier cases that would qualify as day outliers is approximately 67 percent. The cases qualifying as day outliers would receive 69 percent of operating outlier payments in FY 1995. An estimated 33 percent of outlier cases would be cost-only outlier cases, which would receive about 31 percent of operating outlier payments.

The following table illustrates these findings in greater detail:

Type of outlier	Percentage of outlier cases	Percentage of operating outlier payments	Percentage of capital outlier payments	Percentage of total outlier payments
Meets day threshold only	38.0	13.0	10.0	12.0
Meets day and cost thresholds, paid using day methodology	9.0	11.0	9.0	11.0
Meets day and cost thresholds, paid using cost methodology	20.0	45.0	44.0	45.0
Subtotal—All cases meeting day threshold	67.0	69.0	63.0	68.0
Meets cost threshold only	33.0	31.0	37.0	32.0
Total	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 higher percentage of outlier payments for capital-related costs than for operating costs. We estimate the proposed thresholds for FY 1995 would result in outlier payments equal to 5.1 percent of operating DRG payments and 6.3 percent of capital payments based on the Federal rate.

2. Outlier Changes Planned for FY 1996 Through FY 1998

As stated above, section 1886(d)(5)(A) of the Act requires us to phase out payments for day outliers over the FY 1995 through FY 1997 period. We currently expect to meet the statutory reductions in day outlier payments for FY 1996 and FY 1997 solely through a reduction in the marginal cost factor without having to raise the day outlier threshold. If necessary, we will propose achieving the reduction in day outlier payments between FYs 1996 and 1997 through a combination of reducing the marginal cost factor and raising the threshold. There will be corresponding

increases in payments to cost outliers as we phase-out payment to day outliers. We welcome comments on this issue.

E. 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. For discharges occurring before October 1, 1994, rural referral centers receive the benefit of payment based on the other urban payment rate rather than the rural payment rate. As of that date, the other urban and rural payment rates will be the same. However, rural referral centers will continue to receive special treatment under both the disproportionate share hospital payment adjustment and the criteria for geographic reclassification.

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 at least 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. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. In determining the proposed national and regional case-mix index values, we would follow the same methodology we used in the November 24, 1986, final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value includes all urban hospitals nationwide, and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

These values are based on discharges occurring during FY 1993 (October 1, 1992, through September 30, 1993), and include bills posted to HCFA's records through December 1993. Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1994, a hospital's case-mix index value for FY 1993 would have to be at least—

- 1.3028; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

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

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.1976
2. Middle Atlantic (PA, NJ, NY)	1.2040
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3082
4. East North Central (IL, IN, MI, OH, WI)	1.2234
5. East South Central (AL, KY, MS, TN)	1.2499
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2033
7. West South Central (AR, LA, OK, TX)	1.2844
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3572
9. Pacific (AK, CA, HI, OR, WA)	1.3087

The above numbers will be revised in the final rule to the extent required to reflect the updated MedPAR file, which will contain data from additional bills received for discharges through September 30, 1993.

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 1993 case-mix index value in Table 3C in section V of the addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, we are proposing to update the regional standards. The proposed regional standards are based on discharges for urban hospitals' cost reporting periods that began during FY 1992 (that is, October 1, 1991 through September 30, 1992). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1994, the number of discharges a hospital must have for its cost reporting period that began during FY 1993 would have to be at least—

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

Region	No. of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6707
2. Middle Atlantic (PA, NJ, NY)	8965
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	6972
4. East North Central (IL, IN, MI, OH, WI)	7043
5. East South Central (AL, KY, MS, TN)	5363
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5649
7. West South Central (AR, LA, OK, TX)	4385
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8529
9. Pacific (AK, CA, HI, OR, WA)	5768

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1994, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1993 would have to be at least 3,000.

3. Retention of Referral Center Status

Section 412.96(f) states that each hospital receiving the referral center adjustment is reviewed every 3 years to determine if the hospital continues to meet the criteria for referral center status. To retain status as a referral center, a hospital must 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 for the

current year. A hospital may meet any one of the three sets of 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 must meet all of the criteria within any one of these three sections of the regulations in order to meet the retention requirement 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(c)(1) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards would have to be met in the same year.

The requirement for triennial review was originally added to the regulations in 1984, to be effective for cost reporting periods beginning on or after October 1, 1987 (the end of the first 3 years of the referral center adjustment). However, three statutory moratoriums on the performance of the triennial reviews were enacted by Congress. The third of these moratoriums expires at the end of cost reporting periods that began during FY 1994. (See the September 1, 1993 final rule (58 FR 46310) for a detailed explanation of the moratorium and the implementation of the triennial reviews.)

With the expiration of the current moratorium, we will begin reviewing each rural referral center's compliance with the triennial review criteria effective with cost reporting periods beginning on and after October 1, 1994. As noted above, although rural referral centers will no longer be paid a higher standardized amount than other rural hospitals, hospitals approved as rural referral centers continue to be entitled to higher disproportionate share payments and continue to receive preferential consideration before the Medicare Geographic Classification Review Board. Therefore, we believe it is important that only those hospitals that meet the rural referral center triennial review criteria continue to be so classified. Thus, effective with cost reporting periods beginning on and after October 1, 1994, a hospital that has been classified as a referral center for at least 3 years will be subject to the triennial review criteria as discussed below.

In accordance with § 412.96(f)(2), the review process is limited to the hospital's compliance during the last 3 years. Thus, if a hospital meets the criteria in effect for at least 2 of the last 3 years or if it meets the criteria in effect for the current year (that is, the criteria for FY 1995 outlined above in this section of the preamble), it will retain its status for another 3 years. No hospital is 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 1995, a hospital must meet the criteria in § 412.96(c) for FY 1995 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
1994 ..	1992 ..	1992	September 1, 1993.
1993 ..	1991 ..	1991	September 1, 1992.
1992 ..	1990 ..	1990	August 30, 1991.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1992. The hospital has fewer than 275 beds. Its 3-year status as a referral center is protected through June 30, 1995 (the end of its cost reporting period beginning July 1, 1994). 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, 1992, July 1, 1993, and July 1, 1994. The hospital must meet the criteria in effect either for its cost reporting period beginning July 1, 1995, or for two out of the three past periods. For example, to be found to have met the criteria at § 412.96(c) for its cost reporting period beginning July 1, 1993, the hospital's case-mix index value during FY 1991 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 1, 1992 final rule. The hospital's total number of discharges during its cost reporting year beginning July 1, 1991, must have equaled or exceeded 5,000 or the regional standard as published in the September 1, 1992 final rule.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96(b)(1)(i) and (ii) (that is, rural location and at least 275 beds), 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 number of beds 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.

F. Determination of Number of Beds in Determining the Indirect Medical Education Adjustment (§ 412.105)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education program receive an additional payment to reflect the higher indirect operating costs associated with graduate medical education. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are at § 412.105. The additional payment is calculated by multiplying a hospital's DRG revenue (including outlier payments) by the applicable IME adjustment factor. The adjustment factor is calculated by using a hospital's ratio of residents-to-beds in the formula set forth at section 1886(d)(5)(B)(ii) of the Act.

Section 412.105(b) states that the number of beds used in the resident-to-bed ratio is calculated by dividing the number of days during the cost reporting period into "the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units * * *." Since we added this language to the regulations in the September 3, 1985 final rule (50 FR 35679 and 35690), there has been some confusion over whether this definition includes or excludes bed days attributable to neonatal intensive care units. This confusion has resulted in some hospitals contesting their fiscal

intermediaries' inclusion of intensive care neonatal intensive care beds in the hospitals' count of available beds.

Prior to the adoption of § 412.105(b), the definition of available beds was at section 2510.5A of the Provider Reimbursement Manual—Part 1, which was originally used to establish bed-size categories for purposes of applying the cost limits under section 1861(v)(1)(A) of the Act. That definition excluded newborn beds but specifically included beds in intensive care units, coronary care units, and other special care inpatient hospital units. This exclusion of newborn beds was consistent with the exclusion of newborn days and costs from the determination of Medicare's share of allowable routine service costs (see section 2202.11B of the Manual). If a neonatal unit qualifies as an intensive care unit, however, the costs of that unit are included in determining Medicare's costs (see section 2202.7.II.B of the Manual). Correspondingly, the days in a neonatal unit that qualifies as an intensive care unit are counted as intensive care type days rather than nursery days (see section 2202.7.II.A of the Manual). Finally, section 2510.5A of the Manual clearly indicates that intensive care unit beds and special care unit beds are included in a hospital's bed complement.

In the September 3, 1985 final rule, we added the definition of available beds to the regulations governing the IME adjustment (then § 412.118(b)). The expressed purpose for the change was to stop counting beds "based upon the total number of beds available on the first day of the pertinent cost reporting period" and to begin counting based on "the number of available bed days (excluding beds assigned to newborns, custodial beds, and beds in excluded units) during the current cost reporting period divided by the number of days in the cost reporting period" (50 FR 35679). We did not change the definition of available beds. Our current position regarding the treatment of these beds is unchanged from the time when the cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. That is, if the bed days and costs are allowable in the calculation of Medicare's share of inpatient costs, the beds within that unit are included as well.

Some hospitals have asserted that when we excluded beds assigned to newborns, we changed our treatment of neonatal intensive care unit beds. However, we note that the term "newborn" has historically been used synonymously with nursery. Perhaps the clearest illustration of this is the definition of a "newborn inpatient day" as a day that "an infant occupies a newborn bed in the nursery" (see section 2815 of the Provider Reimbursement Manual—Part 2.) This definition dates back at least to 1975. If § 412.105(b) was indeed meant to change our established policy, we would have referenced that intent at the time. This would have been necessary since neonatal intensive care costs and days were still included in the calculation of Medicare's costs. Finally, in August 1988, we issued Provider Reimbursement Manual Transmittal No. 345, revising section 2405.3G of the Manual, which provides implementing instructions for the IME adjustment. As part of this revision, the definition of the number of beds was clarified to specifically exclude beds "* * * assigned to newborns which are not in intensive care areas * * *." Those arguing that § 412.105(b) excludes neonatal intensive care unit beds from the hospital bed count also argue that this Manual issuance is contradictory to the regulations.

In order to clarify our policy, we are proposing to revise the regulations at § 412.105(b) to exclude specifically only beds assigned to newborns in the nursery. Thus, neonatal intensive care beds would not be excluded from the bed count. We would like to stress that this does not represent a policy change in our bed counting rules, but rather a reaffirmation of our longstanding position. Revising the wording of the regulations should alleviate any future misunderstandings, as well as clarify our position regarding previous application of this policy, both before and since the original publication of our bed counting regulations now specified at § 412.105(b).

We are also proposing to make a technical change to § 412.105(d)(1) to correct a reference.

G. Disproportionate Share Adjustment (§ 412.106)

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments for hospitals that serve a disproportionate share of low income patients. Section 1886(d)(5)(F)(vii) of the Act, as added by section 6003(c)(1)(B) of Public Law 101–239 and amended by section 4002(b)(1) of Public Law 101–508, specifies the formula for determining the disproportionate share adjustment percentage for hospitals that are located in an urban area and have 100 or more beds, or are located in a rural area and have 500 or more beds. The statute establishes different payment formulas for different years, including a change in the formula for discharges occurring on or after October 1, 1994.

Regulations concerning the Medicare disproportionate share adjustment are set forth at § 412.106. Under § 412.106(c)(1)(i), a hospital that is located in an urban area and has 100 or more beds, or is located in a rural area and has 500 or more beds, must have a "disproportionate patient percentage" of at least 15 percent to qualify for a disproportionate share payment adjustment. Section 412.106(d)(2) sets forth the formulas for determining the disproportionate payment adjustment factors applicable to these two groups of hospitals.

We are not proposing changes to any part of § 412.106 in this proposed rule. However, we wish to ensure that hospitals are aware of the revised payment formulas that will take effect in FY 1995 pursuant to the statute. Specifically, for discharges occurring on or after October 1, 1994, any such hospital with a disproportionate share patient percentage greater than 20.2 percent will receive a disproportionate share adjustment equal to 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate share patient percentage.

H. Changes Affecting Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs) (§§ 412.109, 485.602, 485.635, and 489.102)

On May 26, 1993, we published a final rule to implement the EACH program (58 FR 30630). The rule set forth the requirements for designating certain hospitals as EACHs or RPCHs, the conditions that an RPCH must meet to participate in Medicare, and the rules for Medicare payment for services furnished by EACHs and RPCHs. The final rule implemented section 1820 of the Act, as added by sections 6003(g) and 6116(b)(2) of Public Law 101–239 and revised by section 4008(d) of Public Law 101–508. The amendments were intended to promote regionalization of rural health services in grant States, improve access to hospital and other health services for rural residents, and enhance the provision of emergency and other transportation services related to health care.

Since the publication of that rule, we have identified several necessary additions to the EACH/RPCH provisions. First, to provide for orderly review and adjudication of disagreements about whether a facility's designation has been terminated properly, we propose to specify under new § 412.109(e) that a determination

by HCFA that a hospital does not meet the criteria for EACH designation, or that a hospital's EACH designation should be terminated, is subject to review under 42 CFR part 405, subpart R.

We also propose several clarifying changes to the definition of "direct services" at § 485.602, as well as clarifying references in § 485.635, the condition of participation on provision of services. These revisions merely would restate more clearly our existing policies under which the services listed in § 485.635(b) ("direct services") must be furnished by employed staff, not under agreements or arrangements.

In addition, we are proposing to revise the range of laboratory services that an RPCH must furnish as direct services. In a final rule with comment period published on December 2, 1993 (58 FR 63533), we revised the RHC regulations at § 491.9 to eliminate, as required direct services, tests not classified as waived under the Clinical Laboratories Improvement Act of 1988 (CLIA). (See 42 CFR 493.15.) We made these changes in the RHC regulations because the CLIA program introduced participation requirements that may cause some RHCs to withdraw from the program, creating a shortage of available medical care in some areas.

Because RPCHs typically are located in rural areas similar to those served by RHCs and serve similar patient populations, and because the RPCH designation criteria in section 1820(f)(1)(H) of the Act state that RPCHs must meet the requirement for direct provision of routine diagnostic services in the statutory definition of "rural health clinic," we believe it is appropriate to impose the same requirements in both settings. Therefore, we propose to revise the RPCH regulations at § 485.635 to require the RHCs to provide directly the following laboratory services:

(1) Chemical examination of urine by stick or tablet method or both (including urine ketones);

(2) Hemoglobin or hematocrit;

(3) Blood glucose;

(4) Examination of stool specimens for occult blood;

(5) Pregnancy tests; and

(6) Primary culturing for transmittal to a certified laboratory.

We note that this change would not prevent any RPCH from providing tests that are not listed in § 485.635(b)(2). An RPCH is free to choose a higher level CLIA certification than the certificate of waiver if it wishes to provide tests of a higher complexity and to comply with all CLIA requirements.

The current regulations do not set out a clear and consistent position on the applicability of the advance directives requirement. Under the regulations in § 485.645(b)(1), swing-bed RPCHs are required to meet a number of skilled nursing facility (SNF) requirements, including § 483.10(b)(4). That regulation requires that the patient be given the right to make an advance directive. (An advance directive is a written instruction, such as a living will or a durable power of attorney for health care, that deals with the provision of health care when the individual is incapacitated. See Subpart I of 42 CFR Part 489.) Thus, the regulations apply the advance directives requirement to RPCH inpatients receiving a SNF level of care in swing beds, but not to inpatients receiving RPCH care.

We believe the RPCH benefit could be administered more simply and equitably if both hospitals and RPCHs were required to comply with the same advance directives requirement. As explained in the preamble to the May 26, 1993 final rule on EACHs (58 FR 30635–30636), as authorized by section 1861(e) of the Act, we have read the word "hospital" to include RPCHs where the context appears to support such a reading. We believe the context of section 1866(a)(1)(Q) of the Act would support this reading, since many patients are likely to seek RPCH care as an alternative to treatment in a hospital or SNF, and many RPCHs will accept patients who are at risk of the kind of incapacitating condition addressed by an advance directive. Thus, we propose to revise the regulations at § 489.102 to provide for more consistent application of the advance directive requirement, by specifying that it will apply to RPCHs on the same basis as to hospitals.

We believe this approach is simpler to administer and expands beneficiary rights. Moreover, since all prospective RPCHs must be (or have been) hospitals and have been required to meet the advance directive requirement, there should not be any added burden.

I. Clarification of Payment to RRC/EACH Hospitals

We wish to clarify a response in the EACH final rule of May 26, 1993 (58 FR 30639–30640), regarding the effect on a rural referral center's (RRC) payment rate should it elect to become an EACH. An RRC that elects to become an EACH is considered to have dual classification; that is, it is classified as an RRC/EACH. Since section 1886(d)(5)(D)(iii)(III) of the Act specifies that an EACH is to be treated as an sole community hospital (SCH), in determining which of the three payment rates will yield the highest aggregate payment, we will use the "other" standardized amount in determining the Federal payment rate for discharges occurring on or after October 1, 1994. (As discussed above, as of that date, the other urban and rural payment rates will be the same.) For discharges occurring before October 1, 1994, the Federal payment rate is based on the "other urban" payment rate.

Thus, an RRC that elects to become an EACH is paid based on whichever of the following rates yields the greatest aggregate payment for the cost reporting period:

- The national Federal rate applicable to the hospital (that is, other urban before October 1, 1994 and "other" on or after that date);
- The updated hospital-specific rate using FY 1982 cost per discharge; or
- The updated hospital-specific rate using the FY 1987 cost per discharge.

J. Direct Graduate Medical Education Payment (§ 413.86)

1. Definition of Initial Residency Period

Section 1886(h)(4) of the Act bases payment for direct graduate medical education (GME) costs on the hospital's number of full-time equivalent (FTE) residents multiplied by a hospital-specific adjusted base year per resident amount. The number of FTE residents is determined by applying a weighting factor to each FTE resident. A resident in an initial residency period is weighted as 1.0 FTE. Residents in approved training programs that are beyond their initial residency period are required by law to be counted as .50 FTE. The initial residency period is defined at § 413.86(g)(1), as the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty plus 1 year, not to exceed 5 years.

Section 13563(b) of Public Law 103–66 amended section 1886(h)(5)(F) of the Act by deleting "plus one year" from the statutory definition of initial residency period, effective July 1, 1995. To conform the regulations to the statute, we propose to revise § 413.86(g)(1) by specifying that, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.

For example, if a resident completed a 3-year internal medicine program and then started a cardiology program that requires an additional 2 years of training, the resident would be counted as 1.0 FTE for the 3 years spent in internal medicine and as a .50 for 2 years in the cardiology program. (Prior

to Public Law 103-66, the resident would have been counted as 1.0 FTE during the first year of the cardiology residency program.)

2. Part-time Resident

Currently, the last sentence of § 413.86(f)(1)(ii) specifies that, for purposes of GME, "[a] part-time resident counts as a partial FTE based on the proportion of time worked as compared to the average time spent by other residents working in the same specialty program."

The definition of part-time resident for purposes of GME is consistent with the definition of part-time resident for purposes of IME. However, the language in the regulations text differs and this difference has led to some confusion. Therefore, we are proposing to revise the language at § 413.86(f)(1)(ii) as follows:

A part-time resident counts as a partial FTE based on the proportion of time worked in the hospital compared to the total time necessary to fill a full-time internship or residency slot.

This definition of part-time resident, for the purpose of determining GME full-time equivalent resident counts, is consistent with the IME definition specified at § 412.105(g).

Thus, in determining the FTE count for a part-time resident, for purposes of GME, the proportion of time the resident works in an approved program in any area of the hospital complex is compared to the total time necessary to fill a full-time slot.

We are also proposing to make a technical change to § 412.113(b)(3) to correct a reference to § 413.86.

K. Other Technical Changes (§ 412.232)

We are republishing provisions in § 412.232(c) that were inadvertently deleted from the regulations text published in the Code of Federal Regulations (CFR) due to an error in amendatory language in our September 1, 1992 final rule. In order to provide the public with the complete text of the provisions of § 412.232(c), pending publication of the next edition of the CFR, we are publishing § 412.232(c) in its entirety.

V. Proposed Changes and Clarifications to the Prospective Payment System for Capital-Related Costs

A. Evaluation of Provisions Relating to Obligated Capital for Hospitals Subject to Lengthy Certificate-of-Need (CON) Process (§ 412.302(c)(2))

Section 412.302(c)(2) of the regulations specifies the conditions under which capital projects may be treated as obligated capital for hospitals subject to a lengthy CON process. Under this provision, a capital project that is subject to a CON process may qualify as obligated capital if several conditions are met. These conditions are:

- The hospital is required under State law to obtain prior approval of the capital project by a designated State or local planning authority in the State in which the hospital is located;
- The hospital filed by December 31, 1989, an initial application meeting the requirements of the State that includes, at a minimum, a detailed description of the project and its estimated cost, and had not received approval or disapproval by September 30, 1990;
- The hospital expended the lesser of $750,000 or 10 percent of the estimated project cost by December 31, 1990; and
- The project is completed and the asset put into use for patient care on or before the earlier of September 30, 1996 or 4 years from the date CON approval is received.

The purpose of allowing hospitals in CON states to qualify projects for recognition as obligated capital under these special conditions was to recognize that in situations where there is a lengthy CON process, hospitals may have deferred making the legal commitments required under the general rule for recognizing obligated capital until the CON approval was received. We believe 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 approval had not been received. Our intent was not to afford more favorable treatment for these hospitals relative to other hospitals, but rather to make a reasonable and equitable allowance for the impact a lengthy CON process may have on the ability of hospitals that have already made a substantial financial commitment to meet the criteria for recognition of obligated capital costs. Thus, the intent was to put these hospitals on an even footing with other hospitals.

Since we established this special provision in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43393–43394), we have received comments from individual hospitals and hospital associations requesting revision to the provision. With one exception, these hospitals come from a single State and indeed most of them are located in a single large urban area of that State. Citing varied problems and delays frequently encountered throughout the CON process, such as a requirement for separate CON approval for each phase of a multi-phase project, the commenters have suggested that the policies be revised as follows:

- 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 use for patient care by up to 3 years.
- Allow a 10-year transition for each phase under the hold-harmless methodology.

We stated in our September 1, 1993 final rule that we would conduct an evaluation of the issues raised by these commenters once we were able to obtain data on the impact of the current provision. We also noted that any reassessment of the current provisions would be made solely within the policy framework used to establish the initial transition payment policies. We emphasized that we would not adopt revisions that would give hospitals subject to CON processes more favorable treatment than other hospitals.

We now have limited, but significant, data available on the impact of the obligated capital provisions. Since the beginning of the capital prospective payment system, the Medicare intermediaries have compiled a special data set to monitor the implementation of the system. These intermediary data have provided us with information concerning virtually all hospitals that have requested recognition of obligated capital and the amount, if any, of the obligated capital approved by the intermediary. Using this data, we have been able to develop some relevant comparisons. The data show, for example, that nationally 42.9 percent (2,281 out of 5,316) of all hospitals requested recognition of obligated capital. A total of $21.2 billion in obligated capital has been recognized by the intermediaries. The average amount of obligated capital recognized is $9.3 million per requesting hospital.

Since most of the comments concerning the effects of the CON provision have come from a small group of hospitals in one particular State with a lengthy CON process, we compared the data for that group of hospitals, and the hospitals in that State as a whole, with the national average and the averages for similar States. We found that the group of hospitals that has recommended revisions to the current rule had an average approved amount of obligated capital far above the national average approved amount per requesting hospital. All of the 21 hospitals in the

group in question requested recognition of obligated capital. Furthermore, 17 of those hospitals (81 percent) received at least partial approval of that request. The average amount of obligated capital approved was $139.5 million. Since 1 of these 21 hospitals received approval for an extraordinarily large obligated capital project, we also computed the average amount of obligated capital approved for the other 20 hospitals. Even excluding the hospital with the extraordinarily large project, the average amount of obligated capital approved in the group in question is $67.5 million. This group of 21 hospitals, in fact, accounted for 13.8 percent of all the obligated capital recognized in the country (6.4 percent for 20 hospitals, excluding the hospital with the extraordinarily large project). This group of hospitals also has averages of obligated capital approved that are significantly above the average for the State in which they are located. In turn, the averages for the State in which they are located are significantly higher than the averages for similar States (that is, States with large populations, CON processes, and/or large urban areas).

Although the fiscal intermediary data base contains data on the amount of obligated capital approved for each hospital, it does not include data on the amount of obligated capital requested by each hospital. We are therefore unable to develop ratios of obligated capital approved to obligated capital requested for specific hospitals and groups of hospitals in order to determine whether that ratio is lower for this group of hospitals than the average for any regional or other groups of hospitals. However, we believe that the large amounts of obligated capital approved for the hospitals that have requested revision of the current rules indicate that the current rules do not disadvantage hospitals subject to lengthy CON processes.

In addition, our current data also cannot show how much of the obligated capital tentatively approved by the intermediaries will eventually meet the deadlines imposed under the general rule for obligated capital and each of the special rules for putting assets into use for patient care. Under the general rule, the asset must be put in use for patient care no later than October 1, 1994 (which is 45 months after the latest date by which the asset must have been obligated under the general rule). In cases of extraordinary circumstances beyond the hospital's control, that deadline can be extended to no later than September 30, 1996. For hospitals in CON states, the deadline for putting the asset into use for patient care is the earlier of September 30, 1996 or 4 years from the date of CON approval (§ 412.302(c)(2)(D)).

Thus, under current regulations, hospitals that receive CON approval after September 30, 1992 may have less than 4 years to complete the project in order to meet the deadline. In the interests of maintaining an equal playing field for those hospitals, we are proposing to change the deadline for putting assets into use for patient care to the later of September 30, 1996 or 4 years from the date of CON approval. We believe that establishing any later deadline for hospitals in CON states would violate the principle of equal treatment by giving those hospitals an advantage over hospitals that must satisfy the upcoming deadline established in the general rule for obligated capital.

On the basis of the available data, it appears that the existing CON provision has otherwise given this group of hospitals fair access to the special protection for obligated capital. The amounts of obligated capital approved for the affected hospitals simply do not support the need for more extensive relief to these hospitals in the context of the obligated capital provisions. Revision of practically every element of the obligated capital provision would be required to accommodate all the requests of the affected hospitals. Since it appears the CON rules have provided fair access to obligated capital protections, we do not believe that it would be appropriate to propose significant changes. We are therefore proposing no other revisions to the obligated capital rules at this time.

However, this does not mean that revisions to other provisions of the capital prospective payment system, such as the exceptions process, are also unwarranted. The same hospitals that have recommended changes in the obligated capital rules have also recommended policy measures in connection with exceptions payments under the prospective payment system for capital-related costs. Specifically, these hospitals have asked that the present 80 percent minimum payment level for urban hospitals with at least 100 beds and a disproportionate share percentage of at least 20.2 percent be guaranteed through the rest of the transition and extended for at least 10 years after the transition. While we do not propose to adopt those precise recommendations, we have tried to address the legitimate concerns of these hospitals in developing the revisions which we are proposing to exceptions payment policy below in section V.C. of this preamble.

B. Specific Adjustment for Taxes to the Capital Prospective Payment System Federal Rate (§ 412.312)

In the August 30, 1991 final rule implementing the capital prospective payment system, we acknowledged the need to study whether special treatment of the property tax component of capital-related costs is appropriate (56 FR 43364–43365). Subsequently, comments received on the May 26, 1993 proposed rule asked that we revisit this issue in a timely manner to eliminate any inequitable payment distributions. One of the commenters also suggested a specific methodology to adjust the capital Federal rate using a capital prospective payment system base-year survey to develop a hospital-specific adjustment to the capital Federal rate payment.

The Medicare cost report has recently been revised to obtain tax data directly from each hospital for cost reporting periods beginning on or after October 1, 1991 (FY 1992). These data are just now becoming available to us. Our preliminary review indicates a need for additional information and analysis. The FY 1992 cost report data currently available show that with slightly less than 90 percent of all prospective payment system hospitals in the data base (only 60 percent of which reflect audited data), only 77 percent of the proprietary hospitals reported property tax payments. This leaves a significant number of proprietary hospitals for which no tax data have been reported. In addition, approximately 13 percent of the non-proprietary hospitals are reporting some form of payments "in lieu of taxes." The nature of the payments "in lieu of taxes" is not yet entirely clear.

Given the limitations of the available data, we believe that it would be premature to develop a proposal for a property tax adjustment. We do not believe that we should proceed with development and implementation of a property tax adjustment until we have determined the status of the reported payments in lieu of taxes and whether an adjustment would be appropriate for these expenses. We also need to determine why a significant number of proprietary hospitals have reported no tax payments and what effect this might have on a budget neutrality adjustment to the Federal rate if a property tax adjustment were adopted. We have therefore asked our regional offices to develop information on a sample of hospitals from each group in order to refine and complete our analysis. We invite submission of relevant information and data by interested

parties and the public during the comment period to this proposed rule.

Furthermore, although we appreciate the concern that this issue addresses, we believe that at this point the possible adverse effects of our current policy are minimal. Capital costs represent less than 10 percent of total costs and a proprietary hospital's average tax cost burden for assessed property represents only 7 to 9 percent of its total capital-related costs. The tax burden for proprietary hospitals thus amounts to less than 1 percent of total costs. In addition, for the first 5 years of the capital prospective payment system transition period, the majority of payments to most hospitals are based on each hospital's own cost experience. Therefore, we do not believe delaying a specific adjustment to proprietary hospitals until more data are available would cause undue hardship to the affected hospitals.

In the interim, we hope to advance the discussion of this issue by raising the issue of whether a property tax adjustment would be appropriate and by presenting one approach to such an adjustment. We welcome comments and recommendations on every aspect of this presentation.

One approach to a methodology for a property tax adjustment for proprietary hospitals is to develop a property tax factor (PTF) from data on hospital-specific tax payments in the most recently audited cost reporting year. The PTF would take the form of a percentage add-on to the Federal rate and would remain fixed for future periods. That is, unless a hospital had property tax costs in its most recently audited cost reporting year, it would not qualify for an adjustment. The PTF would be based on capital cost and property tax information provided on the most current audited cost report, as follows:

(1) Audited cost report property tax data;

(2) Total capital cost for that year;

(3) Property tax unit cost multiplier (Line 1 divided by Line 2);

(4) Medicare inpatient capital cost;

(5) Medicare inpatient property taxes (Line 3 times Line 4);

(6) Medicare discharges;

(7) Medicare inpatient property taxes per discharge (Line 5 divided by Line 6);

(8) Federal capital rate (for fiscal year with most recent audited data);

(9) Property tax factor (Line 7 divided by Line 8).

This approach would be consistent with the philosophy of a prospective payment system. Although the initial determination of the PTF reflects a hospital's actual tax burden in a specific year, the PTF divorces payment from subsequent changes in the tax costs a hospital may experience. Because the PTF would be determined on the basis of tax costs from an audited cost reporting year and computed as a constant ratio of the Federal rate, States could not use property tax changes to capriciously increase Medicare reimbursement. Under this plan, Medicare's payment for taxes would increase with the underlying rate of increase in the Federal rate.

One objection to the PTF is that over time the ratio of actual Medicare allowable property taxes to Medicare inpatient capital costs in a rate year could diverge from the ratio in the year used to set the PTF. Such a divergence would create windfall gains or losses for particular hospitals, but we know of no way to determine the magnitude of possible gains and losses to particular hospitals. The greater the magnitude of such gains and losses, the less appropriate the PTF methodology would be. We welcome information on this issue and recommendations about how to determine the magnitude of such gains and losses, while safeguarding the program from arbitrary increases in hospital taxes.

A related problem is that applying a constant ratio to the Federal rate has the effect of increasing (or decreasing) the amount of the adjustment for property taxes across all hospitals by the same factor as the increase (or decrease) to the national rate. We currently have no data that show conclusively whether property taxes generally increase at the same rate as capital costs as a whole. This is difficult to determine since property tax assessment systems vary enormously from one locality to another, and changes in property taxes can reflect complicated changes in tax rates, methods of property assessment, and the tax base (that is, the percent of property value subject to tax assessment) in different localities, as well as appreciation of existing property values. We know of no definitive sources of information on this matter. We encourage submission of relevant information, observations, and suggestions.

An alternative methodology could employ a hospital-specific add-on amount, as opposed to the hospital-specific ratio discussed above. Such an add-on could be determined on the basis of the base year tax costs per discharge attributable to Medicare. This alternative may be preferable if strong evidence emerges that property taxes do not tend to increase at the same rate as other capital costs. However, in that case, a tax increase index would need to be developed. We welcome comments on the merits of this alternative.

We are especially interested in comments regarding an adjustment for non-proprietary hospitals that make payments in lieu of taxes and on a methodology for determining such an adjustment. As we previously noted, 13 percent of non-proprietary hospitals report payments in lieu of taxes. The uncertainty about the exact nature of those payments is one reason why we have decided to delay implementation of a specific property tax adjustment for those hospitals. However, our initial limited investigation of this issue suggests that those payments do not reflect assessments that can be categorized as capital-related costs under § 413.130(a)(3). It appears that some non-proprietary hospitals may have reflected payments made for assessments that are not based on the valuation of the hospital's real or personal property. Thus, the available evidence does not support adoption of an adjustment for non-proprietary hospitals' payments in lieu of taxes. However, we will continue to study this matter.

Any property tax adjustment would have to be implemented in a budget neutral fashion, so that total estimated payments under the prospective payment system for capital-related costs with such an adjustment would equal total estimated payments in the absence of a property tax adjustment. A property tax adjustment applied to the Federal rate thus requires a corresponding reduction to the base Federal rate to assure budget neutrality. It is impossible to determine the precise magnitude of the required adjustment to the Federal rate until we determine both the status of those proprietary hospitals that are not currently reporting taxes and the nature of the payments reported by non-proprietary hospitals in lieu of taxes. However, since our preliminary data indicates that tax payments by proprietary hospitals are at least 0.77 percent of total capital costs, we believe that a reduction to the base capital rate of at least 0.77 percent would be necessary. The final amount of the necessary adjustment to the Federal rate would depend upon the ultimate determination concerning the proprietary hospitals not reporting tax payments and the nature of the payments reported by non-proprietary hospitals. We welcome comments on the equity of removing tax amounts from the base Federal rate and distributing them only to tax-paying hospitals in the form of an adjustment to the Federal rate payment. Our concern is that special payment

adjustments recognize only costs that are distinguishable and unique. We also wish to avoid granting unwarranted advantages to any particular class of hospitals.

We plan to conduct further analysis on this issue prior to the publication of the final rule. We will also analyze comments and recommendations submitted in response to this discussion. We will make a determination concerning whether to adopt a property tax adjustment, and the form that any such adjustment would take, when we have obtained sufficient relevant data and have resolved all significant problems inherent to any adjustment methodology.

C. Revision of Provision Relating to Exceptions Payment (§ 412.348)

Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules.

Under current § 412.348(b)(1), the minimum payment percentages by class of hospitals for FY 1995 are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of its net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The current regulations also provide that total estimated payments under the exceptions process in a year may not exceed 10 percent of total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year. As we stated in the August 30, 1991 final rule, we will revise the minimum payment percentages during any subsequent transition year, if necessary, to ensure that exceptions payments do not exceed the 10 percent limit. It has not yet been necessary to reduce the original minimum payment percentages to meet the 10 percent limit.

In the final rule for the prospective payment system for capital-related costs, we stated that we would carefully monitor the impact of the capital prospective payment system in order to determine whether "some type of permanent exceptions process is necessary and the circumstances under which additional payments would be made (56 FR 43409)." Since the publication of the final rule for the capital prospective payment system, several commenters have urged us to provide special protection for hospitals that are undertaking major renovation or replacement of aging facilities during the decade of the transition. These commenters have pointed out that, unlike hospitals that undertook major renovation or replacement during the 1980s, many hospitals that undertake capital replacement or renovation projects during the transition do not qualify for the protection for old capital or obligated capital during the transition. In addition, unlike hospitals that will undertake major capital replacement or renovation in the decade after the transition period, such hospitals have not had an opportunity to accrue capital prospective payments to fund the projects. We are aware of a number of major projects, scheduled for completion later in the transition, that could therefore not be included as old or obligated capital, and that involve major replacement or renovation of aging facilities. In the design of the capital prospective payment system, we have made every effort to consider the circumstances of hospitals for whom the transition to prospective payment poses special difficulties. We agree with the commenters that hospitals that need to undertake major renovation or replacement projects during the transition face special difficulties merely because of the timing of their projects. We do not believe that the Medicare program should guarantee to underwrite every major program of replacement or renovation of capital assets. However, under certain circumstances we believe that it is fair to provide special protection, through the exceptions process, for hospitals that find themselves in the circumstances cited.

In addition to the exceptions categories identified above, we are therefore proposing at § 412.348 to provide special protection for some hospitals that are undertaking major projects to renovate or replace aging plant during the transition period. This special protection, which will provide a 70 percent minimum payment level for up to ten years beyond the transition period, will be available only to the following classes of hospitals:

- Sole community hospitals that have a current ratio less than or equal to of 1.75 in the exception year;
- Urban hospitals with at least 100 beds that either have disproportionate share percentages of at least 20.2 percent or receive at least 30 percent of their revenue from State or local funds for indigent care, and that have a current ratio less than or equal to 1.75 in the exception year; and
- Hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent. In addition, the hospital must meet an age of asset test and, if applicable, receive approval for the project from a State or local planning authority. If planning approval is not required, an urban hospital must demonstrate either that it is in a metropolitan statistical area (MSA) that does not have an overall average occupancy rate less than 80 percent or that its capacity is no more than 80 percent of its prior capacity (in terms of bed size).

We believe that this exception should apply only to hospitals that have previously been identified for special protection under the Medicare program (that is, sole community hospitals or large urban hospitals that serve disproportionate shares of indigent patients), or that have heavy utilization by beneficiaries of the Federal health programs. The average hospital utilization by Medicaid beneficiaries is approximately 10 percent. Hospitals with 60 percent Medicare utilization can reasonably claim high Medicare utilization rates. We have therefore determined that, aside from certain sole community hospitals and large urban disproportionate share hospitals, this special exception should be restricted to hospitals with combined Medicare and Medicaid utilization of at least 70 percent.

We are also requiring that sole community hospitals and large urban disproportionate share hospitals must have current ratios of less than or equal to 1.75 in order to be eligible for this special exception. We do not believe that hospitals that do not have high Medicare and Medicaid utilization should be eligible for this special exception unless they are financially vulnerable. The current ratio is perhaps the most widely used measure of hospital liquidity. It is defined as the number of dollars held in current assets per dollar of current liabilities. Thus, higher values reflect a stronger short-term financial condition. A current ratio

of 2.0 or better is a common hospital target for financial performance. We therefore believe that a current ratio of less than or equal to 1.75 is a sufficient indication of financial stress to qualify for special protection under the exceptions policy. The current ratio can be determined from information available on the Medicare cost report (HCFA 2552–92, Worksheet G, Lines 11 and 43).

One concern that we have about the use of the current ratio as a measure is that it may be possible for hospitals to manipulate cost report statistics to meet a current ratio threshold. Some analysis suggests that the current ratio should be supplemented by measures such as days in accounts receivable and/or days in accounts payable in order to reduce the prospects for manipulation. We will continue to study this issue before publication of a final rule on this special exceptions provision. We welcome comments on the use of the current ratio as a measure of hospital financial vulnerability, on the appropriate threshold under this measure, and on whether the current ratio should be supplemented by other measures.

An eligible hospital must pass an age of asset test in order to qualify for an exception. Hospitals almost universally have plant and equipment of varying ages. The average age of a hospital's assets is commonly determined as the ratio of accumulated depreciation to current depreciation expense. The current version of the Medicare cost report (HCFA 2552–92) allows for determination of average age of assets for all hospital assets, for building and fixed equipment alone, or for moveable equipment alone. The average age of buildings and fixed equipment can be determined on the basis of information on the current Medicare cost report (HCFA 2552–92, Worksheet G, Lines 14, 14.01, 16, 16.01, 18, 18.01, 20, and 20.01, and Worksheet A–7, Part III, Column 9, Lines 1 and 3).

We propose a two-part age of asset test to identify aging hospitals that undertake needed major capital replacement or renovation projects during the transition. The test would only consider changes in the average age of building and fixed equipment (determined by the ratio of accumulated depreciation for building and fixed equipment to current depreciation for building and fixed equipment) in order to focus on major capital replacement and renovation projects. We believe that it is appropriate to grant exceptions only to aging hospitals that undertake and complete major capital projects during the capital prospective payment transition period.

The first part of the age-of-asset test is designed to determine whether a hospital had relatively aged fixed assets at the beginning of the capital transition period (that is, the hospital's first cost reporting period beginning on or after October 1, 1991). We would determine a hospital's average age of building and fixed equipment using cost report data for the first year of the transition in comparison to the national average age of buildings and fixed equipment for that year. The threshold for qualifying under this part of the test would be the 75th percentile. We do not believe that the special protection we are proposing under this provision should be extended to hospitals who cannot demonstrate an urgent need for replacement or renovation of facilities. We believe that an average age of assets at or above the 75th percentile nationally is a sufficient indicator that a hospital had a pressing need for renovation or replacement at the beginning of the capital transition period to serve as a threshold qualifier for a special exception.

We would determine whether a hospital is at or above the 75th percentile nationally on the basis of Medicare cost report data for FY 1992. That data is becoming available this year. Preliminary but incomplete data suggest that the average age of buildings and fixed equipment at the 75th percentile is approximately 16.4 years. We intend to make a final determination on the basis of more complete data that will become available at a later date.

The second part of the test would compare the average age of buildings and fixed equipment in the cost reporting period beginning in FY 1992 with the average age of fixed assets in the year the hospital reports the completion of a major capital replacement or renovation. A major renovation or replacement of hospital capital during the transition period should result in a dramatically reduced average age of buildings and fixed equipment compared to the first year of the transition. We are therefore proposing that the test would be whether a hospital's average age of buildings and fixed equipment has declined by at least 50 percent since the first year of payment under the capital prospective payment system. Thus, a hospital whose average age of buildings and fixed equipment is at or above the 75th percentile nationally in the first year of capital prospective payment, and whose average age of buildings and fixed equipment has declined by at least 50 percent in a designated year later in the transition, meets the age-of-assets test.

We welcome comment on the use of an average age of asset measure, on the age-of-assets test as we have conceived it, and on the appropriate threshold levels to apply under such a test.

We do not believe that this special exception for replacement and renovation of old facilities should apply to hospitals whose capital projects preserve the overcapacity that is currently evident in much of the hospital industry. Therefore, a hospital cannot qualify for an exception unless it has received any required approval from a State or local planning authority. If such approval is not required, an urban hospital must demonstrate either that (1) overall average occupancy in its MSA is at least 80 percent, or (2) its capacity is no more than 80 percent of its prior capacity (in terms of bed size). We are exempting rural hospitals from this requirement because of concern about maintaining access to needed services in rural areas.

Hospitals that qualify for exceptions under this special provision may continue to receive exceptions payments for up to 10 years beyond the transition. Exceptions payments will be available to hospitals that meet the special criteria above for 10 years after the date when the hospital meets the age of asset test, provided that the hospital meets the age of asset test no later than the end of the capital prospective payment system transition period for the hospital (that is, the last day of the hospital's last cost reporting period beginning before October 1, 2001). We believe that extending exceptions payments for up to 10 years after the transition should be sufficient for hospitals who must undertake major renovation or replacement of facilities during the transition period.

We would continue to determine the amount of the exceptions payments under this special provision on a cumulative basis. That is, we would determine the hospital's exception payment by comparing the cumulative payments made to the hospital under the capital prospective payments system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels would continue to be deducted from the additional payment that would otherwise be payable for the cost reporting period. In addition, we will apply another test designed to limit the amount of exceptions payments under this special provision. We would reduce the amount of an exception payment

that would otherwise be made for any cost reporting period under this special provision by the amount of any Medicare hospital inpatient prospective payment system payments for the cost reporting period (less 75 percent of operating prospective payment system disproportionate share payments if applicable) that are in excess of Medicare inpatient operating and capital costs. This calculation includes payments under both the capital and operating prospective payment systems. It does not include graduate medical education payments, outpatient service payments, or payments for any other services covered under Medicare Part B. We propose to exclude 75 percent of operating prospective payment system disproportionate share payments from the determination of the Medicare operating prospective payments system payments in order to account for the financial pressure that disproportionate share hospitals experience in other parts of their operations.

Finally, we emphasize that these proposed policies would be subject to reevaluation in the light of passage of comprehensive health care reform by Congress. The hospitals for whom we currently propose to provide special protections may no longer require such protections after the implementation of comprehensive health care financing reform. Therefore, we will carefully monitor the impact of final health care reform legislation on the hospitals that would receive special treatment under the policies proposed above to determine whether such legislation justifies revision of those policies.

We are proposing the following revisions to the regulations text to implement the changes discussed above:

- Under new § 412.348(a), we would define current ratio, fixed assets, and average age of fixed assets.
- The new special exceptions requirements are set forth at proposed § 412.348(g).
- Current paragraphs (a) through (e) have been redesignated as paragraphs (b) through (f), and current paragraph (f) has been redesignated as paragraph (h).
- We are also proposing to make conforming technical changes to § 412.348 to correct references.

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

Currently, § 412.348(e) provides that a hospital may request an additional payment during the capital transition period if the hospital incurs an unanticipated capital expenditure in excess of $5 million (net of insurance proceeds) due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include but are not limited to a flood, fire, or earthquake. A hospital must apply to the HCFA regional office, for a determination by the HCFA Administrator, within 180 days of the extraordinary circumstance that caused the unexpected expenditures in order to qualify for exceptions payments. We propose to revise § 412.348 to clarify our policy and reconcile conflicts between the regulation text and the language and intent of the preamble to the August 30, 1991 final rule that implemented prospective payment system for capital-related costs (56 FR 43411).

With respect to current § 412.348(e)(1), we intend to clarify that the minimum expenditure criteria that the hospital must meet in order to qualify for payments is the net amount of proceeds expected to be recovered by the hospital in connection with the event from any other source including, but not limited to, insurance, litigation, or other government relief funding. In the August 30, 1991 final rule, in response to a comment concerning the exceptions process, we indicated that we intended to provide for an additional payment when a hospital has extraordinary circumstances that result in unanticipated capital spending of at least $5 million. We then stated that in determining whether this threshold was met, we would take into account any insurance proceeds received by the hospital in connection with the extraordinary circumstances. However, we inadvertently failed to list other sources that may reduce the unanticipated capital-related expense to the hospital. Later in that response we noted that HCFA's decision will be contingent on a final determination of the associated costs for the unanticipated circumstance and we provided an example of how the extraordinary circumstance exception policy would be applied. In that example we noted that the hospital must provide evidence of the extent to which the loss will be covered by insurance proceeds or other sources. In the regulations text, we reflected our intention to establish the threshold net of insurance but did not include the other comparable sources, such as court awards for damages, or other governmental relief funds.

The purpose of establishing this exception was to protect hospitals during the transition period from out-of-pocket expenditures at a level that could put severe financial strain on them. Thus, we clearly did not intend to replace or supplement other payment sources that have an obligation to pay or provide special authorization for funding in these same circumstances. As a result, we intend to revise current § 412.348(e)(1) to conform with the example provided in the August 30, 1991 final rule concerning application of the extraordinary circumstances exception policy and, specifically, documentation of evidence of the extent of net loss.

We also propose to correct the provision in current § 412.348(e)(2) regarding the level at which the determination of a hospital's eligibility for an extraordinary circumstance exception payment is made. Although the determination authority was reserved to the HCFA Administrator, we believe that the appropriate official to make this decision is the Director of the Office of Payment Policy, Bureau of Policy Development, Health Care Financing Administration. This change is warranted because it is inappropriate that the HCFA Administrator make a decision that he or she may be called on to review if a hospital requests an administrative appeal of an adverse decision on its exceptions application. As the director of the HCFA component that determines policy on hospital payment in general and exceptions payment policy in particular, the Director of the Office of Payment Policy is ideally suited to make the determination on an exceptions request. The determination is subject to the appeal procedures of subpart R of 42 CFR part 405 when the provider receives the NPR for the cost reporting period for which the provider is seeking additional payments.

E. Funding of Depreciation (§§ 413.134 and 413.153)

Section 1861(v)(1)(A) of the Act gives the Secretary broad latitude to prescribe regulations concerning Medicare payments to providers on a reasonable cost basis. Under this authority, § 413.134(e) provides that, although we do not require the funding of depreciation, we strongly recommend it as a means of conserving funds for the replacement of depreciable assets.

1. Offset of Investment Income

To encourage the funding of depreciation, we have specified at §§ 413.134(e)(1) and 413.153(b)(2)(iii) that investment income earned on funded depreciation will not be used to reduce allowable interest expense. Further, § 413.134(e) stipulates that additions to the funded depreciation account must remain in the account for at least 6 months to be considered valid funding transactions and be eligible for the benefits of a funded depreciation account.

In response to a comment in the August 30, 1991 final rule on the prospective payment system for inpatient hospital capital-related costs (56 FR 43424), we stated that interest on any funds that do not qualify as funded depreciation account funds, which would include funded depreciation deposits of less than 6 months duration, must be used to offset interest expense. Section 226.3 of the Provider Reimbursement Manual (HCFA Pub. 15–1) provides that investment income earned prior to the elapse of the 6-month period will not be offset unless the deposits are actually withdrawn during this period.

We are proposing to revise § 413.134(e)(1) to state specifically that investment income earned during the 6-month period will not be used to offset interest expense unless the funds are withdrawn for an improper purpose during this period. Under this change, if a provider withdraws funds from the funded depreciation account before the expiration of the 6-month time limit, and the withdrawal is made for an allowable purpose as described in § 413.134(e)(3)(i)(A), the investment income earned on the funds is not offset against allowable interest expense.

2. Loans to the General Fund

We propose to revise and clarify our policy regarding loans from the provider's funded depreciation fund to the provider's general fund. Sections 413.153(b)(3)(ii) and (c)(2) permit a provider to lend its funded depreciation funds to its general fund. Moreover, these sections provide that interest expense incurred on such loans are considered allowable costs. Section 226.1 of the Manual amplifies this policy by explaining that, in order for the interest expense incurred on such loans to be allowable, the interest expense must meet the "necessary and proper" tests (set forth in the regulations at § 413.153(b) (2) and (3), and in the Manual at sections 202.2 and 202.3). This section of the Manual also explains that the funds loaned to the general fund must not be used to acquire depreciable assets used to furnish patient care because the provider is expected to use its funded depreciation, rather than to lend it, for that purpose. Finally, this section of the Manual explains that deposits to the funded depreciation fund will not be recognized to the extent that loans of funded depreciation funds to the general fund are outstanding. Rather, such deposits will be considered repayments of the loan to the general fund.

Three other sections of the Manual address loans from a provider's funded depreciation fund to the provider's general fund. Section 226.C of the Manual, in discussing the availability of funded depreciation funds, provides that loans made from funded depreciation do not alter the requirement that funded depreciation must be available for the acquisition of the provider's depreciable assets used to furnish patient care, or for other capital purposes related to patient care. Section 226.3 of the Manual, in discussing the application of the 6-month rule for a deposit to become a valid funding transaction, provides that a loan of funded depreciation funds to the general fund is considered a withdrawal for purposes of applying the 6-month rule. That is, if the provider borrows from funded depreciation for a working capital purpose, and some or all of the funds borrowed were not on deposit in the funded depreciation fund for at least 6 months, the borrowing would be considered a withdrawal from the funded depreciation account. In addition, if a deposit did not satisfy the 6-month rule any investment income earned on the deposit would have to be used to offset otherwise allowable interest expense. Section 226.4B of the Manual, in an example of applying of the last-in, first-out basis to withdrawals from funded depreciation for an improper purpose, also characterizes a loan to the general fund from the funded depreciation fund as a withdrawal.

In recent years, we have received a number of inquiries suggesting that loans from the provider's funded depreciation fund to the provider's general fund are characterized more appropriately as investments of funded depreciation, rather than withdrawals. We agree with the inquirers. The term "withdrawal" implies that the funds have been removed from the funded depreciation account and used, either for a proper purpose (for example, acquisition of a depreciable asset) or an improper purpose (for example, to purchase office supplies). In contrast, the term "investment" implies that the funds have not actually been removed from the funded depreciation account and used; rather, they have been temporarily converted to one or more income producing vehicles (for example, the purchase of U.S. Treasury bills). Because loans from the funded depreciation funds to the general fund generate investment income for the funded depreciation fund, we believe that such loans more properly should be considered as investments, rather than withdrawals.

In conjunction with this change, we had to decide whether such loans would have to meet the "readily marketable" test for allowable funded depreciation investments expressed in § 413.134(e) and section 226 of the Manual. We believe that, because we require that loans made from funded depreciation do not alter the requirement that the funded depreciation be available for the acquisition of depreciable assets used to furnish patient care, or for other capital purposes related to patient care, application of the "readily marketable" test would be redundant. That is, if a provider loans funded depreciation to the general fund, and while that loan is outstanding the provider needs funds to acquire a depreciable asset related to patient care, the provider may not borrow funds to acquire the depreciable asset. Rather, the provider must recall the funds from the general fund loan to use to acquire the asset.

Accordingly, we propose to add paragraph (e)(4) to § 413.134 to address loans from the funded depreciation account. New § 413.134(e)(4) would both consolidate the policies now set forth in the manual sections cited above and revise our policy regarding the characterization of loans from the funded depreciation account. Such loans would be considered investments, rather than withdrawals.

3. Spenddown of "Tainted" Funded Depreciation

The preamble to the August 30, 1991 final rule also addressed the issue of spenddown (56 FR 43421). "Spenddown" is a process whereby we permit providers to "cure" borrowing that was found to be unnecessary because of available funded depreciation by using those funded depreciation funds for a proper purpose. Under spenddown, if additional deposits are made to funded depreciation after the unnecessary borrowing determination, withdrawals from the funded depreciation subsequent to a determination of unnecessary borrowing are made on a last-in, first-out basis (typically, withdrawals for a proper purpose are made on a first-in, first-out basis). The result of this policy is that all additional deposits to funded depreciation must be used before spending can be allotted to the "tainted" funds, that is, the portion of the funded depreciation that resulted in the unnecessary borrowing. In addition, Medicare's policy has been that any other funded depreciation funds in the account at the time of the unnecessary borrowing must be used before the "tainted" funds can be spent down or cured.

Since the publication of the August 30, 1991 final rule, we have received several inquiries asking why our policy on spenddown was not incorporated into the regulations. These inquiries also have pointed out that the last-in, first-out method set forth at § 413.134(e)(3)(i)(C) will not work properly when the unnecessary borrowing is repaid from the funded depreciation account and that account contained untainted funded depreciation at the time of the unnecessary borrowing or received additional deposits after the borrowing. The inquirers suggested that this situation may be rectified by establishing an exception to the last-in, first-out rule when the unnecessary borrowing that caused the "tainting" is repaid out of funded depreciation. In this case, any use of funded depreciation to repay the unnecessary borrowing will be deemed to be from "tainted" funded depreciation. We agree and propose to provide for such an exception in § 413.134(e)(2)(iv).

Similarly, where the provider repays part or all of the principal of the unnecessary borrowing that caused the "tainted" funded depreciation by using general funds, a corresponding amount of the "tainted" funded depreciation must be cured. This is necessary so that the "tainted" portion of the funded depreciation does not exceed the amount of the balance of the unnecessary borrowing that caused the "tainting" in the first place.

We are proposing to revise § 413.134(e) to incorporate the curing process of "tainted" funded depreciation and also to provide that the provider's subsequent repayment of the principal portion of the unnecessary borrowing will be from the "tainted" funds in the funded depreciation. Thus, neither the first-in, first-out nor the last-in, first-out basis would be applicable for such repayments.

4. Necessary and Unnecessary Borrowing

In February 1977, HCFA published § 203 of the Provider Reimbursement Manual to address interest on loans in excess of asset value acquired after 1970. Section 203.D of the Manual states that "[r]epayments of the funds borrowed are applied first to reducing the portion of the loan applied to the allowable cost of the patient care assets, then to the tangible and intangible assets not considered reasonably related to patient care, and lastly to goodwill." We have applied this long-standing principle to cases where a provider repays borrowed funds where some of these funds are deemed to be unnecessary. In these circumstances, we have held that all of necessary borrowing must be repaid before any of the repayments may be applied to the unnecessary borrowing.

We also apply this principle to unnecessary borrowing that causes "tainted" funded depreciation. When a portion of a provider's borrowing is considered unnecessary because of the availability of funded depreciation, subsequent repayments, whether from funded depreciation or general funds, are first applied to the allowable portion of the borrowing and, when all of the allowable borrowing is repaid, to the unallowable portion of the loan. This places the provider in the same position as if the available funded depreciation had been used without any unnecessary borrowing.

These applications have not been clearly set forth in the regulations. Therefore, we propose to revise §§ 413.134(e) and 413.153(d) to clearly address both situations.

We are also proposing to make a technical change to § 413.134(d)(1) to correct a reference.

VI. Proposed Changes for Hospitals Excluded From the Prospective Payment Systems

A. New Requirements for Certain Long-Term Care Hospitals Excluded From the Prospective Payment Systems (§ 412.23)

Section 1861(e) of the Act and the regulations at 42 CFR part 482 define a hospital as an institution that qualifies to participate in Medicare because it meets certain health and safety standards, known as "conditions of participation" (COPs). A hospital must be surveyed for compliance with the COPs by State agencies that work under agreement with HCFA unless, under section 1865 of the Act and regulations at 42 CFR part 488, the hospital is presumed to meet the COPs on the basis of accreditation by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

Recently, some entities have discovered that the process for becoming a provider under the COPs can be manipulated to permit them to receive exclusion from the prospective payment systems. Specifically, hospitals have begun to organize themselves under what they themselves refer to as the "hospital-within a hospital" model. Under this model, an entity may operate in space leased from a hospital, and have most or all services furnished under arrangements by employees of the lessor hospital. The newly organized entity may be operated by a corporation formed and controlled by the lessor hospital, or by a third entity that controls both. In either case, the new entity seeks State licensure and Medicare participation as a hospital, demonstrates that it has an average length of stay of over 25 days, and obtains an exclusion from the prospective payment systems. The effect of this process is to extend the long-term care hospital exclusion to what is for all practical purposes a long-term care hospital unit.

We believe it may not be appropriate for a long-term care "hospital within a hospital" to receive an exclusion from the prospective payment systems. The considerations underlying exclusions from the prospective payment systems may not apply to these entities.

Under the prospective payment systems, hospitals are paid for inpatient services on the basis of prospectively determined rates. Under section 1886(d)(1)(B) of the Act, certain hospitals and units are excluded from the prospective payment systems including, psychiatric, rehabilitation, children's, and long-term care hospitals, and psychiatric and rehabilitation units. These hospitals and units are excluded because they could not be paid appropriately under the prospective payment systems. The statute does not exclude "long-term care units" of general hospitals.

The prospective payment systems are based on an averaging concept which recognizes that some patients will stay longer and consume more resources than expected, while others will have shorter, less costly stays. We expect that an efficiently operated hospital will be able to deliver quality care to Medicare patients at an aggregate cost no greater than its aggregate Medicare payments under the prospective payment systems for each cost reporting period.

The DRG system does not, however, apply well to long-stay hospitals. Those hospitals have few short-stay or low-cost cases, and might be systematically underpaid if the prospective payment method applied. Thus, exclusion of entire long-term care hospitals from the prospective payment systems is appropriate. However, if an entity that provides long-term care is part of a larger hospital, the reasons for exclusion may not apply. A long-term care "hospital within a hospital" is essentially a long-term care hospital unit which accounts for only a part of the larger hospital's patient load. The principles underlying the prospective payment systems do apply to the larger hospital, unlike entire long-term care hospitals. Exclusion of long-term care units could inadvertently encourage

hospitals to try to abuse the prospective payment systems, by diverting all long-stay cases to the excluded unit, leaving only the shorter, less costly cases to be paid for under the prospective payment systems. In such cases, hospitals would profit inappropriately from prospective payments.

For these reasons, we believe it may be inappropriate to grant an exclusion to a long-term care "hospital within a hospital." Moreover, exclusion of long-term care "units" is inconsistent with the statutory scheme. Section 1886(d)(1)(B) of the Act clearly provides for exclusions from the prospective payment systems for long-term care hospitals, and also for psychiatric units and rehabilitation units, but the statute does not provide for exclusion of long-term care units. Also, we note that section 1886(d)(1)(B) of the Act begins with the phrase "as used in this section" in referring to hospitals; we believe this language suggests that the definition of "hospital" for prospective payment purposes may be different from other definitions. Furthermore, section 1886(d)(1)(B) of the Act provides that excluded from the definition of prospective payment systems hospital is a psychiatric or rehabilitation unit of a hospital that is a distinct part of the hospital "as defined by the Secretary."

We believe these distinctions were intended to be meaningful, and that it would undermine the distinctions if we allowed exclusion of long-term care units. Because we believe such exclusions are contrary to the purpose and scheme of section 1886(d)(1)(B) of the Act, we are proposing to revise the regulations to prevent inappropriate exclusions. Section 1871 of the Act provides that the Secretary "shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title," and section 1102 of the Act authorizes the Secretary to "make and publish such rules and regulations * * * as may be necessary to the efficient administration of the functions with which [the Secretary] is charged under this Act."

To avoid recognizing nominal hospitals, while allowing adequate flexibility for legitimate networking and sharing of services, we are proposing additional criteria in 42 CFR part 412, subpart B for determining whether an entity qualifies for exclusion from the prospective payment systems as a separate long-term care hospital. These criteria would be applied to entities seeking exclusion from the prospective payment systems as a long-term care hospital. The revised criteria would apply to entities seeking exclusion as a long-term care hospital for cost reporting periods beginning on or after October 1, 1994, including reapprovals of long-term care exclusions for entities that are currently excluded.

We propose that in addition to meeting any of the classification requirements set forth in § 412.23, for cost reporting periods beginning on or after October 1, 1994, to be excluded from the prospective payment systems, a hospital located in the same building or in one or more entire buildings located on the same campus as another hospital and seeking long-term care exclusion must meet the following requirements:

- *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital from which it obtains space. The hospital's governing body is not under the control of the hospital that provides space, or of any third entity that controls both hospitals.
- *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital that provides space or any third entity that controls both hospitals.
- *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital from which it obtains space. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.
- *Chief executive officer.* The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital that provides space or any third entity that controls both hospitals.
- *Performance of basic hospital functions.* The hospital performs the basic hospital functions specified in §§ 482.21 through 482.27, 482.30, and 482.42 through the use of employees or under contracts or other agreements with entities other than the hospital from which it obtains space, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital that provides space, or with a third entity that controls both hospitals.

For purposes of these proposals, we would consider "control" to exist if an individual or organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. This definition of "control" is now codified in the regulations at § 413.17(b)(3), concerning allowable Medicare costs, and we would apply the same criteria to determine whether hospitals and hospital units should be excluded from the prospective payment systems. Thus, most hospital managers and administrators are familiar with this definition. We welcome comments on this and other issues concerning the proposed exclusion criteria.

Finally, to ensure that hospitals that are excluded from the prospective payment systems are not confused with the types of facilities that can participate separately in Medicare as distinct-part psychiatric hospitals or skilled nursing facilities, we propose to delete all references in the current prospective payment systems regulations to excluded units as "distinct part" facilities.

B. Removal of the 1986 Malpractice Rule (§ 413.56)

We propose removing from the regulations "the 1986 malpractice rule", which is set forth at § 413.56. We also would remove all cross-references to § 413.56. This proposal is a technical change designed to conform the regulations to the various authorities that have previously established that the 1986 malpractice rule is invalid.

The history of Medicare reimbursement policy under the cost-based reimbursement system for provider malpractice insurance costs is described in detail in Sections I. and II.A. of the March 27, 1987 final rule (52 FR 9833). To summarize briefly: for cost reporting periods beginning before July 1, 1979, provider malpractice insurance costs were included in the general and administrative cost center ("G & A pool") with other overhead costs, and apportioned to the Medicare program in accordance with the provider's Medicare utilization rate (52 FR 9834). (See also § 405.452(b)(1) ("the pre-1979 utilization method) redesignated at § 413.53(a)(1)(i).) Effective for cost reporting periods beginning on or after July 1, 1979, "the 1979 malpractice rule" removed provider malpractice

insurance costs from the G & A pool, and directly apportioned those insurance costs based on the ratio of provider malpractice losses paid for Medicare patients compared to losses paid for all patients (52 FR 9834). On April 1, 1986, we published an interim final rule with comment period that replaced the 1979 malpractice rule, effective May 1, 1986, with the 1986 malpractice rule (51 FR 11142). The 1986 malpractice rule was set forth in regulations at § 405.457, subsequently redesignated as § 413.456, and then confirmed in our above-cited March 27, 1987 final rule. The 1986 malpractice rule reestablished reimbursement of skilled nursing facility malpractice insurance costs under the pre-1979 utilization method, § 413.56(c), whereas hospital malpractice insurance costs were reimbursed based on both a hospital's utilization rate and aspects of the claims-paid approach of the 1979 regulation. (See § 413.56(b).)

The Secretary's authority to apply the hospital payment provisions of the 1986 malpractice rule has been eliminated through a series of events. As promulgated initially, the 1986 rule applied retroactively, subject to the Medicare program's general rules of administrative finality, to cost reporting periods beginning on or after July 1, 1979. (See § 413.56(a).) Subsequently, however, the Supreme Court held that the Medicare statute does not generally authorize retroactive rulemaking, *Bowen v. Georgetown University Hosp.*, 488 U.S. 204 (1988) ("*Georgetown*"). Therefore, the Administrator of HCFA issued HCFA Ruling 89–1 (Jan. 26, 1989) which, first, discontinued retroactive application of the 1986 rule and, second, required application of the pre-1979 utilization method to all open hospital malpractice insurance cost claims, and all properly pending appeals of the malpractice issue, for cost reporting periods beginning before the May 1, 1986 effective date of the 1986 rule.

The prospective applicability of the 1986 malpractice rule was circumscribed from its outset by the prospective payment system. For hospitals subject to the prospective payment system, malpractice insurance costs attributable to inpatient services paid under the prospective payment system are subsumed under the prospectively determined payment rates that are applied to the various diagnosis related groups. Thus, the 1986 malpractice rule applied prospectively to only malpractice insurance costs attributable to: (1) outpatient services furnished by prospective payment hospitals; and (2) all services furnished by specialty hospitals and distinct-part hospital units excluded from the prospective payment system.

In the March 27, 1987 final rule, we determined that it was necessary to develop separate "scaling factor formula" values under the 1986 malpractice rule (see § 413.56(b)(3) through (5)), for malpractice insurance costs attributable to hospital outpatient services and for costs attributable to inpatient services furnished by facilities excluded from the prospective payment system (see 52 FR 9836). However, we were unable to derive separate formula values for inpatient and outpatient services for "the R factor" in the formula (that is, the national Medicare malpractice loss ratio, as adjusted for associated claims adjustment expense), due to the difficulty of securing hospital data attributing malpractice claims (and associated claims adjustment expense) separately to outpatient services and inpatient services. Moreover, separate scaling factor formula values for hospital facilities excluded from the prospective payment system were not developed.

In *Children's National Medical Center, et al. v. Sullivan*, Civil Action No. 90–1362–WBB (D.D.C. July 16, 1991) ("*Children's National*"), the Secretary entered into a Consent Order providing that the 1986 malpractice rule is invalid and shall not be enforced, due to the agency's inability to develop separate scaling factor formula values for outpatient services and for inpatient services furnished by hospital facilities excluded from the prospective payment system. The *Children's National* Consent Order was approved by the United States District Court for the District of Columbia on July 16, 1991. The Administrator of HCFA then issued HCFA Ruling 91–1 (Sept. 30, 1991), which, first, provided that the *Children's National* Consent Order governs all open hospital malpractice insurance cost claims, and all properly pending appeals of the malpractice issue, for cost reporting periods beginning on or after May 1, 1986 and, second, required reimbursement of such claims under the pre-1979 utilization method.

The Supreme Court's *Georgetown* decision, the *Children's National* Consent Order, and the two corresponding HCFA Rulings establish that the 1986 malpractice rule is null and void as to all open hospital malpractice insurance cost claims, and all properly pending hospital appeals of the malpractice insurance cost reimbursement issue. See 42 CFR 401.108(c). See also HCFA Transmittal No. 395 (December 1993), which deleted as "obsolete," due to HCFA Ruling 91–1, the implementation provisions for the 1986 rule that were formerly included in § 2214 of the Medicare Intermediary Manual, Part 2. We are proposing to conform Medicare regulations to the actual state of the law governing provider malpractice insurance cost reimbursement by removing § 413.56 from the regulations, and by eliminating all cross-references to § 413.56 from the regulations. As a result of this proposal, the amended Medicare rules would reflect the previously established legal requirement that reasonable cost reimbursement for provider malpractice insurance cost claims that are either open or the subject of properly pending appeals, must be determined under the pre-1979 utilization method.

C. Related Technical Changes (§§ 412.20, 412.22, 412.25, 412.27, 412.29, 412.30, 412.96, 412.105, 412.108, 412.116, 412.130, 412.71, 413.40, 413.53, 413.174 and 482.66)

We are proposing to remove the words "distinct part", wherever they appear, in the following places:

(a) Section 412.20(b)(1);

(b) Section 412.22(b);

(c) The section title and paragraph (a) of § 412.25;

(d) The undesignated introductory texts of §§ 412.27 and 412.29;

(e) The section title of § 412.30;

(f) Section 412.96(c)(1) and (c)(2);

(g) Section 412.105(b), (f)(5) and (g)(1)(iii);

(h) Section 412.108(a)(2);

(i) Section 412.116(a) and (b);

(j) The section title of 412.130;

(k) Section 412.130(a)(2) and (a)(3);

(l) Section 413.40(a)(2)(ii), (b)(1)(i) through (b)(1)(iii) and (f)(2); and

(m) In § 482.66(a)(7)(i), the second appearance of the words "distinct part" are removed.

We also propose to revise the section titles of §§ 412.27 and 412.29 to remove the words "distinct part" and replace them with the word "excluded".

In addition, we propose to make technical changes to §§ 412.71(b), 413.53 and 413.174(b)(4)(iv) to remove and replace obsolete language and to correct references.

VII. ProPAC Recommendations

We have reviewed the March 1, 1994 report submitted by ProPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations 1 through 6 focus on specific features of the President's Health Security Act and other health care reform activities and will be resolved through the legislative

process. Therefore, we are not addressing these recommendations in this document. Recommendations 9, 12, and 13 concerning the update factors for inpatient operating costs are discussed in Appendix D of this proposed rule. Recommendations 10 and 11 concerning the update factors for inpatient capital costs are also discussed in Appendix E. Recommendations 15 and 16 concerning hospital wage data and the hospital wage index are discussed in section III of this preamble. The remaining recommendations are discussed below.

A. Controlling Medicare Spending Across All Sites of Care (Recommendation 7)

Recommendation: Medicare should continue to develop policies to monitor and control total expenditure growth across all sites of care. Payment methods should not unduly favor the choice of one site over another. They should also provide consistent incentives to constrain increases in volume and service intensity across physicians and other providers.

Response: In response to a similar ProPAC recommendation last year, we stated in the proposed rule for FY 1994 that controlling the overall growth of Medicare spending is of critical importance. We believe the hospital inpatient prospective payment system has been effective in slowing the growth in Medicare spending compared with estimates of growth in spending under reasonable cost reimbursement. Also, during the first 2 years of the physician fee schedule, the growth in spending for physician services under Medicare has been reduced. In addition, we are developing a prospective payment system for outpatient hospital services that will provide the appropriate economic incentives to help control the growth of Medicare spending for outpatient services.

While prospective payment has shown promise for controlling Medicare spending growth, we remain concerned about growth in the volume and intensity of Medicare services. Currently, we are using the Medicare volume performance standard to provide physicians with incentives to control volume and intensity.

There are no similar volume control systems for other services. We are continuing to study other mechanisms for controlling expenditures growth, such as bundling payments for multiple services into a single payment.

B. Strengthening Medicare's Risk Contracting Program (Recommendation 8)

Recommendation: The Commission recommends that the Secretary improve Medicare's risk-based managed care program to give more Medicare beneficiaries the option of enrolling in managed care plans. To increase plan participation, deficiencies related to the risk adjustment formula and local differences in payments need to be corrected.

Response: We support giving more Medicare beneficiaries the option of enrolling in managed care plans. We are aware of the need to institute new methodologies for payment to risk plans. Currently, we are sponsoring research on risk adjustment methods, including diagnostic cost groups (DCGs) and ambulatory care groups (ACGs). In addition, our recent grants announcement (Health Care Financing Research and Demonstration Cooperative Agreements and Grants for Fiscal Years 1994 Through 1996) (59 FR 1951) calls for work on risk adjustors, both for the Medicare and the under 65 populations. We have also initiated a demonstration that is expected to test alternative payment methods that may incorporate adjustments for enrollee health status.

With regard to correcting local differences in payment to Medicare risk plans, we note that section 1876 of the Act requires payment to Medicare risk plans to be based on projected Medicare per capita costs for beneficiaries who are not enrolled in managed care plans. Given that there are local differences in Medicare's per capita costs for these beneficiaries, local differences in Medicare's risk plan payment rates are a logical result.

C. Update to the Composite Rate for Dialysis Services (Recommendation 14)

Recommendation: The FY 1995 update recommendation for the composite rate for dialysis services accounts for the following:

- The projected increase in the market basket for dialysis services in FY 1995, estimated at 4.3 percent;
- A positive adjustment of 0.7 percentage points to reflect the additional costs associated with scientific and technological advances;
- A negative adjustment of 1.0 percentage points to encourage productivity improvements; and
- A negative discretionary adjustment of 4.0 percentage points to reflect the relationship between payments and estimated FY 1994 costs.

This results in a net update recommendation of 0.0 percent.

Response: We agree with ProPAC's recommendation not to propose a payment rate increase for dialysis services. The 1991 audited data support this decision. As the Commission points out, these data show that independent renal facility composite payment rates are higher than their Medicare allowable costs, while hospital renal facilities continue to report costs in excess of their payment rates. The audits did not provide an explanation for the higher reported costs of hospital renal facilities relative to independent renal facilities. However, auditors found that hospital renal facilities often fail to maintain adequate records for allocation costs in the renal department. Since hospitals' payments are not affected by renal cost reports, Supplement Worksheet I of HCFA–2552, hospitals do not always complete their cost reports accurately.

Although we realize the importance of regular renal audits, the budget for audits continues to decline. Thus, we do not plan to conduct renal audits in 1994 or 1995. We have requested funds to conduct renal audits in 1996. During this 2-year interval, we would review the 1992 and 1993 cost report data for those renal facilities in the 1991 audit sample.

We believe that this analysis will provide cost information about the ESRD program in lieu of audited data for these years. Furthermore, it will provide a basis for analyzing cost data over time and allow for better comparison of audited and unaudited costs.

D. Nursing Facility Wage Index (Recommendation 17)

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

Response: In recommending an adjustment to SNF payments, we presume that ProPAC is referring to the SNF cost limits. We agree that HCFA should collect the data necessary to develop a SNF wage index. In the conference report on OBRA 1993, the conferees indicated an expectation that HCFA collect such data (H.R. Rep. No. 2264, 103d Cong., 1st Sess. 747 (1993)). However, we do not believe it is prudent to recommend implementing a SNF wage index to adjust the SNF cost limits until the accuracy of those data and impact of the resulting wage index

have been thoroughly analyzed. Under current Medicare rules, most SNFs are paid their reasonable costs for routine services subject to a cost limit. The current methodology for computing the SNF routine service cost limits utilizes the hospital wage index to account for geographic variations in wages. Only about 35 percent of facilities have costs at or above these cost limits.

We have maintained that, because hospitals and SNFs generally compete for employees in the same labor market, one would expect that the relationship of hospital area average wages to hospital national average wages would fairly represent the relationship of SNF area average wages to SNF national average wages. Therefore, we believe the hospital wage index is an accurate mechanism for adjusting the SNF routine service cost limits for geographic variations in wages. While certain limited studies have suggested that a SNF-specific wage index may be more accurate, no substantial empirical data have been offered to refute our policy. The study undertaken by ProPAC utilized only limited data to develop a simulated wage index. Due to the limited scope of this study, we believe it is not a sufficient basis for refuting the accuracy of the hospital wage index relative to SNF wages.

We plan to begin collecting SNF wage data for potential use in the development of a SNF wage index. These data will help us answer two important questions related to the development of a SNF wage index. The first is whether SNFs, which are smaller than hospitals and have less sophisticated accounting systems, can develop and provide accurate wage index data on a national basis. If such data can be provided, our second question is whether differences between the resulting wage index and the hospital wage index would be significant enough to justify the increased Medicare costs involved and the increased reporting and information collection burden on SNFs (especially small and rural SNFs), the fiscal intermediaries, and HCFA.

The collection of SNF wage data also will allow us to determine the potential impact of a SNF wage index on payments to individual SNFs. A change in the wage index may favorably impact SNFs in some areas while it may disadvantage SNFs in other areas (possibly significantly), even within the same State. While this latter point is not a reason to avoid the use of a SNF wage index, it does point out the absolute necessity for collecting accurate wage index data from SNFs for construction of the wage index. Our experience with the development of a home health agency (HHA) wage index is also relevant. In 1988, HCFA implemented an HHA-specific wage index based on data received from HHAs. Subsequently, HCFA and Congress received numerous complaints from providers concerning the burden that the reporting requirements posed and the accuracy of the data. As a result, Congress retroactively repealed its mandate for use of the HHA wage index and required continued use of the hospital wage index. This caused great confusion among both providers and fiscal intermediaries.

Until SNF wage data have been collected and examined, we believe it is premature to recommend their use for the adjustment of either the SNF cost limits or any future prospective payment system that may require a wage adjustment.

E. Improving Outlier Payment Policy (Recommendation 18)

Recommendation: The Commission believes the outlier payment provisions of the Omnibus Budget Reconciliation Act of 1993 will improve the current policy for identifying outlier cases and determining outlier payments under the prospective payment system. However, the following changes also should be implemented for FY 1995:

- The estimated cost of the case and the outlier payment amount should no longer be adjusted to reflect the hospital's indirect medical education and disproportionate share status.
- The marginal cost factor for cost outliers should be increased to 80 percent.

These changes would further increase the effectiveness of outlier payment in protecting against the risk of large losses on some cases. They would also improve the distribution of outlier payments across hospitals, including hospitals that receive a large number of transfer cases.

Response: The Commission's first recommendation with regard to improving outlier payment policy concerns the methodology we use to determine whether the cost of a case exceeds the cost outlier threshold. ProPAC is asking that Medicare no longer standardize hospital costs to remove the effects of the indirect costs of medical education (IME) and the costs associated with serving a disproportionate share of low income patients (DSH). The effect of standardizing the hospital's charges to remove the effects of their IME and DSH adjustments is to lower the "costs" of cases, for purposes of applying the cost outlier threshold, for teaching and disproportionate share hospitals relative to other hospitals.

We responded to this same recommendation in our May 26, 1993 proposed rule (58 FR 30255). In that response, we noted that sections 1886(d)(5)(B)(i) and 1866(d)(5)(F)(ii) of the Act require that we pay hospitals for IME and DSH costs associated with their outlier payments. Given this statutory requirement, we believe it would be inappropriate to implement the Commission's recommendation without a change to the law.

In that same response, we also stated our belief that the adjustment for IME and to the prospective payment rate is currently higher than the additional cost of serving a Medicare beneficiary at a teaching hospital. The policy advocated by ProPAC in this recommendation would have the effect of increasing outlier payments to teaching hospitals. Relative to the costs associated with teaching activity, we are concerned that the teaching adjustment may overcompensate teaching hospitals for their Medicare cases. For this reason, we believe it would be inappropriate to implement ProPAC's recommendation without making a reduction in the level of the IME adjustment.

We concur with ProPAC's second recommendation regarding raising the marginal cost factor for cost outliers to 80 percent from its current level of 75 percent. We currently pay 75 percent of the difference between the cost of a case and the cost outlier threshold. Paying 75 percent of costs beyond a threshold protects hospitals against inordinate losses resulting from the costliest Medicare cases. As we describe in section IV.D. of this proposed rule, section 13501(c) of Public Law 103–66 requires that we phase-out payments for day outliers, while simultaneously increasing payments for cost outliers. We believe the change mandated by the statute improves Medicare's outlier policy by focusing outlier payments on the costliest cases. Consistent with focusing Medicare's outlier payments on cases with the greatest losses, we are raising the marginal cost factor to 80 percent. We note that raising the marginal cost factor to 80 percent necessitates an increase in the fixed loss cost outlier threshold in order to maintain outlier payments at 5.1 percent of estimated total prospective payments.

F. Level of the Indirect Medical Education Adjustment to PPS Operating Payments (Recommendation 19)

Recommendation: The Commission recommends that the indirect medical education adjustment to prospective payments for hospital inpatient

operating costs be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1995. This reduction should be implemented with the anticipated decrease in indirect medical education payments returned to all hospitals through a proportionate increase in the standardized payment amounts. The Commission also recommends continuation of the indirect medical education adjustment to operating payments until an alternative system of compensating appropriately for the higher costs of patient care in teaching institutions is fully operational.

Response: The first part of this recommendation is identical to ProPAC's recommendation on the level of the IME adjustment for FY 1994, to which we responded in the May 26, 1993 proposed rule (58 FR 30255) and September 1, 1993 final rule (58 FR 46326) containing the changes to the prospective payment systems for FY 1994. We agree that the IME adjustment should be reduced. Although we have disagreed with ProPAC in the past over the degree of reduction, we have proposed reductions as part of the President's budgets for the last several years.

With respect to ProPAC's methodology for estimating the indirect cost effect of teaching without accounting for the DSH adjustment, we explained our opposition to this suggestion in the September 1, 1993 final rule (58 FR 46328). To reiterate, our analysis indicates that there is evidence of significantly higher costs related to DSH among urban hospitals with 100 or more beds (see O'Dougherty et al., *Health Care Financing Review*, Winter 1992, p. 31). Since these hospitals receive over 96 percent of all DSH payments, we believe ProPAC's claim that "DSH payments generally do not reflect differences in costs" is overstated. We do agree, however, that the current level of DSH payments exceeds the measured cost effect of DSH even among urban hospitals with 100 or more beds. In that regard, we point out that in the regression model used to estimate the teaching effect, we did not specify the DSH variable as the level of DSH payments, but instead set it equal to the DSH percentage for urban hospitals with 100 or more beds and zero for all other hospitals. (For a complete description of our estimating model, see the August 30, 1991 final rule implementing the capital prospective payment system, 56 FR 43370.) As ProPAC alludes to in its report, not controlling for DSH leads to its higher IME cost estimate relative to our IME cost estimate.

The remainder of ProPAC's recommendation raises policy issues related to the appropriate level of IME funding as the transition is made from the current system to the new health care system. Since these transition issues are currently being addressed as part of the health care reform debate, we are not responding in this document to this part of ProPAC's recommendation.

G. Prospective Payment Method for Outpatient Services (Recommendation 20)

Recommendation: The Commission believes a prospective payment system for hospital outpatient services should be implemented. Outpatient payment reform should result in consistent policies across all sites and providers. Payment should be based on a prospective price per unit of service until other methods can be developed that would appropriately control the volume of services. The payment rate should be adjusted to reflect justifiable cost differences across settings.

Response: We appreciate ProPAC's support for efforts to develop a prospective payment system for hospital outpatient services. We share the Commission's view that a hospital outpatient prospective payment system can provide meaningful incentives for controlling costs. We also believe that such a system could have the potential to be adapted for other outpatient settings, resulting in more consistent policies across varying sites of service. We look forward to the Commission's comments when our report on a hospital outpatient prospective payment system is issued.

H. Revision of Payment Formula for Outpatient Services (Recommendation 21)

Recommendation: Until prospective payment systems can be implemented for hospital outpatient services, the blend formula used to calculate hospital payments for ambulatory surgery center-approved procedures, radiology services, and diagnostic services should be revised. The formula should subtract beneficiary copayment after the total payment has been calculated. The resulting reduction in Medicare program payments to hospitals should be used to partially offset increases in program expenditures due to reducing beneficiary liability.

Response: We agree that the blend formula used to calculate Medicare payments to hospitals for ambulatory surgical center-approved procedures, radiology services, and certain other diagnostic procedures should be revised, as suggested by ProPAC. It should be noted that the President's proposed Health Security Act contains a provision that would make the correction suggested by ProPAC.

I. Beneficiary Liability for Hospital Outpatient Services (Recommendation 22)

Recommendation: Beneficiary coinsurance for hospital outpatient services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, beneficiary copayment would need to be estimated because it is not known at the time of service delivery.

Response: We share ProPAC's concern that beneficiaries may be paying a disproportionate share of the total payment for hospital outpatient services under the current cost based system. However, we are in the process of developing a prospective payment system for hospital outpatient services that will be moving away from costs and charges as a basis for payment. We believe that it would be most appropriate to make any changes to beneficiary coinsurance in conjunction with the implementation of this hospital outpatient prospective payment system. Therefore, as we develop this system, we are reviewing the issue of beneficiary liability and are working to come up with an approach that will be fair to beneficiaries, while minimizing the negative financial impact on the Medicare program.

J. Limit the Length of Outpatient Observation Stays (Recommendation 23)

Recommendation: The Commission recommends limiting the length of hospital outpatient observation stays. Further, these changes should be coordinated with Peer Review Organizations (PROs) so that appropriate short stay admissions are not denied. ProPAC supports HCFA's efforts in this regard.

Response: We appreciate ProPAC's support for our efforts to limit the length of hospital outpatient observation stays. Later this year, we plan to release Part A Intermediary Manual and Hospital Manual instructions to help curb inappropriate use of outpatient observation services, including lengthy stays of days and weeks. These instructions will require hospitals to admit patients who have been under observation in outpatient departments for two consecutive midnights.

Release of this new national policy will provide needed consistency throughout the country in applying outpatient observation service

guidelines, reduce inappropriate use of such services, and reduce the beneficiary's liability for Part B copayments.

On August 13, 1993, we released a letter to the Executive Directors of all PROs to clarify PRO responsibilities when conducting reviews of cases involving short hospital stays. PROs were asked to assure that their review staffs base their determinations on the beneficiary's need for inpatient services rather than basing the decision on the payment consequences.

VIII. Other Required Information

A. Paperwork Reduction Act

As discussed in detail in section III.C. of this preamble, we are proposing several changes to forms used to gather hospital wage data, specifically the Worksheet S–3, Part II, of the Medicare cost report, and the provider cost report questionnaire (HCFA–339). The current information collection requirements associated with these items have been approved by the Office of Management and Budget (OMB) under approval numbers 0938–0050 and 0938–0301, respectively. We are proposing that the changes to these forms would be effective for cost reporting periods beginning on or after October 1, 1994. However, these changes will not be effective until OMB approval is received under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

B. Requests for Data from the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format or cartridges; however, some files are available on diskette. Data files are listed below with the cost of each. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to HCFA-PUF) to cover the cost, to the following address: Health Care Financing Administration, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, Maryland 21207–0520, (410) 597–5151.

1. Expanded Modified MedPAR-Hospital (National)

The Medicare Provider Analysis and Review (MedPAR) file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in the United States. The records are stripped of most data elements that will permit identification of beneficiaries. Provider numbers and beneficiary claim numbers have been encrypted to protect the privacy of individuals. The hospital is identified by the 6 position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), and amended by the July 2, 1985 notice (50 FR 27361). The national file consists of approximately 11 million records. Under the requirements of these notices, a data release must be signed by the purchaser before release of these data. For all files requiring a signed data release agreement, please write or call to obtain a blank agreement form before placing order. Two versions of this file are created each year. They support the following:

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**, usually available by the end of May. This file is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**, usually available by the first week of September. This file is derived from the MedPAR file with a cutoff of 9 months after the end of the fiscal year (June file).

Media: Tape/Cartridge
File cost: $3,415.00 per fiscal year
Periods available: FY 1988 through FY 1993, and FY 1992 for Severity DRGs

2. Expanded Modified MedPAR-Hospital (State)

The State MedPAR file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in a particular State. The records are stripped of most data elements that will permit identification of beneficiaries. Provider numbers and beneficiary claim numbers have been encrypted to protect the privacy of individuals. The hospital is identified by the 6 position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the December 24, 1984 **Federal Register** notice, and amended by the July 2, 1985 notice. This file is a subset of the Expanded Modified MedPAR-Hospital (National) as described above. Under the requirements of these notices, a data release must be signed by the purchaser before release of these data. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**, usually available by the end of May. This file is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**, usually available by the first week of September. This file is derived from the MedPAR file with a cutoff of 9 months after the end of the fiscal year (June file).

Media: Tape/Cartridge
File cost: $1,050.00 per State per year
Periods available: FY 1988 through FY 1993

3. HCFA Hospital Wage Index Data

This tape contains four files. Included are: (1) the hospital hours and salaries for FY 1991 used to create the proposed FY 1995 prospective payment system wage indexes; (2) a history of all wage indexes used since October 1, 1983; (3) a list of State and county codes used by SSA and FIPS (Federal Information Processing Standards), county name, and Metropolitan Statistical Area (MSA); and (4) a file of hospitals that were reclassified for the purpose of the FY 1995 wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**, usually by the end of May.
- Final Rule published in the **Federal Register**, usually by the first week of September.

Media: Tape/Cartridge
File cost: $500.00
Periods available: FY 1995 PPS Update

We note that the files also are available individually as indicated below.

(1) HCFA Hospital Wage Index Survey Only (usually available by the end of March for the NPRM and the middle of August for the final rule.)

(2) Urban and Rural Wage Indices Only

(3) PPS SSA/FIPS MSA State and County Crosswalk Only (usually available by the end of March)

(4) Reclassified Hospitals by Provider Only

Media: Diskette
File cost: $145.00 Each

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

The PPS–I Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552–84). The dataset includes only the most

current cost report (as submitted, final settled or reopened) submitted for a Medicare participating hospital by the Medicare Fiscal Intermediary to HCFA. The majority of these cost reports have been settled by the Medicare fiscal intermediary. This file is no longer updated.

Media: Tape/Cartridge
Price: $715.00

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

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

Media: Tape/Cartridge
Price: $715.00

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

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

Media: Tape/Cartridge
Price: $715.00

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

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

Media: Tape/Cartridge
Price: $715.00

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

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

Media: Tape/Cartridge
Price: $715.00

9. PPS–VI Minimum Data Set, Cost Reporting Periods Beginning on or After October 1, 1988, and Before October 1, 1989

The PPS–VI Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report for the hospital fiscal periods beginning on or after October 1, 1988, and before January 1, 1989, and for the hospital fiscal periods beginning on or after January 1, 1989, and before October 1, 1989 (Forms HCFA 2552–85 and 2552–89, respectively). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This dataset is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge
Price: $715.00

10. PPS–VII Minimum Data Set, Cost Reporting Periods Beginning on or After October 1, 1989, and Before October 1, 1990

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

Media: Tape/Cartridge
Price: $715.00

11. PPS–VIII Minimum Data Set, Cost Reporting Periods Beginning on or After October 1, 1990, and Before October 1, 1991

The PPS–VIII Minimum Data Set contains cost, statistical, financial and other information from the Medicare hospital cost report (Form HCFA 2552–89) for the hospital fiscal periods beginning on or after October 1, 1990, and before Octeber 1, 1991. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge
Price: $715.00

12. PPS–IX Minimum Data Set, Cost Reporting Periods Beginning on or After October 1, 1991 and Before October 1, 1992

The PPS–IX Minimum Data Set contains cost, statistical, financial and other information from the Medicare Hospital Cost Report (Form HCFA 2552–89) for the hospital fiscal periods beginning on or after October 1, 1991 and before October 1, 1992. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge
File Cost: $715.00

13. PPS–VI Capital Data Set, Cost Reporting Periods Beginning on or After October 1, 1988, and before October 1, 1989

The PPS–VI Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report for the hospital fiscal periods beginning on or after October 1, 1988, and before January 1, 1989, and for the hospital fiscal periods beginning on or after January 1, 1989, and before October 1, 1989 (Forms HCFA 2552–85 and 2552–89, respectively). The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge
Price: $715.00

14. PPS–VII Capital Data Set, Cost Reporting Periods Beginning on or After October 1, 1989, and Before October 1, 1990

The PPS–VII Capital Data Set contains selected data for capital related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report (Form 2552–89) for the hospital fiscal periods beginning on or after October 1, 1989, and before October 1, 1990. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge
Price: $715.00

15. PPS–VIII Capital Data Set, Cost Reporting Periods Beginning on or After October 1, 1990, and Before October 1, 1991

The PPS–VIII Capital Data Set contains selected data for capital related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report (Form 2552–89) for the hospital fiscal periods beginning on or after October 1, 1990, and before October 1, 1991. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge
Price: $715.00

16. PPS–IX Capital Data Set, Cost Reporting Periods Beginning on or After October 1, 1991, and Before October 1, 1992

The PPS–VIII Capital Data Set contains selected data for capital related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report (Form 2552–89) for the hospital fiscal periods beginning on or after October 1, 1991, and before October 1, 1992. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge
Price: $715.00

17. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements. Beginning with December 1991, the individual records were enlarged to include elements related to the capital prospective payment system.
Media: Tape/Cartridge
File Cost: $500.00 per file
Periods available: FY 1987 through FY 1994 (December updates)
Media: Diskette
File Cost: $265.00
Periods Available: FY 1994 PPS Update

18. HCFA Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**, usually by the end of May.
- Final rule published in the **Federal Register**, usually by the first week of September.

Media: Diskette
Price: $145.00 per year
Periods available: FY 1985 through FY 1993, and FY 1992 for Severity DRGs

19. Table 5 DRG File

This file contains a listing of DRGs, DRG narrative description, relative weight, geometric and arithmetic mean lengths of stay, and day outlier trim points as published in the **Federal Register**. The hardcopy image has been copied to diskette. There are two versions of this file as published in the **Federal Register**:

1. NPRM, usually published by the end of May.
2. Final rule, usually published by the first week of September.

Media: Diskette
File cost: $145.00
Periods available: FY 1994 PPS Update, and Severity DRGs

20. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, the PPS-VI and PPS-VII Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the final rule is published in the **Federal Register**, usually during the first week of September.
Media: Diskette
File Cost: $145.00
Periods available: FY 1994 PPS Update

21. AOR/BOR Tables

This diskette contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are "Before Outliers Removed" and the AOR is "After Outliers Removed." (Outliers refers to statistical outliers, not payment outliers.)
Media: Diskette
File cost: $145.00
Periods available: FY 1994 PPS Update, and Severity DRGs

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

In addition, certain other data, such as area wage data and data used to construct the Puerto Rico standardized amounts, are available in hard copy format. Commenters interested in examining hard copy data should contact John Davis at (410) 966–5654.

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

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

C. Public Comments

Because of the large number of items of correspondence we normally receive

on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the "Dates" section of this preamble and respond to those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5) of the Act that our final rule for FY 1995 be published by September 1, 1994, we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 482

Grant programs-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR chapter IV would be amended as set forth below:

A. Part 412 would be amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102, 1815(e), 1820, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395i-4, 1395hh, and 1395ww).

Subpart A—General Provisions

2. In § 412.4, paragraphs (a)(3), (b) introductory text, (b)(2), and (b)(3)(ii) are revised, a new paragraph (b)(4) is added, and paragraph (d)(1) is revised to read as follows:

§ 412.4 Discharges and transfers.

(a) * * *

(3) For discharges occurring before October 1, 1994, the patient is transferred to a hospital or hospital unit that is excluded from the prospective payment systems under subpart B of this part.

(b) *Transfers.* A discharge of a hospital inpatient is not counted for purposes of the prospective payment systems when the patient is transferred—

* * * * *

(2) From the care of a hospital paid under this section to the care of another such hospital;

(3) * * *

(ii) Whose first cost reporting period under the prospective payment systems has not yet begun; or

(4) For discharges occurring on or after October 1, 1994, from the care of a hospital paid under this section to the care of a hospital or hospital unit that is excluded from the prospective payment systems under subpart B of this part.

* * * * *

(d) *Payment to a hospital transferring an inpatient to another hospital or unit.* (1) A hospital that transfers an inpatient under the circumstances described in paragraph (b)(2), (b)(3), or (b)(4) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D, E, and M of this part if the patient had been discharged to another setting. The per diem is determined by dividing the appropriate prospective payment rates (as determined under subparts D, E, and M of this part) by the geometric mean length of stay for the specific Diagnosis-Related Group (DRG) into which the case falls. Payment is graduated by paying twice the per diem for the first day of the stay, and paying the per diem amount for each subsequent day, up to the full DRG payment amount as described in this paragraph.

* * * * *

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

3. In § 412.23, paragraph (e) is revised to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraphs (e)(1) and (e)(2) of this section, and, where applicable, the additional requirements in paragraph (e)(3) of this section.

(1) The hospital must have a provider agreement under part 489 of this chapter to participate as a hospital

(2) The hospital must have an average length of inpatient stay greater than 25 days—

(i) As computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period; or

(ii) If a change in the hospital's average length of stay is indicated, as computed by the same method for the immediately preceding six-month period.

(3) For cost reporting periods beginning on or after October 1, 1994, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following additional requirements:

(i) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital from which it obtains space. The hospital's governing body is not under the control of the hospital that provides space, or of any third entity that controls both hospitals.

(ii) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital that provides space or any third entity that controls both hospitals.

(iii) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital from which it obtains space. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) *Chief executive officer.* The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital that provides space

or any third entity that controls both hospitals.

(v) *Performance of basic hospital functions.* The hospital performs the basic hospital functions specified in §§ 482.21 through 482.27, 482.30, and 482.42 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital from which it obtains space, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital that provides space, or with a third entity that controls both hospitals.

(4) For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

* * * * *

§ 412.27 [Amended]

4. In § 412.27, the section heading is revised to read "*Excluded psychiatric units: Additional requirements.*"

§ 412.29 [Amended]

5. In § 412.29, the section heading is revised to read "*Excluded rehabilitation units: Additional requirements.*"

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

6. In paragraph (d)(2) of § 412.60, the second sentence is revised to read as follows:

§ 412.60 DRG classification and weighting factors.

* * * * *

(d) * * *

(2) * * * If the intermediary decides that a higher-weighted DRG should be assigned, the case will be reviewed by the appropriate PRO to verify the change in DRG assignment as specified in § 466.71(c)(2) of this chapter.

* * * * *

7. In § 412.63, paragraph (m)(1), the paragraph heading of paragraph (r), and paragraphs (r)(1) introductory text, (r)(1)(i), (r)(2) introductory text, (r)(2)(i), and (s)(2) are revised to read as follows:

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

* * * * *

(m) * * *

(1) Plus, for hospitals located in rural areas, the percentage increase necessary so that the average standardized amounts computed under paragraph (c) through (i) of this section are equal to the average standardized amounts for hospitals located in an urban area other than a large urban area.

* * * * *

(r) *Computing Federal rates for inpatient operating costs for hospitals located in large urban and other* areas. * * *

(1) For hospitals located in a large urban area in the United States or that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large urban area in the United States or in that region; and

* * * * *

(2) For hospitals located in an other area in the United States or that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in an other area in the United States or that region; and

* * * * *

(s) * * *

(2) HCFA makes a midyear correction to the wage index for an area only if a hospital can show that—

(i) The intermediary or HCFA made an error in tabulating the hospital's data; and

(ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year. A midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

* * * * *

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

8. In § 412.71, paragraph (b) introductory text is revised, paragraph (b)(1) is removed and paragraphs (b)(2) through (b)(8) are redesignated as paragraphs (b)(1) through (b)(7). The revision is to read as follows:

§ 412.71 Determination of base-year inpatient operating costs.

* * * * *

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with § 413.53(a)(1)(i) of this chapter, and exclude the following:

* * * * *

Subpart F— Payment for Outlier Cases

9. In § 412.80, the introductory text of paragraphs (a)(1) and (a)(1)(ii) are revised, and a new paragraph (a)(1)(iii) is added to read as follows:

§ 412.80 General provisions.

(a) *Basic rule.* (1) For discharges before October 1, 1994, except as provided in paragraph (a)(2) of this section concerning transferring hospitals, HCFA provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by HCFA, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the conditions specified in paragraphs (a)(1)(i) and (a)(1)(ii) of this section is met. For discharges occurring on or after October 1, 1994, except as provided in paragraph (a)(2) of this section concerning transferring hospitals, HCFA provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the conditions specified in paragraphs (a)(1)(i) and (a)(1)(iii) of this section is met.

* * * * *

(ii) For discharges occurring before October 1, 1994, 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 operating costs and, effective with cost reporting periods beginning on or after October 1, 1991, capital costs, by applying cost-to-charge ratios as described in § 412.84(h), exceed the greater of the following: * * *

(iii) For discharges occurring on or after October 1, 1994, 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 operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA.

* * * * *

10. In § 412.82, paragraph (c) is revised 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 a percentage of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under subpart D of this part by the arithmetic mean length of stay for that DRG. HCFA issues the applicable percentage of the average per diem payment in the annual publication of the prospective payment rates in accordance with § 412.8(b).

* * * * *

§ 412.84 [Amended]

11. In paragraph (j) of § 412.84, remove the words "75 percent" from wherever they appear in the paragraph and add, in their place, the words "80 percent".

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

12. In § 412.96, 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, and before October 1, 1994, 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.

* * * * *

13. Section 412.105 is amended as follows:

a. Paragraph (b) is revised.

b. In paragraph (d)(1), the phrase "set forth in paragraph (c)(1) of this section." is revised to read "set forth in paragraph (c) of this section."

The revision is to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns who are not in intensive care areas, custodial care beds, and beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

* * * * *

14. In § 412.109, a new paragraph (e) is added to read as follows:

§ 412.109 Special treatment: Essential access community hospitals (EACHs).

* * * * *

(e) *Review of HCFA Determination.* A determination by HCFA that a hospital does not meet the criteria for EACH designation, or that a hospital's EACH designation should be terminated, is subject to review under part 405, subpart R of this chapter.

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

§ 412.113 [Amended]

15. In § 412.113(b)(3), the phrase "Except as provided in § 413.86(c)(1) of this chapter," is revised to read "Except as provided in § 413.86(c) of this chapter,".

Subpart L—The Medicare Geographic Classification Review Board

16. In § 412.232, paragraph (c) is 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.

(1) *Aggregate hourly wage.* The aggregate average hourly wage for all hospitals in the rural county must be equal to at least 85 percent of the average hourly wage in the adjacent urban area; or

(2) *Aggregate hourly wage weighted for occupational mix.* The aggregate average hourly wage for all hospitals in the rural county, weighted for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

* * * * *

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

17. In § 412.302, paragraph (c)(2)(i)(D) is revised to read as follows:

§ 412.302 Introduction to capital costs.

* * * * *

(c) * * *

(2) * * *

(i) * * *

(D) The hospital put the asset into patient use on or before the latter of September 30, 1996 or 4 years from the date the certificate of need was approved.

* * * * *

18. Section 412.348 is revised to read as follows:

§ 412.348 Exception payments.

(a) *Definitions.* As used in this section—

Average age of fixed assets. The average age of fixed assets is the ratio of accumulated depreciation for buildings and fixed equipment to current depreciation expense for buildings and fixed equipment. The average age of fixed assets is determined from information on the Medicare cost report.

Current ratio. Current ratio means the ratio of current liabilities to current assets. The current ratio is determined from information on the Medicare cost report.

Fixed assets. Fixed assets mean buildings and fixed equipment.

(b) *Criterion for additional payment during the transition period.* An additional payment is made to a hospital paid under either the fully prospective payment methodology or the hold-harmless payment methodology as determined under paragraph (c) of this section for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001.

(c) *Minimum payment level by class of hospital.* (1) HCFA establishes a minimum payment level by class of hospital. The minimum payment level for a hospital will equal a fixed percentage of the hospital's capital-related costs. The minimum payment levels may be no greater than the percentages of allowable capital-related costs that follow:

(i) 90 percent for sole community hospitals.

(ii) 80 percent for hospitals located in an urban area for purposes of § 412.63(a) with at least 100 beds, as determined under § 412.105(b), that have a disproportionate share patient percentage of at least 20.2 percent as determined under § 412.106(b), and for hospitals located in an urban area for purposes of § 412.63(a) with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2).

(iii) 70 percent for all other hospitals.

(2) HCFA will issue the minimum payment levels for each class of hospital in determining the additional exception payment in the annual notice of capital prospective payment rates, published in accordance with § 412.8(b).

(d) *Additional payments.* A hospital is entitled to an additional payment if its capital payments for the cost reporting period would otherwise be less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive minus any offset amount determined under paragraph (e)(2) of this section.

(e) *Determining a hospital's exception payment amount*—(1) *Cumulative comparison.* For each cost reporting period beginning before October 1, 2001, the hospital's exception 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 the prospective payment system.

(2) *Offsetting amounts.* Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels is deducted from the additional payment that would otherwise be payable for a cost reporting period.

(f) *Additional payment exception for extraordinary circumstances.* (1) A hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million (net of proceeds from other payment sources such as insurance, litigation decisions and other State, local or Federal government funding programs) due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, fire, or earthquake.

(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 Director, Office of Payment Policy, Bureau of Policy Development, HCFA 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.

(3) Except for sole community hospitals, the additional payment is based on a minimum payment amount of 85 percent for Medicare's share of allowable capital-related costs attributable to the extraordinary circumstances. For sole community hospitals, the minimum payment amount is 100 percent.

(4) The minimum payment level applicable under paragraph (c)(1) of this section is adjusted to take into account the 85 percent minimum payment level (100 percent for sole community hospitals) under paragraph (f)(3) of this section for the unanticipated capital-related costs. The additional payment for the cost reporting period equals the difference between the adjusted minimum payment level and the capital payments the hospital would otherwise receive less any offset amount determined under paragraph (e)(2) of this section.

(g) *Special exceptions process.* For eligible hospitals that meet an age of assets test, receive any required approval from a State or local planning authority, and, in the case of urban hospitals, meet an excess capacity test, an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period.

(1) *Eligible hospitals.* The following classes of hospitals are eligible to receive exceptions payments under this special exceptions provision:

(i) Sole community hospitals that have a current ratio less than or equal to 1.75 in the exception year.

(ii) Hospitals located in an urban area under § 412.63(a) with at least 100 beds, as determined under § 412.105(b), that either have a disproportionate share of at least 20.2 percent as determined under § 412.106(b) or qualify for disproportionate share payments under § 412.106(c)(2), and that have a current ratio less than or equal to 1.75 in the exception year.

(iii) Hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

(2) *Age of assets test.* A hospital meets the age of assets test if—

(i) Its average age of fixed assets is at or above the 75th percentile for the hospital's first cost reporting period beginning on or after October 1, 1991; and

(ii) Its average age of fixed assets in a subsequent cost reporting period (but no later than the last cost reporting period beginning before October 1, 2001) declines by at least 50 percent from its average age of fixed assets in the first cost reporting period beginning on or after October 1, 1991.

(3) *Planning authority approval.* The hospital must obtain any required approval from a State or local planning authority.

(4) *Excess capacity test for urban hospitals.* Urban hospitals that are not required to receive approval from a State or local planning authority must demonstrate that either—

(i) The overall average occupancy rate in its metropolitan statistical area is at least 80 percent; or

(ii) Its capacity is no more than 80 percent of its prior capacity (in terms of bed size).

(5) *Minimum payment level.* The minimum payment level for qualifying hospitals will be 70 percent.

(6) *Limitation on the period for exception payments.* A qualifying hospital may receive an exceptions payment for up to 10 years from the year in which it first meets the age of assets test, provided that it meets the age of asset test no later than the last cost reporting period beginning before October 1, 2001.

(7) *Determining a hospital's exception payment amount*—(i) *Cumulative comparison.* For each cost reporting period, the hospital's exception 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 the prospective payment system.

(ii) *Offsetting amounts.* Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels is deducted from the additional payment that would otherwise be payable for a cost reporting period.

(iii) *Other offset.* Any amount by which the hospital's Medicare inpatient operating and capital prospective payments exceed its Medicare inpatient operating and capital costs is deducted from the additional payment that would otherwise be payable for the cost reporting period.

(h) *Limit on exception payments.* Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

§§ 412.20, 412.22, 412.25, 412.27, 412.29, 412.30, 412.96, 412.105, 412.108, 412.116 and 412.130 [Amended]

19. In part 412, remove the words "distinct part", wherever they appear, in the following places:

a. Section 412.20(b)(1);

b. Section 412.22(b);

c. Section heading of § 412.25;

d. Section 412.25(a) introductory text;

e. Section 412.27, the introductory text for the section;

f. Section 412.29, the introductory text for the section;

g. Section heading of § 412.30;

h. Section 412.96(c)(1) introductory text and (c)(2)(i) introductory text;

i. Section 412.105(b), (f)(5) and (g)(1)(iii);

j. Section 412.108(a)(2);

k. Section 412.116(a) and (b)(1) introductory text;

l. Section heading of § 412,130; and

m. Section 412.130 (a)(2) and (a)(3).

B. Part 413 would be amended as follows:

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

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

Authority: Secs. 1102, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 13951 (a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Public Law 100–360 as amended by sec. 608(d)(3) of Public Law 100–485 (42 U.S.C. 1395ww (note)) and sec. 101(c) of Public Law 101–234 (42 U.S.C. 1395ww (note)).

Subpart C—Limits on Cost Reimbursement

§ 413.40 [Amended]

2. In paragraph (a)(2)(ii), (b)(1)(i) through (b)(1)(iii) and (f)(2) of § 413.40, remove the words "(distinct parts)" and "distinct part", wherever they appear.

Subpart D—Apportionment

3. In § 413.53, paragraph (a)(1)(i) is revised to read as follows:

§ 413.53 Determination of cost of services to beneficiaries.

(a) * * *

(1) *Departmental method*—(i) *Methodology.* Except as provided in paragraph (a)(1)(ii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas as defined in paragraph (b) of this section, taking into account, in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other intensive care type inpatient hospital units.

* * * * *

§ 413.56 [Removed and Reserved]

4. Section 413.56 is removed and reserved.

Subpart F—Specific Categories of Costs

5. Section 413.86 is amended as follows:

a. In paragraph (f)(1)(ii), the third sentence is revised.

b. In paragraph (g)(1) introductory text, a new sentence is added after the second sentence.

The revision and addition are to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(f) * * *

(1) * * *

(ii) * * * A part-time resident counts as a partial FTE based on the proportion of time worked in the hospital compared to the total time necessary to fill a full-time internship or residency slot.

* * * * *

(g) * * *

(1) * * * Effective July 1, 1995, an *initial residency period* is defined as the minimum number of years required for board eligibility. * * *

* * * * *

Subpart G—Capital-Related Costs

6. Section 413.134 is amended as follows:

a. In paragraph (d)(1), the phrase "where permitted under § 413.134(a)(3)," is revised to read "when permitted under paragraph (a)(3) of this section,".

b. Paragraphs (e)(1) and (e)(2)(ii) are revised, and paragraphs (e)(2)(iii), (e)(2)(iv) and (e)(4) are added.

The revisions and additions are to read as follows:

§ 413.134 Depreciation: Allowance for depreciation based on asset costs.

* * * * *

(e) * * *

(1) *Incentive.* As an incentive for funding, investment income on funded depreciation is not treated as a reduction of allowable interest expense. Investment income earned on deposits before the 6-month period elapses are not offset unless the deposits are withdrawn for an improper purpose during this period.

(2) * * *

(ii) Borrowing for a purpose for which funded depreciation account funds should have been used makes the borrowing unnecessary to the extent that funded depreciation account funds were available at the time of the borrowing. Available funds in the funded depreciation account, to the extent of the unnecessary borrowing, are called "tainted" funds. Interest expense incurred on borrowing for a capital purpose is not an allowable cost to the extent that funded depreciation account funds were available at the time of the borrowing.

(iii) A provider can remove the "unnecessary" characterization of borrowing, and thereby cure tainted funded depreciation, by using the tainted funds for a proper purpose described in paragraph (e)(3)(i) of this section. However, any funded depreciation that existed at the time of the unnecessary borrowing and is not classified as tainted must be used before any of the tainted funds.

(iv) When only a portion of the borrowing is considered unnecessary under paragraph (e)(2)(ii) of this section, subsequent repayments of such borrowing from general funds is applied first to the allowable portion of the borrowing and then, when all of the allowable borrowing is repaid, to the unallowable portion of the borrowing. When funds from the funded depreciation account are used for the repayment of the unnecessary borrowing, an equivalent amount of tainted funds is cured without regard to the provisions of paragraphs (e)(2)(ii) and (e)(3)(i)(C) of this section. Similarly, where general funds are used to pay for the unallowable borrowing after the necessary borrowing has been repaid, an equivalent amount of tainted funded depreciation is cured without regard to the provisions of paragraphs (e)(2)(ii) and (e)(3)(i)(C) of this section.

* * * * *

(4) *Loans from funded depreciation.* (i) When the general fund of the provider borrows from the funded depreciation to obtain working capital for normal operating expenses to furnish patient care, interest incurred by the general fund is an allowable operating cost only if the interest expense is supported by documents that evidence that the funds were borrowed and that payment of interest and repayment of the funds are required, is separately identified in the provider's accounting records, and meets the necessary and proper tests described in §§ 413.153 (b)(2) and (b)(3).

(ii) Loans from funded depreciation to the general fund are considered investments of funded depreciation, but do not have to meet the readily marketable test described in paragraph (e) of this section. Loans made from funded depreciation are subject to the requirement that funded depreciation must be available for the acquisition of depreciable assets used to furnish patient care, or for other capital

purposes related to patient care. Costs incurred to secure lines of credit from lending institutions to ensure such availability are not allowable costs.

(iii) Funding of depreciation from general funds will not be recognized to the extent of any outstanding loans from the funded depreciation account to the general fund. Deposits from the general fund into the funded depreciation account must be first applied to reduce any loans outstanding from the funded depreciation to the general fund. When the loans are repaid in full, general funds deposited in the funded depreciation account are considered as repayments of the general fund. Therefore, any subsequent interest expense of the general fund paid to the funded depreciation fund is not an allowable cost.

* * * * *

7. In § 413.153, paragraph (d)(2) is revised and a new paragraph (d)(3) is added to read as follows:

§ 413.153 Interest expense.

* * * * *

(d) * * *

(2) In determining whether a loan was made for the purpose of acquiring a facility, we apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill, and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill. Repayments of the funds borrowed are applied first to the tangible assets, then to the intangible assets other than goodwill, and lastly to the goodwill.

(3) When a provider borrows funds for a purpose related to patient care, but only some of the funds are necessary, repayments of the loan are applied first to pay for the necessary portion of the loan. Only after all of the necessary portion has been repaid are any repayments applied to the unnecessary portion of the loan.

* * * * *

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services

8. In § 413.174, paragraph (b)(4)(iv) is revised to read as follows:

§ 413.174 Recordkeeping and cost reporting requirements for outpatient maintenance dialysis.

* * * * *

(b) * * *

(4) * * *

(iv) Sections 413.64, Payments to providers, and §§ 413.13, 413.30, 413.35, 413.40, 413.74, and §§ 405.465 through 405.482 of this chapter, Principles of reimbursement for services by hospital-based physicians.

C. Part 482 would be amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

Authority: Secs. 1102, 1136, 1138, 1814(a)(6), 1861 (e), (f), (r), (v)(1)(G), (z), and (ee), 1864, 1871, 1883, 1886, 1902(a)(30), and 1905(a) of the Social Security Act (42 U.S.C. 1302, 1320b–6, 1338, 1395f(a)(6), 1395x (e), (f), (k), (r), (v)(1)(G), (z), and (ee), 1395aa, 1395aa, 1395hh, 1395tt, 1395ww, 1396a(a)(30), and 1396(a)).

Subpart E—Requirements for Specialty Hospitals

2. In paragraph (a)(7)(i) of § 482.66, the second sentence is revised to read as follows:

§ 482.66 Special requirements for hospital providers of long-term care services ("swing-beds").

(a) * * *

(7) * * *

(i) * * * Also excluded from the bed count are beds in separately certified "distinct part" SNFs and NFs and beds in a psychiatric or rehabilitation unit that is excluded from the prospective payment system.

* * * * *

D. Part 485 would be amended as follows:

PART 485—CONDITIONS OF PARTICIPATION AND CONDITIONS FOR COVERAGE: SPECIALIZED PROVIDERS

1. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102, 1124, 1138, 1820, 1861 (aa), and (cc) and 1871 of the Social Security Act; (42 U.S.C. 1302, 1320a–3, 1320b–8, 1395i–4, 1395x (aa) and (cc) and 1395hh); and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart F—Conditions of Participation: Rural Primary Care Hospitals (RPCHs)

2. Section 485.602 is revised to read as follows:

§ 485.602 Definitions.

As used in this subpart, unless the context indicates otherwise:

Direct services means services provided by employed staff of the RPCH, not services provided through arrangements or agreements.

3. In § 485.635, paragraph (b) is revised to read as follows:

§ 485.635 Condition of participation: Provision of services.

* * * * *

(b) *Standard: Direct services.* (1) *General.* The RPCH staff furnishes, as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.

(2) *Laboratory services.* The RPCH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include:

(i) Chemical examination of urine by stick or tablet method or both (including urine ketones);

(ii) Hemoglobin or hematocrit;

(iii) Blood glucose;

(iv) Examination of stool specimens for occult blood;

(v) Pregnancy tests; and

(vi) Primary culturing for transmittal to a certified laboratory.

(3) *Radiology services.* Radiology services furnished at the RPCH are provided as direct services by staff qualified under State law, and do not expose RPCH patients or staff to radiation hazards.

(4) *Emergency procedures.* In accordance with the requirements of § 485.618, the RPCH provides as direct services medical emergency procedures as a first response to common life-threatening injuries and acute illness.

* * * * *

E. Part 489 would be amended as follows:

PART 489—PROVIDER AND SUPPLIER AGREEMENTS

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1861, 1864, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh).

Subpart I—Advance Directives

2. In § 489.102, paragraph (a) introductory text is revised to read as follows:

§ 489.102 Requirements for providers.

(a) Hospitals, rural primary care hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the provider and are required to:

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 5, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: May 10, 1994.

Donna E. Shalala,

Secretary.

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

Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges On or After October 1, 1994 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1994

I. Summary and Background

In this addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth new proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1994, except for sole community hospitals and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be comprised of 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, 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 comprised of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act).

As discussed below in section II, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III we discuss our proposed changes for determinating the prospective payment rates for Medicare inpatient capital-related costs. Section IV sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum in section V.

II. Proposed Changes to Prospective Payment Rates For Inpatient Operating Costs for FY 1995

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the manner in which we are changing some of the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 1994. As discussed in section IV.C of this proposed rule, section 1886(d)(3)(A)(iii) specifies that for discharges occurring in the fiscal year beginning October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an other urban area. Pursuant to section 1886(b)(3)(B)(i)(X) of the Act, we will update the rural standardized amount by the amount necessary to equate the rural standardized amount with the other urban standardized amount. As there will no longer be separate other urban and rural standardized amounts, we will refer to the urban and rural standardized amounts that will be effective beginning with FY 1995 as the "other standardized amount." As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and weighting factors for discharges in FY 1995.

In summary, the proposed standardized amounts set forth in Tables 1a, 1b, and 1c of section V of this addendum reflect—

- Updates of 1.1 percent for large urban and other urban hospitals (that is, the market basket percentage increase of 3.6 percent minus 2.5 percentage points) and an update for rural hospitals of approximately 8.4 percent (that is, the amount required to equate the rural standardized amount with the other urban standardized amount);
- Revised labor and nonlabor shares of the national average standardized amounts to reflect the national average labor portion of the standardized amounts for urban and rural hospitals (the revised labor and nonlabor shares of the Puerto Rico standardized amounts reflect the Puerto Rico average labor portion of the standardized amounts for urban and rural hospitals);
- An adjustment to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1994 budget neutrality factor and applying a revised factor; and
- An adjustment to apply the revised outlier offset by removing the FY 1994 outlier offsets and applying a new offset.

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 1995 were made. That is, the standardization adjustments reflected in the FY 1995 standardized amounts are the same as those reflected in the FY 1994 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 Other Averages Within Geographic Areas

Beginning in FY 1995, section 1886(d)(3) of the Act requires the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other 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 other 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 "urban areas" as those areas within a Metropolitan Statistical Area (MSA). A "large urban area" is defined as an urban area with a population of more than 1,000,000. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a "large urban area" are referred to as "other urban areas." Areas that are not included in MSAs are considered "rural areas" under section 1886(d)(2)(D). Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment will be based on the other standardized amount for discharges from hospitals located in other urban and rural areas.

Based on 1991 population estimates published by the Bureau of the Census, 54 areas meet the criteria to be defined as large urban areas for FY 1995. These areas are identified by an asterisk in Table 4a.

Table 1a contains the two national standardized amounts that we are proposing be applicable to most hospitals. 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 large urban standardized amount and the national other 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 two standardized amounts that would be applicable to most hospitals in Puerto Rico.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the large urban, other urban, and rural average standardized amounts for FY 1994 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. As explained earlier, there are currently separate large urban, other urban and rural standardized payment amounts, and section 1886(d)(3)(A) of the Act provides for the elimination of separate other urban and rural payment amounts beginning in FY 1995. Section 1886(b)(3)(B)(i)(X) of the Act, as amended by section 13501(a)(1) of Public Law 103–66, specifies the following update factors for the standardized amounts for FY 1995:

- For hospitals located in large urban and other urban areas, the market basket percentage increase minus 2.5 percentage points.
- For hospitals located in rural areas, the market basket percentage increase plus the amount necessary to make the rural standardized amount equal the standardized amount for other urban areas.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecasted hospital market basket increase for FY 1995 is 3.6 percent. For FY 1995, this yields an update to the urban average standardized amounts of 1.1 percent (3.6 percent minus 2.5 percent). To satisfy the requirement of section 1886(b)(3)(i)(X) of the Act that the update for hospitals located in a rural area be equal to that for hospitals located in an other urban area beginning in FY 1995, we estimate that an overall update of the market basket rate of increase (that is, 3.6 percent) plus approximately 4.8 percentage points will be necessary. Thus, we are proposing an update to the other urban and rural average standardized amounts for FY 1995 of 8.4 percent. However, as explained below, we are currently estimating that the overall increase in the rural standardized amount will be approximately 4.6 percent, as a result of two adjustments that must be made to the updated standardized amounts. These adjustments were previously applied differentially to the urban and rural standardized amounts.

First, we are adjusting the FY 1994 standardized amounts to remove the effects of the FY 1994 geographic reclassifications and outlier payments before applying the FY 1995 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. As these reductions were larger for urban than rural hospitals, restoring the reductions results in a larger increase in the urban standardized amounts than the rural standardized amounts. After applying an update of 1.1 percent to the adjusted urban standardized amount, we estimate that an overall update of 7.3 percent is required to equate the rural and other urban standardized amounts.

However, the estimated actual increase in the standardized amounts for rural hospitals will be less because we also have to reduce the standardized amounts for the effects of geographic reclassification and outliers. For FY 1995, there will be a single reduction to the standardized amounts for each of these factors, rather than separate

adjustments to the urban and rural standardized amounts based on the effect of geographic reclassification and outliers in each respective area. For instance, in FY 1994, we reduced the urban standardized amounts by 5.4 percent and the rural standardized amounts by 2.3 percent to account for outliers in each respective area. For FY 1995, we will apply one adjustment for the effect of outliers—a single reduction in the standardized amounts of 5.1 percent. Similarly, there were separate reductions to the standardized amounts in FY 1994 for the effects of geographic reclassification of 0.7 percent for urban hospitals and 0.1 percent for rural hospitals. Our proposed standardized amounts reflect a single reduction for this factor of 0.6 percent. After including offsets to the standardized amounts for outliers and geographic reclassification, we estimate that there will be an actual increase of 4.6 percent to the rural standardized amounts and 1.5 percent to the urban standardized amounts. A more detailed explanation of the impact of the single standardized amount for other urban and rural hospitals and single adjustments for the effects of outliers and geographic reclassification is included in Appendix A of this proposed rule.

With the phase-out of the rural payment amount, rural hospitals and other urban hospitals will be paid based on the same standardized amount. Since Congress has mandated the elimination of separate payment rates based on whether a hospital is located in an urban or rural area, we believe it is appropriate to revise the national average standardized amounts based on national average labor/nonlabor shares. Therefore, we propose to adjust the labor and nonlabor proportions of the standardized amount to reflect the national average. (We are revising the Puerto Rico standardized amounts by the average labor share in Puerto Rico of 82.7 percent.) Currently, the rural labor share represents 75.6 percent of the standardized amount while the urban labor share represents 70.8 percent. This differential is the result of standardization of labor-related costs by the area wage index. Because rural hospitals generally have lower wage index values than urban hospitals, the standardization process resulted in a higher labor share for rural hospitals. We are therefore proposing to adjust the labor/nonlabor proportions of the standardized amounts that will be applicable to both rural and urban hospitals based on the national average. As a result, the national average labor share (as reflected in the hospital market basket) will equal 71.4 percent of the standardized payment amounts.

Although the update factor for FY 1995 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, 1994 on our initial recommendation of update factors for FY 1995 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act), as well as our responses to ProPAC's recommendation concerning the update factor, is set forth as Appendix D to this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

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

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

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the DRG reclassification changes and recalibration of the relative weights be budget neutral and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be implemented in a budget neutral manner, we compared aggregate payments using the FY 1994 relative weights and the wage index effective October 1, 1993 to aggregate payments using the proposed FY 1995 relative weights and wage index. The same methodology was used for the FY 1994 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.997647. This budget neutrality adjustment factor is applied to the standardized amounts without removing the effects of the FY 1994 budget neutrality adjustment. We do not remove the prior budget neutrality adjustment because the statute requires that aggregate payments after the changes in the DRG relative weights and wage index equal estimated payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we are proposing to continue to apply the same FY 1995 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1994, 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).)

b. 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 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.

Prior to FY 1995, section 1886(d)(8)(D) of the Act required the Secretary to adjust the urban standardized amounts 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 were equal to the aggregate prospective payments that would have been made absent these provisions. The rural standardized amounts were also adjusted to ensure that aggregate payments to rural hospitals not affected by these provisions neither increased nor decreased as a result of these provisions. Beginning October 1, 1994, the Secretary is required to adjust the standardized amounts by the same

factor to account for the effects of reclassification. We applied an adjustment of 0.993814 to ensure that the effects of reclassification are budget neutral.

The adjustment factors are applied to the standardized amounts after removing the effects of the FY 1994 budget neutrality adjustment factors. We note that the proposed FY 1995 adjustments reflect wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 14, 1994. The effects of any additional reclassification changes resulting from appeals and review of the MGCRB's decisions for FY 1995 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the final rule for FY 1995.

c. Outliers. Section 1886(d)(5)(A) of the Act provides 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. Under section 1886(d)(3)(B) of the Act, the Secretary has been required to separately reduce the urban and rural national standardized amounts by the proportion of estimated total DRG payments attributable to outliers in each respective area. Beginning with FY 1995, section 1886(d)(3)(B) requires the Secretary to adjust both the large urban and other national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Section 1886(d)(9)(B)(iv) of the Act requires that the urban and other standardized amounts applicable to hospitals in Puerto Rico be reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act directs that outlier payments in any year may not be less than 5 percent nor more than 6 percent of total payments projected or estimated to be made based on the prospective payment rates.

Section 13501(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) amended section 1886(d)(5)(A) with respect to outliers beginning in FY 1995. With regard to cost outliers, section 13501(c) of Public Law 103–66 requires that the Secretary modify the methodology for determining the cost outlier threshold. For discharges occurring before October 1, 1994, a hospital may receive payment for a cost outlier if the adjusted costs for a discharge exceed a fixed multiple of the DRG payment for the case or a fixed dollar amount. Effective for discharges occurring on or after October 1, 1994, a hospital may receive payment for a cost outlier if adjusted costs exceed the DRG prospective payment rate plus a fixed dollar amount. As discussed in section IV.D of the preamble, we refer to this revised cost outlier threshold as "fixed loss."

Section 13501(c) of Public Law 103–66 also amended section 1886(d)(5)(A) of the Act with respect to day outliers. Beginning with FY 1995, section 1886(d)(5)(A) requires the Secretary to reduce the proportion of total outlier payments paid under the day outlier methodology. Under the requirements of section 1886(d)(5)(A)(v), the proportion of outlier payments made under the day outlier methodology, relative to the proportion of outlier payments made under the day outlier methodology in FY 1994 (which we estimated at 31.3 percent in our September 1, 1993 final rule (58 FR 46348)), shall be 75 percent in FY 1995, 50 percent in FY 1996 and 25 percent in FY 1997. After September 30, 1997, the Secretary will no longer pay for day outliers under the provisions of section 1886(d)(5)(A)(i). Again, the changes required by section 1886(d)(5)(A) are discussed in detail in section IV.D of the preamble to this proposed rule.

i. FY 1995 Outlier Thresholds. For FY 1994, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 23 days or 3.0 standard deviations. The marginal cost factor for day outliers (or the percent of Medicare's average per diem payment paid for each outlier day) is equal to 55 percent in FY 1994. The cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or $36,000 ($33,000 for hospitals that have not yet entered the prospective payment system for inpatient capital-related costs). The marginal cost factor for cost outliers (or the percent of costs paid after costs for the case exceed the threshold) is 75 percent. We applied an outlier adjustment to the FY 1994 standardized amounts of 0.945960 for the urban rates, 0.977157 for the rural rates, and 0.9454 for the capital Federal rate.

For FY 1995, we propose to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 22 days or 3.0 standard deviations. We are also proposing to reduce the marginal cost factor for each outlier day from 55 percent to 49 percent in FY 1995.

Our proposed policy will reduce the proportion of outlier payments paid to day outliers as required by section 1886(d)(5)(A) of the Act. We are also proposing a fixed loss cost outlier threshold in FY 1995 equal to the prospective payment rate for the DRG plus $23,300 ($21,400 for hospitals that have not yet entered the prospective payment system for capital-related costs). Additionally, we are proposing to increase the marginal cost factor for cost outliers from 75 to 80 percent.

Pursuant to section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that estimated outlier payments equal 5.1 percent of estimated DRG payments. In conjunction with the elimination of the rural standardized amount, we considered raising the proportion of operating payments estimated to be paid as outliers from 5.1 percent to 5.5 percent. This is the percentage offset that currently applies to the urban standardized amounts and is in the middle of the 5 to 6 percent range for outlier payments required by statute. Raising the proportion of operating payments paid as outliers would reduce the financial risk to hospitals in treating outlier cases. However, financing 5.5 percent in outlier payments would require reducing the average standardized amounts by 5.5 percent. We welcome comments on this issue.

The model that we use to determine the outlier thresholds necessary to target our desired outlier payment percentage for FY 1995 uses the FY 1993 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 January 1994 update of the provider-specific file used in the PRICER program. In estimating payments we convert billed charges to costs for purposes of estimating cost outlier payments. As we explained in the September 1, 1993 final rule (58 FR 46347), prior to FY 1994, we used a charge inflation factor to adjust charges to costs; beginning with FY 1994, we are currently using a cost inflation factor to estimate costs. In other words, instead of inflating the FY 1993 charge data by a charge inflation factor for 2 years in order to estimate FY 1995 charge data and then applying the cost-to-charge ratio, we adjust the charges by the cost-to-charge ratio and then inflate the estimated costs for 2 years of cost inflation. In this manner, we will be automatically adjusting for any changes in the cost-to-charge ratios that may occur, since the relevant variable is the costs estimated for a given case.

In setting the proposed FY 1995 outlier thresholds, we used a cost inflation factor of 1.04735. This is the average increase in cost per case between PPS–7 (data from cost reporting

periods beginning in FY 1990) and PPS–9 (data from cost reporting periods beginning in FY 1992), for a matched set of hospitals. We made an audit adjustment for any cost report that had not been settled, based on the average ratio between submitted and final cost report data. This adjustment was made separately for Medicare inpatient capital costs and Medicare inpatient operating costs. We used the actual settlement ratio for PPS–7 (data from cost reporting periods beginning in FY 1990), since most cost reports for that period had been settled. We also used the settlement ratio from PPS–7 for the PPS–8 cost reports, since the PPS–8 settlement ratio currently available is based on many fewer hospitals (approximately 37 percent, as opposed to 92 percent for PPS–7).

When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We estimate the proposed thresholds for FY 1995 would result in outlier payments equal to 5.1 percent of operating DRG payments and 6.3 percent of capital payments based on the Federal rate.

As stated in the September 1, 1993 final rule (58 FR 46348), we have established outlier thresholds that would be applicable to both inpatient operating costs and inpatient capital-related costs. As explained earlier, we will apply a reduction of approximately 5.1 percent to the FY 1995 standardized amounts to account for the proportion of PPS payments paid to outliers. The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1995 are as follows:

Operating standardized amounts	Capital federal rate
0.948772	0.9372

We would apply the proposed outlier adjustment factors after removing the effects of the FY 1994 outlier adjustment factors on the standardized amounts and the capital Federal rate.

ii. Other Changes Concerning Outliers. Table 5 of section V of this addendum contains the DRG relative weights, geometric and arithmetic mean lengths of stay, as well as the day outlier threshold for each DRG. 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, because no arithmetic mean length of stay was calculated based on the original data.

Table 8a in section V of this addendum 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. These Statewide average ratios would replace the ratios published in the September 1, 1993 final rule (58 FR 46439), effective October 1, 1994. Table 8b contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.279 or greater than 1.314 and capital cost-to-charge ratios lower than 0.013 or greater than 0.241. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. 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 1995.

iii. FY 1993 and FY 1994 Outlier Payments. In the May 26, 1993 proposed rule (58 FR 30271), we estimated that actual FY 1993 outlier payments would be approximately 4.5 percent of actual FY 1993 total DRG payments. We also estimated that total DRG payments for FY 1993 would be higher than estimated at the time that we set the FY 1993 outlier thresholds. Our estimates of actual outlier payments and actual total DRG payments were computed by simulating payments using actual FY 1993 bill data available at the time. Our current estimate is that actual FY 1993 outlier payments were approximately 4.1 percent of total DRG payments. At the same time, we estimate that FY 1993 total DRG payments per case were 1.6 percent higher than we estimated when we set the FY 1993 outlier thresholds (1.9 percent higher if indirect teaching and disproportionate share payments are included). These estimates are based on simulations using the January 1994 update of the provider-specific file and the December 31, 1993 update of the MedPAR file.

In our June 4, 1992 proposed rule (57 FR 23645), we discussed several factors that could explain the difference between estimated outlier payments and actual outlier payments, relative to total DRG payments. With regard to FY 1993 outlier payments, we note that the percentage increase in the Medicare case-mix index was 0.8 percent between FY 1992 and FY 1993, which was a lower rate of increase than for prior years. Although the case-mix index is not a factor in setting the outlier thresholds, lower growth in FY 1993 indicates that the average severity of a Medicare case increased less in FY 1993 than in prior years.

We also believe that use of a charge inflation factor in setting the FY 1993 outlier thresholds may account for some of the difference. As we explained in our June 4, 1992 proposed rule, charges have historically grown faster than costs. In setting thresholds for FY 1993, we used the most recently available Medicare data, but that data contained 2-year old cost-to-charge ratios. Thus, the cost-to-charge ratios used to set the FY 1993 outlier thresholds are higher than those used to determine payments. Consequently, actual FY 1993 outlier payments as a percent of actual total DRG payments may be lower than we estimated when setting outlier thresholds.

To address this problem in FY 1994, we began using a cost inflation factor rather than a charge inflation factor to update billed charges for purposes of estimating outlier payments. We believed that this refinement would improve our estimation methodology.

In the September 1, 1993 final rule, we set the outlier thresholds so that estimated operating outlier payments were equal to 5.1 percent of estimated total estimated operating prospective payments. We currently estimate that FY 1994 outlier payments will be 4.0 percent of total DRG payments. This figure is based on a computer simulation of payments in FY 1994 using FY 1993 bill data.

We believe that actual outlier payments as a percentage of actual total DRG payments may be lower than estimated because actual hospital costs may be lower than reflected in the estimation methodology. Our most recent data on hospital costs show a significant trend in declining rates of increase. Thus, the cost inflation factor of 8.3 percent used to estimate FY 1994 outlier payments (based on the best available data) appears to have been overstated. Based on more recent data, we are using a cost inflation factor of 4.7 percent to set outlier payments for FY 1995. Also, although we estimate that FY 1994 outlier payments will approximate 4.0 percent of total DRG payments, we note that the estimate of the market basket rate of increase used to set the FY 1994 rates was 4.3

percentage points, while the latest FY 1994 market basket rate of increase forecast is 2.8 percent. Thus, the net effect is that hospitals are receiving higher FY 1994 payments than would have been established based on a more recent forecast of the market basket rate of increase.

B. Adjustments for Area Wage Levels and Cost of Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that would be made by the intermediaries in determining the prospective payment rates as described in this addendum. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Tables 1a, 1b, and 1c, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) 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 multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 4e of this addendum.

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 1995, 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. If the Office of Personnel Management releases revised cost-of-living adjustment factors before August 1, 1994, we will publish them in the final rule and use them in determining FY 1995 payments.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II of the preamble, 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. The intermediary makes an adjustment to the prospective payment rate by multiplying the standardized amount by the relative weight for the DRG to which the discharge is assigned.

Table 5 of section V of this addendum contains the relative weights that we propose to use for discharges occurring in FY 1995. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 1995

General Formula for Calculation of Prospective Payment Rates for FY 1995

Prospective payment rate for all hospitals located outside Puerto Rico except sole community hospitals=Federal rate.

Prospective payment rate for sole community hospitals=Whichever of the following 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, 1994 and before October 1, 1995, except for sole community hospitals and hospitals in Puerto Rico, the hospital's rate is comprised exclusively of the Federal national rate.

The Federal rates are determined as follows:

Step 1—Select the appropriate national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban or other (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 relative weight corresponding to the appropriate DRG (see Table 5, section V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals)

Sections 1886(d)(5)(D)(i) and (b)(3)(C) of the Act provide that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, 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.

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 1995. We are proposing to increase the hospital-specific rates by 1.4 percent (the hospital market basket percentage increase minus 2.2 percentage points) for sole community hospitals located in all areas in FY 1995. Section 1886(b)(3)(C)(ii) of the Act, as amended by Public Law 103-66, 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 FY 1995, is the market basket rate of increase minus 2.2 percentage points. Prior to FY 1994, the update to the hospital specific rates was

applied according to a hospital's cost reporting period. However, beginning with FY 1994, the update to the hospital specific rate is applied on a Federal fiscal year basis under amended section 1886(b)(3)(C)(ii). Section 1886(b)(3)(C)(ii) required us to apply the FY 1994 update taking into account the portion of the 12-month cost reporting period beginning during FY 1993 that occurred during FY 1994. In our September 1, 1993 final rule with comment (58 FR 46308), we described a methodology for calculating a "deemed FY 1993" update which affected payment rates in FY 1994. Based on public comments, we have revised our interpretion of section 1886(b)(3)(C)(ii) and decided to prorate the FY 1994 applicable update based on the number of months after the end of a hospital's cost reporting period that occurred in FY 1994. This revision was outlined in a separate final rule.

b. Calculation of Hospital-Specific Rate. For sole community hospitals, the applicable FY 1995 hospital-specific rate would be calculated by multiplying a hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (that is, 2.4 percent), which equals the average update for all prospective system hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, .997647) as discussed in section II.A.4.b. of this addendum. This resulting rate would be used in determining under which rate a sole community hospital is paid for its discharges beginning on or after October 1, 1994, 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, 1994 and Before October 1, 1995

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 or other 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 4 by the appropriate DRG relative weight (see Table 5, section V of the addendum).

b. National Rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section 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 appropriate DRG relative weight (see Table 5, section V of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1995

The prospective payment system for hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, hospital inpatient capital-related costs are paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of the historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352 of the regulations. Below we discuss the factors that we propose to use to determine the Federal rate and the hospital-specific rate for FY 1995. The proposed rates would be effective for discharges occurring on or after October 1, 1994.

We computed the FY 1992 standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992 we updated the standard Federal rate 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, and § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the estimated aggregate payments after any changes resulting from the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FY 1992 through FY 1995, § 412.352 requires that the Federal rate also be 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. In addition, Public Law 103–66 required that, effective for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent.

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 adjustment factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. The hospital-specific rate is updated each year after FY 1992 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 payment adjustment 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 described more fully 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 under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital. Hospitals in Puerto Rico are paid based on 75 percent of the Puerto Rico rate and 25 percent of the Federal rate.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

For FY 1994, the Federal rate was $378.34. With the changes we are proposing to the factors used to establish the Federal rate, we are proposing that the FY 1995 Federal rate would be $353.87.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 1994 Federal rate. In particular, we explain why the FY 1994 Federal rate has decreased 6.47 percent compared to the FY 1993 Federal rate. We also explain that aggregate payments under the capital proposal are estimated to increase by 2.24 percent.

The major factor contributing to the decrease in the FY 1994 rate in comparison to FY 1993 is the requirement at § 412.352 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 were approximately 92.98 percent of reasonable costs, that capital payments for FY 1993 were approximately 97.44 percent of reasonable costs, and that capital payments for FY 1994 were approximately 93.05 percent of reasonable costs. The data thus indicate that the budget neutrality adjustments for FY 1992, FY 1993, and FY 1994 were not sufficient to meet the 90 percent target and that, as a consequence, the Federal rates for both FY 1992, FY 1993, and FY 1994 were higher than they should have been. 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 available to refine the budget neutrality adjustment for subsequent years. The result is a lower budget neutrality adjustment factor for FY 1995 than FY 1994, which is the cause of the decrease in the Federal rate.

Although the Federal rate for FY 1995 is 6.47 percent lower than the FY 1994 Federal rate, we estimate that total capital payments per case will increase 2.24 percent in FY 1995. The increase in total payments per case is due to the increase in the budget neutrality target to equal 90 percent of estimated FY 1994 capital costs per case. Since section 1886(g)(1)(A) of the Act requires that estimated payments equal 90 percent of estimated reasonable costs for capital-related expenses, payments under the capital prospective payment system can be expected to increase as capital costs per case increase. The increase in payments per case from FY 1994 to FY 1995 (2.24 percent) is less than the total estimated increase in capital costs per case between FY 1994 and FY 1995 (5.70 percent) because estimated FY 1994 payments were 3.39 percent higher than the FY 1994 budget neutrality target. As a result, payments must increase less than the full increase in costs to prevent estimated payments for FY 1995 from exceeding 90 percent of reasonable cost. Specifically, the increase in payments from FY 1994 to FY 1995 is determined by dividing the increase in cost per case by the excess of FY 1994 payments over the budget neutrality target (that is, 1.0570/1.0339 = 1.0224, an increase of 2.24 percent). We discuss the determination of the budget neutrality target in section III.A.3 below.

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 percent change in the Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

1. Standard Federal Rate Update

Section 412.308(c)(1)(i) provides that for FY 1993 through FY 1995, the standard Federal rate is updated on the basis of a lagged 2-year moving average of 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. For FY 1995, the increase is based on the increase in Medicare inpatient capital-related costs per case from FY 1990 through FY 1992. These are the most recent fiscal years for which cost report data are available. To determine the amount of the increase, we apportioned a hospital's costs and discharges to each fiscal year based on the number of months in the hospital's cost reporting period that occurred during the applicable fiscal year. Thus, an individual hospital may have more than one cost report included in the calculation.

We are proposing that the FY 1995 update factor for the Federal rate be 2.22 percent. The following chart, based on the December 1993 update of HCRIS, shows how this figure was computed:

CAPITAL COSTS PER CASE INCREASE FROM COST REPORT DATA

Fiscal year	No. hospitals 1st HCR	No. hospitals 2nd HCR [1]	Unadj. capital cost per case	Increase in cost per case (unadj.) (percent)	Audit adjusted capital cost per case [2]	Increase in adjusted cost per case (percent)	Average 2-year increase in adjusted cost per case (percent)	Observed CMI (percent)	CMI adjusted increase (percent)	Update (average 2-year increase of CMI adjusted rate of increase) (percent)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1990	4251	5412	$543.27	.....	$540.05	.....	.....	.....	.....	.....
1991	4171	5323	584.69	7.62	567.92	5.16	.....	2.52	2.57	.....

CAPITAL COSTS PER CASE INCREASE FROM COST REPORT DATA—Continued

Fiscal year	No. hospitals 1st HCR	No. hospitals 2nd HCR [1]	Unadj. capital cost per case	Increase in cost per case (unadj.) (percent)	Audit adjusted capital cost per case [2]	Increase in adjusted cost per case (percent)	Average 2-year increase in adjusted cost per case (percent)	Observed CMI (percent)	CMI adjusted increase (percent)	Update (average 2-year increase of CMI adjusted rate of increase) (percent)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1992	4098	4733	633.80	8.40	587.53	3.45	4.30	1.55	1.87	2.22

[1] Columns 1 and 2 represent the numbers of hospital cost reports used in developing capital costs per case figures in column 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 capital costs per case, adjusted for the anticipated effects of cost report audits and reopenings, from the December 1993 update of HCRIS. For settled cost reports, and audit adjustment factor of 1.0043 was used in each fiscal year for adjusting capital costs per case figures from column 3 for the effects of audits and reopenings. For as-submitted cost reports, the adjustment factors were as follows: FY 1990—0.9256, FY 1991—0.9172, FY 1992—0.9250.

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

For the final rule, we will recalculate the FY 1995 update factor on the basis of the June 1994 update of HCRIS.

We note that the effect of the update on the Federal rate is limited by the requirement of budget neutrality until FY 1996. Thus, although the update factor for inflation is 2.22 percent, the FY 1995 Federal rate is lower than the FY 1994 Federal rate because of the effects of the budget neutrality adjustment. We also note that the FY 1995 budget neutrality target is determined by the estimate of FY 1995 capital costs, not by the 2-year average update factor applied to the FY 1995 Federal rate. We further discuss the basis for the budget neutrality target in section III.A.4 below.

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, 40 percent for cost reporting periods beginning in FY 1995 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 estimated outlier payments are 5.1 percent of estimated inpatient operating 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 all hospitals were paid according to 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model all hospitals as if paid 100 percent of the Federal rate 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.

In the September 1, 1993 final rule, we estimated that outlier payments for FY 1994 would equal 5.46 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9454 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d of the addendum, we estimate that outlier payments will equal 6.28 percent of inpatient capital-related payments based on the Federal rate in FY 1995. We are therefore proposing an outlier adjustment factor of 0.9372 to the Federal rate. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We believe the increase in capital-related outlier payments for FY 1995 results from a combination of the lower proposed capital standard payment amount and the change to a fixed loss threshold for cost outlier payments. As a result, estimated capital outlier payments for FY 1995 represent a higher percentage of total capital standard payments than in FY 1994.

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 1995 is .9913 (.9372/.9454). Thus, the proposed outlier adjustment would reduce the FY 1995 Federal rate by 0.87 percent (.9913–1) compared with the FY 1994 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Weights 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 the Federal rate after any changes resulting from the annual reclassification and recalibration of the DRG weights and changes in the geographic adjustment factor equal estimated aggregate payments that would have been made on the basis of the Federal rate without such changes. We used the actuarial model described in Appendix B to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and

weights and in the geographic adjustment factor. We also used the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then used these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the geographic adjustment factor.

For FY 1994, we calculated a GAF/DRG budget neutrality factor of 1.0053. In this proposed rule, we are applying a factor of 1.00115. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that aggregate payments each year be no more than it is estimated that they would have been in the absence of the changes from the annual DRG reclassification and recalibration and in the geographic adjustment factor. The incremental change in the adjustment from FY 1994 to FY 1995 is 1.00115.

We note that this factor accounts for DRG reclassifications and recalibration and changes in the geographic adjustment factor. It also incorporates the effects on the geographic adjustment factor of FY 1995 geographic reclassification decisions made by the MGCRB compared to FY 1994 decisions. However, it does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors or in the large urban add-on.

4. Budget Neutrality Adjustment Factor to Assure Aggregate Payments Equal 90 Percent of Reasonable Cost Payments

Section 1886(g)(1)(A) of the Act requires that aggregate payments made each year in FY 1992 through FY 1995 for hospital inpatient services be reduced in a manner that results in payments equal to 90 percent of the amount the Secretary estimates would have been payable on a reasonable cost basis for inpatient capital-related costs in that year. No retroactive increase or decrease is made if aggregate payments are greater than or less than 90 percent of actual Medicare inpatient capital-related costs for that year.

Section 412.352 of the regulations provides that HCFA determines an adjustment to the hospital-specific rate and the Federal rate proportionately, so that the estimated payments for capital in each year from FY 1992 through FY 1995 will equal 90 percent of what would have been payable that year on a reasonable cost basis. The effect of this provision is that the reduction required under section 1886(g)(1)(A) of the Act is realized entirely through a reduction in the prospective payments for capital costs (that is, no reduction is made for this purpose in the reasonable cost payments for old capital) in FY 1992 through FY 1995.

For FY 1994, we determined that a budget neutrality factor of 0.8947 was required so that estimated aggregate payments for inpatient capital-related costs would equal 90 percent of what would have been payable on a reasonable cost basis in that year. For FY 1995, we are proposing a budget neutrality factor of 0.7986.

As we explain in Appendix B, we determine the budget neutrality adjustment factor on the basis of a projected FY 1995 capital costs per case budget neutrality target. We develop this target from available data on average Medicare capital costs per case for all short-term acute care hospitals subject to the capital prospective payment system (that is, data from excluded and waiver hospitals were eliminated). For the FY 1995 proposed rule, we have actual data for FY 1992 from the December 1993 HCRIS update. We also have revised estimates of the rates of increase in Medicare capital costs per case for the years FY 1993 through FY 1995.

At the time of the final rule for FY 1994, we had estimated that there would be a 30.53 percent increase in Medicare inpatient capital cost per case between FY 1992 and FY 1995. In this proposed rule for FY 1995, we estimate that there will be a 12.83 percent increase in Medicare inpatient capital cost per case between FY 1992 and FY 1994, a decline of 13.56 percent (1.1283/1.3053=.8644, or −13.56 percent) in the estimated rate of increase since the final rule for FY 1995. The following chart shows how the rate-of-increase estimates for FY 1992 through FY 1995 were calculated in the final rule for FY 1994 and in this proposed rule for FY 1995.

COMPARISON OF FACTORS FOR MEDICARE INPATIENT CAPITAL COST PER CASE INCREASES—FY 1994 FINAL RULE (FR) AND FY 1995 PROPOSED RULE (PR)

[In percentages]

Estimate for FY	Total inpatient capital (1)			Medicare share (2)			Medicare inpatient capital (1)×(2)=(3)			Medicare enrollment			Admissions incidence			Medicare admissions (4)×(5)=(6)			Estimated increases in medicare inpatient capital cost per case (3)/(6)=(7)		
	FY94 FR	FY95 PR	Change	FY94 FR	FY95 PR	Change	FY94 FR	FY95 PR	Change	FY94 FR	FY95 PR	Change	FY94 FR	FY95 PR	Change	FY94 FR	FY95 PR	Change	FY94 FR	FY95 PR	Change
1993	8.00	5.23	−2.56	3.30	0.52	−2.69	11.56	5.77	−5.19	2.03	2.67	0.63	1.02	1.00	−0.02	3.07	3.70	0.61	8.24	2.00	−5.77
1994	9.00	7.00	−1.83	3.60	1.00	−2.51	12.92	8.07	−4.30	2.11	2.13	0.02	1.03	1.11	0.08	3.16	3.26	0.10	9.46	4.65	−4.39
1995	10.00	8.00	−1.82	3.50	1.00	−2.42	13.85	9.08	−4.19	2.04	1.83	−0.21	−1.27	1.34	0.07	3.34	3.19	−0.14	10.17	5.70	−4.06

The chart shows the causes of the decline in the rate-of-increase projections since the final rule for FY 1994. As the chart shows, the decline in the rate of increase projections is due almost entirely to a decline in the rate of increase projections for Medicare inpatient capital. (As the chart also shows, the rate of increase projections for Medicare enrollment, Medicare admissions incidence, and Medicare admissions, have changed only marginally.) In turn, the decline in the rate of increase projections for Medicare inpatient capital is the result of declines in the rate of increase projections for total inpatient capital and Medicare share. For FY 1993, the panel survey data that we use to develop the projected rate of increase for total inpatient capital shows a decline in actual interest payments compared to FY 1992. We believe that this decline in interest payments is due to refinancing of debt instruments by hospitals to take advantage of lower interest rates. For FY 1994 and FY 1995, we are projecting that total inpatient capital cost increases will return to the level at which increases for depreciation costs alone have been running (i.e., 7–8 percent) as the number of refinancings declines. The projection of the rate of increase in Medicare share for FY 1993 is similarly grounded in panel survey data. The panel survey data for that year show that, contrary to our previous assumption, Medicare day share has not been increasing in proportion to the increase in Medicare admissions. We have accordingly reduced the FY 1994 and FY 1995 rate of increase projections

for Medicare share to account for that fact.

In addition to the decline in the rate of increase estimates since the FY 1994 final rule, there has been a slight (−0.54 percent) decrease in the FY 1992 cost per case in the December 1993 HCRIS data, compared to the June 1993 HCRIS data that we used for FY 1994. The following chart shows the combined effect of the reduced rates of increase estimates and the reduced FY 1992 cost per case by comparing the projections from FY 1992 to FY 1995 at the time of the FY 1994 final rule and in this proposed rule.

EFFECT OF REVISED RATE OF INCREASE ESTIMATES ON CALCULATION OF FISCAL YEAR 1995 BUDGET NEUTRALITY TARGET

	Capital cost per case	Percent change in rate of increase	Percent change in capital cost per case
Fiscal year 1992 cost per case:			
Final FY 94: 6/93 HCRIS	[1] $594.09	N/A	−.054
Proposed FY 95: 3/94 HCRIS	[2] 590.87	.....	.....
Fiscal year 1993 adjusted cost:			
Final FY 94: 8.24%	643.05	−5.77	−6.27
Proposed FY 95: 2.00%	602.72	.....	.....
Fiscal year 1994 adjusted cost:			
Final FY 94: 9.45%	703.85	−4.39	−10.38
Proposed FY 95: 4.65%	630.78	.....	.....
Fiscal year 1995 adjusted cost:			
Final FY 94: 10.17%	775.43	−4.06	−14.01
Proposed FY 95: 5.70%	666.75	.....	.....
Cumulative	.....	−13.56.	

[1] Fiscal year 1992 cost per case based on June 1993 HCRIS data, audit-adjusted, excluding waiver hospitals and PPS-excluded hospitals.
[2] Fiscal year 1992 cost per case based on December 1993 HCRIS data, audit-adjusted, excluding waiver hospitals and PPS-excluded hospitals.

The chart shows that the cumulative effect of the revised rates of increase is to lower the FY 1994 budget neutrality target by 13.56 percent. Together with the 0.54 percent decline due to updated HCRIS data, this accounts for the 14.01 percent reduction in the FY 1995 capital cost per case budget neutrality target compared to the level estimated at the time of the FY 1994 final rule.

For FY 1994, we employed a budget neutrality factor of 0.8947 to realize the 90 percent target. In this proposed rule for FY 1995, the budget neutrality adjustment factor is 0.7986. The budget neutrality factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. The net adjustment to the FY 1994 Federal rate would therefore be .7986/.8947 or 0.8926. For the final rule, we will recalculate the budget neutrality factor on the basis of the most recent data available.

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 1994, we estimated that exceptions payments would equal 5.15 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9485 (1−.0515) in determining the Federal rate. For FY 1995, we estimate that exceptions payments will equal 2.03 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we propose to apply an exceptions reduction factor of 0.9797 (1−.0203) to determine the FY 1995 Federal rate.

The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. The net adjustment to the FY 1995 Federal rate is therefore .9797/.9485, or 1.0329. The proposed exceptions reduction factor for FY 1995 is thus 3.29 percent higher than the factor for FY 1994.

6. Standard Federal Rate for FY 1995

For FY 1994, the Federal rate was $378.34. With the changes we are proposing to the factors used to establish the Federal rate, the FY 1995 Federal rate would be $353.87. The proposed changes are as follows:

- The FY 1995 update factor would be 1.0222.
- The FY 1995 outlier adjustment factor would be 0.9372.
- The FY 1995 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the geographic adjustment factor would be 1.00115.
- The FY 1995 budget neutrality adjustment factor that is applied to the standard Federal payment rate and the hospital-specific rate to assure that aggregate payments equal 90 percent of payments that would have been made on a reasonable cost basis would be 0.7986.
- The FY 1995 exceptions payments adjustment factor would be 0.9797.

Since the Federal rate has already been adjusted for differences in case mix, wages, cost of living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we propose to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factors for changes in the DRG relative weights and the geographic adjustment factor.

We are providing a chart that shows how each of the factors and adjustments for FY 1995 affected the computation of

the proposed FY 1995 Federal rate in comparison to the FY 1994 Federal rate. The FY 1995 update factor has the effect of increasing the Federal rate 2.22 percent compared to the rate in FY 1994, while the geographic and DRG budget neutrality factor has the effect of increasing the Federal rate by 0.12 percent. The FY 1995 exceptions reduction factor has the effect of increasing the Federal rate by 3.29 percent compared to the exceptions reduction for FY 1994. The proposed FY 1995 budget neutrality adjustment factor has the effect of reducing the final FY 1994 rate by 10.74 percent compared to the budget neutrality reduction in FY 1994. The combined effect of all the proposed changes is to decrease the proposed Federal rate by 6.47 percent compared to the Federal rate for FY 1994.

COMPARISON OF FACTORS AND ADJUSTMENTS—FISCAL YEAR 1994 FEDERAL RATE AND PROPOSED FISCAL YEAR 1995 FEDERAL RATE

		Change	Percent Change
Update factor [1]:			
Fiscal year 1994:	1.0304		
Proposed Fiscal year 1995:	1.0222	1.0222	2.22
GAF/DRG adjustment factor [1]:			
Fiscal year 1994:	1.0053		
Proposed Fiscal year 1995:	1.00115	1.00115	0.12
Outlier adjustment factor [2]:			
Fiscal year 1994:	0.9454		
Proposed Fiscal year 1995:	0.9372	0.9913	−0.87
Exceptions adjustment factor:			
Fiscal year 19942:	0.9485		
Proposed Fiscal year 1995:	0.9797	1.0329	3.29
Budget neutrality adjustment factor [2]:			
Fiscal year 1994:	0.8947		
Proposed Fiscal year 1995:	0.7986	0.8926	−10.74
Federal rate:			
Fiscal year 1994:	$378.34		
Proposed Fiscal year 1995:	353.87	0.9353	−6.47

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 1994 to FY 1995 resulting from the application of the 1.00115 GAF/DRG budget neutrality factor for FY 1995 is 1.00115.

[2] The outlier reduction factor, the exceptions reduction factor, and the budget neutrality factor to assure that payments do not exceed 90 percent of what it is estimated would have been paid on the basis of reasonable cost are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 1995 exceptions reduction factor is 0.9797/0.9485, or 1.0329.

We have refined our proposed budget neutrality and exceptions reduction factors for FY 1995 on the basis of the best available data. We have not retroactively adjusted the Federal rate for FY 1994 in determining the rate for FY 1995.

7. Special Rate for Puerto Rico Hospitals

For FY 1994, the special rate for Puerto Rico hospitals was $291.03. With the changes we are proposing to the factors used to determine the rate, we are proposing that the FY 1995 special rate for Puerto Rico will be $272.20.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1995 be determined by adjusting the FY 1994 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 1995, we are proposing that the hospital-specific rate be updated by a factor of 1.0222.

2. Exceptions Payment Adjustment Factor

For FY 1992 through FY 2001, the updated hospital-specific rate is multiplied 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 1995, we estimate that exceptions payments will be 2.03 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore propose that the updated hospital-specific rate be reduced by a factor of 0.9797. 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 1995 hospital-specific rate is therefore .9797/.9485, or 1.0329.

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, 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 1995, we are proposing a budget neutrality factor of 0.7986. 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 1995 hospital-specific rate is therefore .7986/.8947, or 0.8926.

4. Net Change to Hospital-Specific Rate

We are providing a chart below to show the proposed net change to the hospital-specific rate. The chart shows the factors for FY 1994 and FY 1995 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1994 to FY 1995 is 0.9424, which represents a decrease of 5.76 percent to

the hospital-specific rate. The proposed FY 1995 hospital-specific rate for each hospital is determined by multiplying the FY 1994 hospital-specific rate by the cumulative net adjustment of 0.9424.

PROPOSED FISCAL YEAR 1995 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update factor:			
Fiscal year 94	1.0304	.....	.....
Proposed fiscal year 95	1.0222	1.0222	2.22
Exceptions payment adjustment factor:			
Fiscal year 94	0.9485	.....	.....
Proposed fiscal year 95	0.9797	1.0329	3.29
Budget neutrality factor:			
Fiscal year 94	0.8947	.....	.....
Proposed fiscal year 95	0.7986	0.8926	−10.74
Cumulative adjustments:			
Fiscal year 94	0.8744	.....	.....
Proposed fiscal year 95	0.8241	0.9424	−5.76

Note: The update factor for the hospital-specific rate is applied cumulatively in determining the rates. Thus, the incremental increase in the update factor from fiscal year 1994 to fiscal year 1995 is 1.0222. In contrast, the exceptions payment adjustment factor and the budget neutrality factor are not applied cumulatively. Thus, for example, the incremental increase in the budget neutrality factor from fiscal year 1994 to fiscal year 1995 is .7986/.8947, or .8926.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1995

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, when 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) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (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, 1994 (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 for the remainder of 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 1995 are 40 percent of the adjusted Federal rate and 60 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 40 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1995. Thus, a fully prospective hospital will receive 40 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1995. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100

percent of the Federal rate is included in the hospital's outlier payments.

The proposed rules to establish outlier thresholds for FY 1995 are published in section II.A.4.c of the Addendum to this proposed rule. For FY 1995 we are proposing that a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $23,300. We are also proposing that a case qualifies as a day outlier for FY 1995 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 22 days.

During the capital prospective payment system transition period, any hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The minimum payment levels for portions of cost reporting periods occurring in FY 1995 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 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

IV. Proposed Rate-of-Increase 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 rate-of-increase percentages (update factors). The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Effective with cost reporting periods beginning on or after October 1, 1991, a hospital that has Medicare inpatient operating costs in excess of its ceiling is paid its ceiling plus 50 percent of its costs in excess of the ceiling. Total payment may not exceed 110 percent of the ceiling. A hospital that has inpatient operating costs less than its ceiling will continue to be paid its costs plus the lower of—

- Fifty percent of the difference between the inpatient operating costs and the ceiling; or
- Five percent of the ceiling.

Each hospital's target amount is adjusted annually, at the beginning of its cost reporting period, by an applicable rate-of-increase percentage. For cost reporting periods beginning on or after October 1, 1993 and before October 1, 1994, section 1886(b)(3)(B) of the Act provides that the applicable rate-of-increase percentage is the market basket percentage increase minus the lesser of one percentage point or the percentage point difference between 10 percent and the hospital's "update adjustment percentage" except for hospitals with an "update adjustment percentage" of at least 10 percent. The rate-of-increase percentage for hospitals in the latter case will be the market basket percentage increase. The "update adjustment percentage" is the percentage by which a hospital's allowable inpatient operation costs exceeds the hospital's ceiling for the cost reporting period beginning in Federal fiscal year 1990. For cost reporting periods beginning on or after October 1, 1994 and before October 1, 1997, the update adjustment percentage is the update adjustment percentage from the previous year plus the previous year's applicable reduction. The applicable reduction and applicable percentage are then determined in the same manner as for FY 1994. The most recent forecasted market basket increase for FY 1995 for hospitals and hospital units excluded from the prospective payment system is 3.7 percent.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 1d, 3C, 4a, 4b, 4c, 4d, 4e, 5, 6a, 6b, 6c, 6d, 6e, 6f, 6g, 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 1993 and Hospital Average Hourly Wage for Federal Fiscal Year 1995 Wage Index
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, and Length of Stay Outlier Cutoff Points Used in the Prospective Payment System
Table 6a—New Diagnosis Codes
Table 6b—New Procedure Codes
Table 6c—Invalid Diagnosis Codes
Table 6d—Revised Diagnosis Code Titles
Table 6e—Revised Procedure Code Titles
Table 6f—Additions to the CC Exclusions List
Table 6g—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 93 MEDPAR Update 12/93 GROUPER V11.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 93 MEDPAR Update 12/93 GROUPER V12.0
Table 8a—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) April 1994
Table 8b—Statewide Average Capital Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) April 1994
Table 9—1993 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 areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,707.19	$1,084.39	$2,664.33	$1,067.23

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)	2,838.28	1,136.90	2,793.33	1,118.90	2,793.33	1,118.90
2. Middle Atlantic (PA, NJ, NY)	2,590.32	1,037.58	2,549.32	1,021.16	2,549.32	1,021.16
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,652.11	1,062.33	2,610.13	1,045.51	2,610.13	1,045.51
4. East North Central (IL, IN, MI OH, WI)	2,889.93	1,157.60	2,844.18	1,139.26	2,844.18	1,139.26
5. East South Central (AL, KY, MS, TN)	2,506.18	1,003.88	2,466.50	987.98	2,466.50	987.98
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	2,708.96	1,085.10	2,666.07	1,067.92	2,666.07	1,067.92
7. West South Central (AR, LA, OK, TX)	2,636.66	1,056.14	2,594.92	1,039.42	2,594.92	1,039.42
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,619.72	1,049.35	2,578.25	1,032.74	2,578.25	1,032.74
9. Pacific (AK, CA, HI, OR, WA)	2,678.36	1,072.84	2,635.96	1,055.86	2,635.96	1,055.86

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large Urban Areas		Other Areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
National	$2,680.76	$1,073.81	$2,680.76	$1,073.81
Puerto Rico	2,415.12	502.29	2,376.88	494.33

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	RATE
National	$353.87
Puerto Rico	$272.20

Table 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1993; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1995 WAGE INDEX

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
010001	01.3420	15.05	010095	01.0740	09.76	020027	00.9447	.....	030095	01.1907	.....	040091	01.3688	19.00
010004	01.0476	10.14	010096	01.0307	.....	030001	01.3709	18.78	040001	01.1219	11.01	040093	00.9667	10.76
010005	01.1175	13.17	010097	00.9013	11.13	030002	01.7652	19.83	040002	01.1970	13.30	040095	00.8495	10.35
010006	01.3879	13.78	010098	00.9474	12.29	030003	01.3771	19.56	040003	00.9783	12.33	040100	01.1202	13.79
010007	01.0771	11.93	010099	01.0412	11.87	030004	01.0291	11.84	040004	01.2751	15.36	040105	01.0229	11.32
010008	00.9887	09.72	010100	01.2293	13.10	030006	01.5829	16.65	040005	00.9361	10.85	040106	01.1842	09.69
010009	01.0696	14.73	010101	01.0924	13.51	030007	01.2297	14.86	040007	01.6608	16.45	040107	01.1705	15.19
010010	01.1143	11.37	010102	00.8939	11.19	030008	01.9721	19.55	040008	01.0900	10.26	040109	01.0816	11.14

Table 3C.—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1993; Hospital Average Hourly Wage for Federal Fiscal Year 1995 Wage Index—Continued

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
010011	01.4690	17.34	010103	01.6296	14.09	030009	01.2268	14.70	040010	01.2161	12.51	040114	01.7750	15.03
010012	01.3013	13.75	010104	01.5973	14.71	030010	01.3951	17.87	040011	00.9919	10.61	040116	01.3746	17.22
010015	01.0334	12.39	010108	01.2484	12.94	030011	01.4456	18.72	040013	00.9019	10.97	040118	01.1411	12.62
010016	01.1878	12.69	010109	01.0713	12.62	030012	01.2298	15.25	040014	01.2065	14.27	040119	01.1532	12.83
010018	00.8714	14.94	010110	00.9980	10.56	030013	01.2248	16.12	040015	01.1017	11.30	040124	01.1956	12.65
010019	01.2433	12.48	010112	01.1608	12.89	030014	01.4715	18.10	040016	01.6758	14.44	040126	00.9911	10.09
010021	01.2801	13.82	010113	01.6215	12.67	030016	01.3387	21.17	040017	01.3327	11.19	050002	01.3608	24.36
010022	00.9846	14.35	010114	01.2590	14.30	030017	01.4178	16.52	040018	01.2814	15.40	050006	01.3545	16.51
010023	01.3947	14.63	010115	00.8736	13.94	030018	01.7499	19.61	040019	01.1968	11.70	050007	01.5316	24.12
010024	01.3212	14.19	010117	00.9040	17.92	030019	01.2389	19.51	040020	01.4919	12.24	050008	01.5692	24.13
010025	01.2142	11.22	010118	01.2169	14.55	030022	01.5013	17.29	040021	01.2687	13.19	050009	01.5115	22.22
010027	00.8693	12.83	010119	01.0976	14.41	030023	01.2798	15.17	040022	01.8431	12.85	050013	01.9538	21.58
010029	01.4511	13.86	010120	00.9957	13.31	030024	01.6683	18.15	040024	01.0205	10.84	050014	01.0954	19.15
010031	01.2743	12.35	010121	01.1816	12.93	030025	01.1226	13.58	040025	00.9309	10.28	050015	01.3226	20.74
010032	00.9122	13.01	010122	00.8442	.....	030027	01.1406	14.27	040026	01.5721	14.46	050016	01.1459	19.69
010033	01.9025	17.10	010123	01.2703	15.56	030030	01.6899	21.32	040027	01.3041	11.24	050017	02.0516	22.91
010034	01.0487	12.98	010124	01.2775	14.78	030033	01.2468	14.70	040028	01.0211	08.78	050018	01.3060	16.74
010035	01.1925	13.41	010125	01.0384	11.83	030034	01.1108	15.82	040029	01.1563	13.43	050019	00.8715	.....
010036	01.1288	14.33	010126	01.0658	11.19	030035	01.2902	18.75	040030	00.9032	11.23	050021	01.3029	19.57
010038	01.2377	14.62	010127	01.5502	15.59	030036	01.1810	17.67	040031	00.8130	10.74	050022	01.4834	21.23
010039	01.6339	14.65	010128	00.9523	11.41	030037	01.9369	20.11	040032	00.9855	09.75	050024	01.4206	22.43
010040	01.4400	16.28	010129	01.0844	10.44	030038	01.5192	18.07	040035	00.9250	09.29	050025	01.6169	21.40
010043	01.0178	12.49	010130	01.0868	13.73	030040	01.0077	16.22	040036	01.3628	14.75	050026	01.4947	20.53
010044	01.0350	14.66	010131	01.2385	16.21	030041	00.9257	16.66	040037	01.1689	10.55	050028	01.3246	15.49
010045	01.1157	11.53	010134	00.8763	10.46	030043	01.1903	19.23	040039	01.2340	11.05	050029	01.2621	24.70
010046	01.3949	12.45	010136	00.8956	13.02	030044	01.0476	13.44	040040	01.1168	14.85	050030	01.3462	17.25
010047	00.9809	08.62	010137	01.2463	14.66	030046	00.9874	17.75	040041	01.3478	12.64	050032	01.2648	20.61
010049	01.0941	13.78	010138	00.9621	11.08	030047	00.9435	16.97	040042	01.2495	12.86	050033	01.4525	24.11
010050	00.9541	10.19	010139	01.6340	19.91	030049	00.9657	14.22	040044	00.9053	09.86	050036	01.7641	21.61
010051	00.8938	07.25	010143	01.1684	14.49	030054	00.8935	12.19	040045	01.0369	13.67	050038	01.4514	27.19
010052	00.9459	12.78	010144	01.3170	15.09	030055	01.2526	15.39	040047	00.9986	12.83	050039	01.6270	20.18
010053	01.0696	12.36	010145	01.2440	16.15	030059	01.3014	18.17	040048	01.2044	12.62	050040	01.2672	22.53
010054	01.1993	13.64	010146	01.1200	15.02	030060	01.0476	13.68	040050	01.1348	10.29	050041	01.2871	23.30
010055	01.3844	14.09	010148	00.9561	11.17	030061	01.5819	16.15	040051	01.0615	11.86	050042	01.2658	17.72
010056	01.3818	16.34	010149	01.4268	15.65	030062	01.3433	14.98	040053	01.1476	13.70	050043	01.4999	25.99
010058	01.0025	07.49	010150	01.0421	13.50	030064	01.5451	16.64	040054	01.0561	10.02	050045	01.2470	17.59
010059	01.0580	13.64	010152	01.3659	14.13	030065	01.5203	18.30	040055	01.3698	13.50	050046	01.1624	21.80
010061	01.0054	14.30	010153	02.7788	18.16	030067	01.0966	14.05	040058	01.1385	12.39	050047	01.7578	27.86
010062	00.9869	10.43	010155	01.0043	09.32	030068	00.9690	13.73	040060	00.9459	12.62	050051	01.1101	15.76
010064	01.8446	14.55	020001	01.4478	24.33	030069	01.3048	18.16	040062	01.5107	14.60	050052	01.8867	.....
010065	01.4383	13.58	020002	00.9554	21.71	030071	00.8846	.....	040063	01.5592	14.49	050054	01.2707	17.87
010066	00.9167	08.90	020004	01.0549	23.25	030072	00.8577	.....	040064	00.9000	09.17	050055	01.2716	25.35
010068	01.2901	17.41	020005	00.8748	22.74	030073	01.1491	.....	040066	01.1047	12.97	050056	01.4274	21.51
010069	01.1443	12.42	020006	01.0673	22.50	030074	01.0145	.....	040067	01.0706	10.71	050057	01.4671	18.64
010072	01.1737	11.43	020007	00.9203	18.20	030075	00.9415	.....	040069	01.0147	11.34	050058	01.4160	21.51
010073	00.9141	08.91	020008	01.0488	24.76	030076	00.9714	.....	040070	00.9926	10.66	050060	01.4775	17.76
010078	01.2195	14.43	020009	01.0479	19.58	030077	00.9788	.....	040071	01.3838	15.71	050061	01.2809	19.57
010079	01.1299	11.88	020010	01.0530	26.51	030078	01.0573	.....	040072	01.1024	12.66	050063	01.4005	19.94
010080	00.9871	11.70	020011	01.0005	21.11	030079	00.6048	.....	040074	01.2110	13.36	050065	01.5209	22.66
010081	01.8425	16.28	020012	01.2989	22.42	030080	01.6490	18.80	040075	01.1243	10.83	050066	01.2423	22.96
010083	01.0472	15.00	020013	00.9887	28.18	030083	01.2864	19.53	040076	01.0898	12.49	050067	01.3622	21.76
010084	01.3987	16.55	020014	01.0902	23.36	030084	01.1305	.....	040077	00.9152	09.81	050068	01.0968	16.17
010085	01.2018	14.98	020017	01.3908	22.51	030085	01.4462	17.81	040078	01.2594	14.24	050069	01.6106	22.39
010086	01.0069	11.41	020018	00.9955	.....	030086	01.1425	17.91	040080	01.0441	14.19	050070	01.2341	27.81
010087	01.8189	13.54	020019	00.8069	.....	030087	01.6225	16.84	040081	00.8897	09.28	050071	01.2940	27.45
010089	01.1427	14.71	020020	00.8059	.....	030088	01.3583	17.48	040082	01.2362	14.75	050072	01.3291	27.78
010090	01.5674	15.24	020021	00.7674	.....	030089	01.4020	17.92	040084	01.0794	12.59	050073	01.2413	27.89
010091	00.9618	11.17	020024	01.0985	21.11	030092	01.4797	16.73	040085	01.2333	13.67	050074	01.1081	26.44
010092	01.3537	14.56	020025	00.9424	21.76	030093	01.3608	16.81	040088	01.3005	13.30	050075	01.3725	27.54
010094	01.1717	16.12	020026	01.3206	.....	030094	01.2937	17.50	040090	00.9091	11.44	050076	01.5761	28.16

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050077 ...	01.5888	21.33	050172 ...	01.3184	19.50	050278 ...	01.4113	20.78	050391 ...	01.3501	18.94	050503 ...	01.2838	21.76
050078 ...	01.3429	23.69	050173 ...	01.2800	21.21	050279 ...	01.2214	18.52	050392 ...	00.9938	14.75	050506 ...	01.4404	24.03
050079 ...	01.4659	29.24	050174 ...	01.6603	24.97	050280 ...	01.5529	20.37	050393 ...	01.4112	23.29	050510 ...	01.3259	27.75
050080 ...	01.3017	23.23	050175 ...	01.3332	22.08	050281 ...	01.4099	19.38	050394 ...	01.4900	19.55	050512 ...	01.3095	28.18
050081 ...	01.6255	19.94	050177 ...	01.2291	17.98	050282 ...	01.3130	21.41	050396 ...	01.5505	22.84	050515 ...	01.3002	28.20
050082 ...	01.5067	22.06	050179 ...	01.2486	17.01	050283 ...	01.2409	25.87	050397 ...	01.0685	18.46	050516 ...	01.6453	22.41
050084 ...	01.5688	21.41	050180 ...	01.5089	28.43	050286 ...	00.9236	20.24	050401 ...	01.2124	16.24	050517 ...	01.2752	19.39
050088 ...	01.1161	22.27	050181 ...	01.2434	22.67	050289 ...	01.7583	25.03	050404 ...	01.2031	15.52	050522 ...	01.3951	25.98
050089 ...	01.3890	17.98	050183 ...	01.2199	18.72	050290 ...	01.6125	24.11	050408 ...	01.1134	14.52	050523 ...	01.2343	24.38
050090 ...	01.2810	20.35	050186 ...	01.5126	22.72	050291 ...	01.2418	22.82	050407 ...	01.2727	22.69	050526 ...	01.3692	23.17
050091 ...	01.2021	24.16	050188 ...	01.4071	23.46	050292 ...	01.0899	20.59	050410 ...	01.0230	24.20	050528 ...	01.2460	15.17
050092 ...	00.9137	17.43	050189 ...	00.9779	19.77	050293 ...	01.1454	19.45	050411 ...	01.3083	27.43	050531 ...	01.3634	20.08
050093 ...	01.5318	19.94	050191 ...	01.4374	22.19	050295 ...	01.4479	19.53	050414 ...	01.2959	24.31	050534 ...	01.4949	22.13
050095 ...	01.2160	29.20	050192 ...	01.2147	18.02	050296 ...	01.2165	23.31	050417 ...	01.2310	14.24	050535 ...	01.3594	22.44
050096 ...	01.2536	20.89	050193 ...	01.3657	20.72	050298 ...	01.1893	18.06	050418 ...	01.3350	22.55	050537 ...	01.3233	20.44
050097 ...	01.4638	16.38	050194 ...	01.2171	23.28	050299 ...	01.2957	22.08	050419 ...	01.3458	16.62	050539 ...	01.1707	21.36
050099 ...	01.5707	21.78	050195 ...	01.5808	28.26	050300 ...	01.3000	17.35	050420 ...	01.4446	21.82	050541 ...	01.5404	27.82
050100 ...	01.8059	23.83	050196 ...	01.3418	17.36	050301 ...	01.3553	16.92	050421 ...	01.4212	22.08	050542 ...	01.1191	13.71
050101 ...	01.3948	22.78	050197 ...	01.9405	25.14	050302 ...	01.3664	23.01	050423 ...	00.9847	16.65	050543 ...	00.9021	21.03
050102 ...	01.3802	19.71	050199 ...	01.3409	18.65	050305 ...	01.5587	27.33	050424 ...	01.7253	.....	050545 ...	00.8636	20.90
050103 ...	01.6487	19.35	050204 ...	01.3590	21.05	050307 ...	01.4328	16.76	050425 ...	01.2768	25.74	050546 ...	00.8588	21.22
050104 ...	01.3975	20.54	050205 ...	01.3860	17.92	050308 ...	01.5305	30.21	050426 ...	01.3363	22.67	050547 ...	00.9978	22.15
050107 ...	01.2997	19.86	050207 ...	01.2834	18.15	050309 ...	01.3553	17.39	050427 ...	00.8642	21.11	050549 ...	01.7500	24.00
050108 ...	01.4869	22.51	050208 ...	01.2820	23.14	050310 ...	01.2482	19.13	050430 ...	01.0378	14.73	050550 ...	02.3752	21.19
050109 ...	02.1024	23.09	050211 ...	01.3048	26.33	050312 ...	01.8372	20.46	050431 ...	01.1481	21.80	050551 ...	01.3686	22.23
050110 ...	01.2300	18.29	050213 ...	01.3361	18.97	050313 ...	01.1905	20.49	050432 ...	01.5702	21.41	050552 ...	01.2522	19.17
050111 ...	01.3371	18.50	050214 ...	01.5530	20.85	050315 ...	01.3130	20.06	050433 ...	01.2087	13.93	050557 ...	01.5951	20.11
050112 ...	01.4563	22.04	050215 ...	01.5201	24.70	050317 ...	01.2464	22.00	050434 ...	01.0841	18.98	050559 ...	01.3602	23.50
050113 ...	01.1277	26.39	050217 ...	01.2348	15.90	050320 ...	01.3742	27.40	050435 ...	01.2208	16.54	050560 ...	01.4461	22.18
050114 ...	01.4083	27.65	050219 ...	01.3050	19.43	050324 ...	01.8379	22.28	050436 ...	01.0234	15.83	050561 ...	01.1552	27.90
050115 ...	01.5724	20.93	050220 ...	01.6373	18.06	050325 ...	01.2822	20.26	050438 ...	01.5703	22.52	050564 ...	01.2896	26.82
050116 ...	01.5110	21.77	050222 ...	01.5416	19.26	050327 ...	01.5963	20.41	050440 ...	01.3051	17.95	050565 ...	01.2043	19.30
050117 ...	01.2909	18.00	050224 ...	01.5769	20.63	050328 ...	01.4331	25.87	050441 ...	01.8336	25.65	050566 ...	00.9537	15.29
050118 ...	01.2111	22.47	050225 ...	01.3867	19.07	050329 ...	01.2272	20.16	050443 ...	00.9414	11.92	050567 ...	01.6119	17.35
050121 ...	01.4281	18.50	050226 ...	01.3703	19.25	050331 ...	01.3813	28.94	050444 ...	01.2662	19.12	050568 ...	01.3214	19.87
050122 ...	01.5309	22.28	050228 ...	01.3574	28.38	050333 ...	00.9543	17.59	050446 ...	00.9121	17.49	050569 ...	01.2319	21.62
050124 ...	01.1949	22.67	050230 ...	01.3971	23.56	050334 ...	01.5605	27.46	050447 ...	01.0660	19.33	050570 ...	01.7230	24.72
050125 ...	01.3559	23.19	050231 ...	01.4915	21.30	050335 ...	01.2485	18.97	050448 ...	01.1675	21.09	050571 ...	01.4640	22.91
050126 ...	01.3906	22.84	050232 ...	01.8417	24.76	050336 ...	01.3208	18.34	050449 ...	01.3221	20.80	050573 ...	01.6776	22.60
050127 ...	01.3033	22.13	050233 ...	01.2555	26.78	050337 ...	01.3970	24.13	050451 ...	00.8860	16.91	050575 ...	01.2563	21.28
050128 ...	01.5335	20.01	050234 ...	01.2753	18.69	050342 ...	01.4351	15.53	050454 ...	01.8239	24.08	050577 ...	01.2346	20.65
050129 ...	01.4961	20.29	050235 ...	01.4825	24.01	050343 ...	01.0576	15.51	050455 ...	01.8556	21.40	050578 ...	01.3664	23.75
050131 ...	01.2653	23.99	050236 ...	01.5336	22.42	050345 ...	01.4979	19.74	050456 ...	01.3067	22.43	050579 ...	01.3955	24.73
050132 ...	01.3960	21.23	050238 ...	01.4985	23.50	050348 ...	01.5558	24.59	050457 ...	01.9297	27.09	050580 ...	01.4070	21.12
050133 ...	01.3169	19.07	050239 ...	01.4936	21.81	050349 ...	00.9553	14.35	050458 ...	00.8608	22.37	050581 ...	01.4767	22.03
050135 ...	01.2049	24.37	050240 ...	01.4862	25.19	050350 ...	01.3982	21.96	050459 ...	01.2485	29.05	050583 ...	01.6915	20.33
050136 ...	01.3894	21.51	050241 ...	01.3108	27.24	050351 ...	01.5038	26.10	050464 ...	01.8722	21.87	050584 ...	01.3064	20.35
050137 ...	01.2685	28.56	050242 ...	01.4019	25.08	050352 ...	01.3180	21.27	050468 ...	01.4071	13.23	050585 ...	01.3335	25.78
050138 ...	01.7806	29.95	050243 ...	01.5391	21.44	050353 ...	01.5294	21.82	050469 ...	01.1161	17.38	050586 ...	01.3292	22.31
050139 ...	01.3319	28.23	050245 ...	01.4078	23.48	050355 ...	00.9418	12.78	050470 ...	01.1282	16.91	050587 ...	01.2915	19.72
050140 ...	01.3405	28.60	050248 ...	01.1352	22.92	050357 ...	01.9560	21.24	050471 ...	01.7664	23.28	050588 ...	01.2571	26.65
050144 ...	01.5703	21.85	050251 ...	01.1011	15.38	050359 ...	01.0668	18.20	050476 ...	01.2760	14.66	050589 ...	01.3244	22.33
050145 ...	01.3480	23.97	050253 ...	00.9026	14.33	050360 ...	01.4403	27.20	050477 ...	01.4080	24.42	050590 ...	01.2877	20.82
050146 ...	01.3134	.....	050254 ...	01.1834	18.88	050363 ...	02.0568	20.97	050478 ...	01.0122	20.41	050591 ...	01.2159	19.81
050147 ...	00.6839	16.46	050256 ...	01.7804	20.44	050366 ...	01.3064	18.50	050481 ...	01.4379	23.28	050592 ...	01.2442	19.32
050148 ...	01.0960	14.81	050257 ...	01.0788	15.23	050367 ...	01.2722	24.59	050482 ...	00.9607	14.95	050593 ...	01.4496	24.80
050149 ...	01.3550	21.03	050258 ...	01.3469	20.82	050369 ...	01.2917	22.10	050483 ...	01.1758	19.39	050594 ...	02.0996	23.13
050150 ...	01.3002	21.08	050260 ...	00.9852	18.54	050373 ...	01.3104	22.71	050485 ...	01.6348	21.08	050597 ...	01.2906	22.04
050152 ...	01.3969	24.04	050261 ...	01.1831	16.58	050376 ...	01.3833	23.30	050486 ...	01.3887	22.96	050598 ...	01.4691	27.45
050153 ...	01.6374	26.51	050262 ...	01.7785	24.23	050377 ...	00.8593	15.28	050488 ...	01.3346	24.28	050599 ...	01.6386	16.11
050154 ...	01.3031	24.09	050263 ...	01.3131	23.85	050378 ...	01.0643	24.65	050489 ...	01.0503	23.76	050601 ...	01.3012	27.93
050155 ...	01.1490	22.21	050264 ...	01.4286	20.69	050379 ...	01.1506	16.12	050491 ...	01.3654	22.42	050603 ...	01.4450	20.02
050158 ...	01.5261	27.23	050267 ...	01.5610	23.58	050380 ...	01.6344	25.52	050492 ...	01.1875	19.19	050604 ...	01.4080	26.67
050159 ...	01.3367	19.16	050270 ...	01.3528	21.37	050382 ...	01.4210	21.49	050494 ...	01.0804	21.35	050607 ...	01.2383	19.43
050167 ...	01.3826	21.03	050272 ...	01.3906	17.78	050385 ...	01.3893	23.35	050496 ...	01.7873	27.58	050608 ...	01.1536	16.21
050168 ...	01.5785	22.94	050274 ...	01.1350	20.00	050387 ...	00.9157	12.76	050497 ...	00.9525	11.97	050609 ...	01.3281	29.05
050169 ...	01.5337	22.37	050276 ...	01.2419	27.73	050388 ...	00.8750	15.42	050498 ...	01.3025	20.21	050613 ...	01.0145	22.54
050170 ...	01.4515	20.26	050277 ...	01.4520	21.98	050390 ...	01.3121	20.66	050502 ...	01.6475	21.63	050615 ...	01.4462	21.07

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050616 ...	01.2668	20.14	060018 ...	01.2478	14.35	070018 ...	01.3461	25.96	100044 ...	01.4385	17.59	100129 ...	01.3576	17.02
050618 ...	01.2205	15.89	060020 ...	01.5148	13.63	070019 ...	01.2546	21.49	100045 ...	01.4586	14.39	100130 ...	01.1735	17.79
050619 ...	01.3454	19.03	060022 ...	01.6489	17.08	070020 ...	01.4090	22.14	100046 ...	01.3491	16.46	100131 ...	01.3011	18.69
050622 ...	01.2594	21.36	060023 ...	01.4618	16.23	070021 ...	01.1805	22.73	100047 ...	01.7883	16.54	100132 ...	01.4678	14.76
050623 ...	01.2415	21.16	060024 ...	01.6545	22.87	070022 ...	01.6425	22.82	100048 ...	00.9941	11.41	100135 ...	01.4981	14.49
050624 ...	01.2593	23.39	060026 ...	01.4360	18.06	070023 ...	01.2170	20.41	100049 ...	01.2745	16.51	100137 ...	01.2378	15.05
050625 ...	01.5187	22.82	060027 ...	01.4463	18.37	070024 ...	01.3190	19.55	100050 ...	01.1777	14.96	100138 ...	00.9841	10.25
050630 ...	01.2840	23.63	060028 ...	01.3973	18.91	070025 ...	01.6812	22.92	100051 ...	01.2637	14.91	100139 ...	01.0354	16.00
050633 ...	01.3224	20.24	060029 ...	00.9745	13.15	070026 ...	01.1737	22.90	100052 ...	01.4135	14.15	100140 ...	01.1950	16.26
050635 ...	01.3005	27.91	060030 ...	01.3474	16.34	070027 ...	01.2102	22.98	100053 ...	01.3040	17.73	100142 ...	01.1735	15.12
050636 ...	01.3914	21.83	060031 ...	01.5041	16.92	070028 ...	01.4587	21.83	100054 ...	01.3343	16.83	100143 ...	02.0179	.....
050637 ...	01.1286	21.41	060032 ...	01.4297	19.33	070029 ...	01.2280	19.44	100055 ...	01.3835	15.30	100144 ...	01.2923	12.10
050638 ...	00.9629	24.33	060033 ...	01.0659	11.58	070030 ...	01.2106	22.70	100056 ...	01.4682	21.01	100145 ...	01.3601	13.45
050641 ...	01.1445	12.65	060034 ...	01.4734	17.45	070031 ...	01.2886	18.49	100057 ...	01.3224	15.19	100146 ...	01.1054	15.35
050643 ...	00.9463	.....	060036 ...	01.1802	13.52	070033 ...	01.2662	22.64	100059 ...	01.6370	16.57	100147 ...	01.1178	12.08
050644 ...	00.9876	21.63	060037 ...	01.0016	12.14	070034 ...	01.3205	23.33	100060 ...	01.6849	17.02	100150 ...	01.3137	15.58
050660 ...	01.1294	.....	060038 ...	01.0138	11.55	070035 ...	01.3536	21.55	100061 ...	01.5760	20.45	100151 ...	01.8123	17.47
050661 ...	00.9004	17.84	060041 ...	00.9757	12.12	070036 ...	01.2995	25.17	100062 ...	01.7345	15.56	100154 ...	01.6034	16.55
050662 ...	00.8162	20.98	060042 ...	00.9336	13.29	080001 ...	01.5955	20.42	100063 ...	01.2715	14.64	100156 ...	01.1648	16.74
050663 ...	01.1104	20.81	060043 ...	01.0173	10.83	080002 ...	01.2126	15.45	100067 ...	01.4192	14.72	100157 ...	01.5925	17.06
050666 ...	00.9587	23.34	060044 ...	01.2606	14.53	080003 ...	01.3146	18.22	100068 ...	01.4448	15.32	100159 ...	01.0454	15.40
050667 ...	01.0628	23.63	060046 ...	01.0839	14.51	080004 ...	01.3343	16.62	100069 ...	01.3373	15.97	100160 ...	01.2104	16.10
050668 ...	01.1227	23.59	060047 ...	00.9059	12.30	080005 ...	01.3780	15.58	100070 ...	01.4119	16.41	100161 ...	01.4468	18.23
050671 ...	01.1408	25.26	060049 ...	01.0436	16.46	080006 ...	01.2292	14.99	100071 ...	01.2555	14.91	100162 ...	01.4019	16.66
050672 ...	00.6536	19.59	060050 ...	01.2061	12.70	080007 ...	01.2443	15.70	100072 ...	01.2274	14.14	100165 ...	01.2153	16.85
050674 ...	01.1806	26.59	060052 ...	01.1046	12.22	090001 ...	01.4395	18.92	100073 ...	01.7772	18.60	100166 ...	01.4564	18.62
050675 ...	01.5233	13.30	060053 ...	00.9701	12.72	090002 ...	01.1469	16.35	100074 ...	01.2353	17.34	100167 ...	01.3520	20.21
050676 ...	01.0310	12.91	060054 ...	01.2556	14.73	090003 ...	01.3337	22.14	100075 ...	01.6602	16.96	100168 ...	01.3310	17.37
050677 ...	01.3039	29.81	060056 ...	00.9390	12.62	090004 ...	01.5440	22.25	100076 ...	01.4829	18.32	100169 ...	01.8247	17.12
050678 ...	01.1010	24.06	060057 ...	00.9491	20.55	090005 ...	01.2751	20.28	100077 ...	01.3344	15.68	100170 ...	01.4798	15.72
050680 ...	01.2170	22.47	060058 ...	00.9388	10.75	090006 ...	01.3492	19.65	100078 ...	01.1773	16.18	100172 ...	01.3807	13.20
050682 ...	00.9485	10.78	060060 ...	01.0545	11.33	090007 ...	01.3332	19.75	100079 ...	01.1808	14.43	100173 ...	01.6413	15.21
050684 ...	01.2065	22.04	060062 ...	00.9885	11.79	090008 ...	01.5360	23.18	100080 ...	01.5561	17.32	100174 ...	01.4223	18.01
050685 ...	01.1498	24.19	060063 ...	01.1531	10.58	090010 ...	00.9704	24.67	100081 ...	01.1438	11.05	100175 ...	00.9507	15.25
050686 ...	01.3521	27.79	060064 ...	01.4240	19.02	090011 ...	01.9539	22.57	100082 ...	01.5130	16.68	100176 ...	01.9273	22.43
050688 ...	01.2100	25.21	060065 ...	01.3963	18.91	100001 ...	01.4755	16.11	100083 ...	01.2907	14.73	100177 ...	01.3233	16.58
050689 ...	01.4361	25.57	060066 ...	00.9247	10.92	100002 ...	01.4477	17.78	100084 ...	01.4897	15.78	100179 ...	01.6567	17.36
050690 ...	01.3430	27.92	060068 ...	01.2113	14.39	100004 ...	01.0426	11.37	100085 ...	01.3162	18.81	100180 ...	01.4305	17.00
050693 ...	01.2805	28.69	060070 ...	01.0193	15.33	100005 ...	01.1676	10.61	100086 ...	01.3967	20.75	100181 ...	01.6785	15.78
050694 ...	01.3233	21.34	060071 ...	01.2363	14.78	100006 ...	01.5872	17.22	100087 ...	01.7516	19.08	100183 ...	01.3645	17.97
050695 ...	01.2523	25.38	060072 ...	00.9067	.....	100007 ...	01.8626	17.77	100088 ...	01.6031	16.52	100186 ...	01.3873	15.09
050696 ...	02.1294	26.65	060073 ...	01.0035	15.52	100008 ...	01.6722	18.69	100089 ...	01.2394	15.39	100187 ...	01.3648	20.35
050697 ...	01.1817	.....	060075 ...	01.2510	16.15	100009 ...	01.5732	19.14	100090 ...	01.3507	15.49	100189 ...	01.2844	20.80
050698 ...	01.0828	23.39	060076 ...	01.4167	14.58	100010 ...	01.3922	18.78	100092 ...	01.5228	15.54	100191 ...	01.3365	17.44
050699 ...	00.8397	.....	060085 ...	00.9715	08.89	100012 ...	01.5330	17.48	100093 ...	01.4605	13.19	100196 ...	01.5278	15.84
050700 ...	01.3721	.....	060087 ...	01.6124	18.10	100014 ...	01.2841	16.40	100098 ...	01.2636	16.57	100199 ...	01.2095	18.69
050701 ...	01.2544	.....	060088 ...	01.0255	13.60	100015 ...	01.2998	17.02	100099 ...	01.2457	14.53	100200 ...	01.3761	21.17
050702 ...	01.2301	.....	060090 ...	00.9595	11.72	100017 ...	01.6648	15.75	100100 ...	01.4537	16.89	100203 ...	01.1543	18.05
050703 ...	00.8584	.....	060096 ...	01.0163	18.00	100018 ...	01.3502	17.76	100102 ...	01.0628	15.90	100204 ...	01.5521	16.81
050704 ...	01.1767	.....	060100 ...	01.3718	20.86	100019 ...	01.4523	17.17	100103 ...	01.0168	15.39	100206 ...	01.3816	21.64
050705 ...	02.8281	.....	060103 ...	01.2629	18.66	100020 ...	01.3567	17.23	100105 ...	01.3999	16.60	100207 ...	01.3831	19.04
050706 ...	00.9345	.....	060104 ...	01.3353	18.64	100022 ...	01.7086	21.32	100106 ...	01.0493	13.29	100208 ...	01.7426	18.61
050707 ...	00.8718	.....	070001 ...	01.7491	21.77	100023 ...	01.3279	14.40	100107 ...	01.2660	18.22	100209 ...	01.5360	19.87
050708 ...	00.8707	.....	070002 ...	01.8085	23.72	100024 ...	01.3809	19.06	100108 ...	01.0548	15.87	100210 ...	01.7022	15.54
060001 ...	01.4811	19.15	070003 ...	01.1494	21.97	100025 ...	01.5786	14.73	100109 ...	01.3304	15.27	100211 ...	01.2770	17.28
060003 ...	01.2871	17.53	070004 ...	01.1568	21.82	100026 ...	01.5007	13.18	100110 ...	01.4363	16.61	100212 ...	01.6217	16.73
060004 ...	01.0753	17.28	070005 ...	01.3284	23.96	100027 ...	00.8567	11.51	100112 ...	00.9782	10.90	100213 ...	01.6398	17.36
060006 ...	01.2663	15.07	070006 ...	01.3028	25.81	100028 ...	01.2753	15.02	100113 ...	02.0716	15.79	100217 ...	01.1813	17.84
060007 ...	01.2642	12.50	070007 ...	01.3876	22.29	100029 ...	01.4463	18.08	100114 ...	01.4901	17.00	100220 ...	01.8037	17.82
060008 ...	01.0108	13.26	070008 ...	01.2477	20.66	100030 ...	01.2726	16.73	100117 ...	01.2942	16.44	100221 ...	01.4528	17.64
060009 ...	01.4433	18.59	070009 ...	01.2619	21.54	100032 ...	01.8944	16.62	100118 ...	01.1782	15.44	100222 ...	01.2534	17.00
060010 ...	01.5626	18.49	070010 ...	01.4558	21.31	100034 ...	01.6897	17.25	100121 ...	01.2318	12.92	100223 ...	01.4309	16.46
060011 ...	01.2311	20.96	070011 ...	01.2121	21.19	100035 ...	01.5541	15.75	100122 ...	01.3611	14.84	100224 ...	01.4390	18.78
060012 ...	01.4222	14.56	070012 ...	01.1724	22.67	100038 ...	01.6487	18.93	100124 ...	01.3583	16.19	100225 ...	01.3933	19.07
060013 ...	01.3011	16.63	070013 ...	01.3356	22.91	100039 ...	01.7033	20.12	100125 ...	01.1450	15.06	100226 ...	01.3664	17.05
060014 ...	01.6988	20.85	070015 ...	01.3013	22.09	100040 ...	01.6908	16.07	100126 ...	01.4583	17.85	100227 ...	00.9833	17.48
060015 ...	01.5477	17.63	070016 ...	01.2496	22.14	100042 ...	01.2013	20.82	100127 ...	01.6130	16.84	100228 ...	01.2300	18.52
060016 ...	01.1622	10.83	070017 ...	01.3625	22.45	100043 ...	01.4167	16.03	100128 ...	02.1646	18.67	100229 ...	01.3900	16.27

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
100230 ...	01.3263	18.30	110030 ...	01.2645	16.95	110115 ...	01.6528	17.83	120002 ...	01.2217	15.87	140010 ...	01.3101	18.77
100231 ...	01.7128	17.42	110031 ...	01.2900	20.89	110117 ...	00.9252	11.64	120003 ...	00.9686	20.59	140011 ...	01.1180	12.97
100232 ...	01.2625	16.44	110032 ...	01.1290	13.22	110118 ...	01.0460	10.01	120004 ...	01.3006	18.29	140012 ...	01.2087	15.31
100234 ...	01.3611	17.94	110033 ...	01.4228	18.34	110120 ...	01.0429	10.51	120005 ...	01.2765	17.03	140013 ...	01.5994	14.68
100235 ...	01.3838	15.58	110034 ...	01.4418	15.64	110121 ...	01.1441	11.37	120006 ...	01.1577	21.83	140014 ...	01.0948	15.12
100236 ...	01.4843	15.80	110035 ...	01.3123	17.12	110122 ...	01.2847	14.70	120007 ...	01.6191	20.22	140015 ...	01.2255	12.74
100237 ...	02.1485	22.04	110036 ...	01.6990	18.05	110124 ...	01.0975	14.20	120009 ...	00.9941	18.32	140016 ...	00.9811	10.62
100238 ...	01.3721	17.27	110037 ...	01.0668	09.10	110125 ...	01.1846	14.60	120010 ...	01.7086	20.04	140018 ...	01.3993	17.67
100239 ...	01.4964	17.74	110038 ...	01.3932	12.03	110127 ...	00.9029	09.56	120011 ...	01.2355	26.59	140019 ...	00.9331	11.96
100240 ...	00.7985	14.20	110039 ...	01.3483	16.87	110128 ...	01.1445	15.46	120012 ...	00.9017	16.54	140024 ...	01.0133	12.34
100241 ...	00.9439	11.33	110040 ...	01.0515	12.16	110129 ...	01.5341	12.01	120014 ...	01.2144	19.14	140025 ...	01.1030	15.27
100242 ...	01.3147	14.92	110041 ...	01.1478	14.35	110130 ...	01.0852	09.68	120015 ...	00.7376	19.23	140026 ...	01.1244	13.42
100243 ...	01.4253	16.65	110042 ...	01.0563	13.66	110132 ...	01.1502	12.20	120016 ...	00.9880	18.55	140027 ...	01.2037	14.63
100244 ...	01.3604	16.21	110043 ...	01.5753	13.73	110134 ...	00.8603	10.02	120018 ...	00.9138	17.94	140029 ...	01.3194	16.19
100246 ...	01.3451	19.50	110044 ...	01.1396	12.22	110135 ...	01.1047	13.78	120019 ...	01.2284	17.90	140030 ...	01.5352	19.79
100248 ...	01.6651	17.89	110045 ...	01.1248	19.62	110136 ...	01.1607	13.15	120021 ...	00.8779	19.14	140031 ...	01.0307	11.46
100249 ...	01.2753	16.66	110046 ...	01.2166	14.30	110140 ...	00.8308	13.51	120022 ...	01.6508	20.55	140032 ...	01.2858	14.20
100252 ...	01.2002	17.43	110048 ...	01.0990	13.14	110141 ...	00.8985	09.72	120024 ...	01.0150	15.72	140033 ...	01.2505	17.22
100253 ...	01.3611	16.33	110049 ...	01.0655	14.55	110142 ...	01.0156	10.29	120026 ...	01.2780	20.12	140034 ...	01.1750	14.54
100254 ...	01.6064	17.14	110050 ...	01.0814	11.33	110143 ...	01.2843	17.24	120027 ...	01.3586	19.59	140035 ...	01.1563	09.85
100255 ...	01.3252	20.39	110051 ...	00.9789	15.64	110144 ...	01.1674	12.74	130001 ...	01.0148	13.17	140036 ...	01.1223	14.22
100256 ...	01.8452	18.38	110052 ...	00.9264	14.74	110146 ...	00.9386	11.89	130002 ...	01.3673	14.35	140037 ...	01.0229	11.74
100258 ...	01.7064	17.96	110054 ...	01.2709	15.38	110149 ...	01.0758	11.01	130003 ...	01.2239	16.63	140038 ...	01.1479	13.82
100259 ...	01.4448	16.66	110056 ...	00.8858	12.63	110150 ...	01.2959	14.47	130005 ...	01.3647	16.13	140039 ...	01.0245	11.51
100260 ...	01.3841	17.08	110059 ...	01.3072	12.94	110152 ...	01.1655	11.82	130006 ...	01.7673	16.81	140040 ...	01.2480	13.79
100262 ...	01.3971	18.96	110061 ...	01.0258	08.05	110153 ...	00.9827	15.92	130007 ...	01.5351	16.38	140041 ...	01.1585	14.31
100263 ...	01.3560	17.78	110062 ...	00.9617	10.81	110154 ...	00.9834	11.86	130008 ...	00.9305	12.71	140042 ...	01.1053	12.72
100264 ...	01.3747	15.50	110063 ...	01.0889	11.47	110155 ...	01.0504	12.55	130009 ...	00.9680	13.18	140043 ...	01.2469	15.68
100265 ...	01.3078	16.66	110064 ...	01.2603	15.82	110156 ...	00.9625	11.50	130010 ...	00.9419	15.53	140045 ...	01.0057	12.10
100266 ...	01.3057	15.42	110065 ...	00.9738	11.47	110157 ...	01.1062	15.28	130011 ...	01.3629	13.99	140046 ...	01.2869	14.33
100267 ...	01.3075	18.95	110066 ...	01.3014	15.59	110161 ...	01.2406	18.47	130012 ...	00.9957	16.65	140047 ...	01.2210	11.40
100268 ...	01.2432	21.03	110069 ...	01.1733	14.92	110162 ...	00.8551	.....	130013 ...	01.2686	16.91	140048 ...	01.3075	19.73
100269 ...	01.3512	21.42	110070 ...	00.9992	11.51	110163 ...	01.4226	16.50	130014 ...	01.3483	16.35	140049 ...	01.3583	17.97
100270 ...	00.8848	11.94	110071 ...	01.0202	09.41	110164 ...	01.3721	17.39	130015 ...	00.8789	11.45	140051 ...	01.3491	18.90
100271 ...	01.5981	16.88	110072 ...	01.0029	12.37	110165 ...	01.2814	15.93	130016 ...	00.8534	15.89	140052 ...	01.2829	14.67
100273 ...	01.0658	16.49	110073 ...	01.2832	12.22	110166 ...	01.4919	15.76	130017 ...	01.0063	12.65	140053 ...	01.7736	16.02
100275 ...	01.3391	20.17	110074 ...	01.4458	16.63	110168 ...	01.6681	17.53	130018 ...	01.5841	19.65	140054 ...	01.3068	22.11
100276 ...	01.3211	20.62	110075 ...	01.1310	13.64	110169 ...	00.7635	17.87	130019 ...	01.1681	14.07	140055 ...	00.9319	11.82
100277 ...	01.0745	12.90	110076 ...	01.3167	16.41	110171 ...	01.3480	19.39	130021 ...	00.9239	10.63	140058 ...	01.1573	14.34
100278 ...	00.8454	16.01	110078 ...	01.5683	21.62	110172 ...	01.2274	25.10	130022 ...	01.1192	15.42	140059 ...	01.0737	11.39
100279 ...	01.4267	21.86	110079 ...	01.3817	19.60	110174 ...	01.0087	12.79	130024 ...	01.1025	14.66	140061 ...	01.1005	15.08
100280 ...	01.4186	.....	110080 ...	01.1821	14.65	110176 ...	01.1874	18.24	130025 ...	01.1127	15.36	140062 ...	01.2328	20.99
100281 ...	01.2150	.....	110082 ...	02.0157	23.13	110177 ...	01.3898	18.41	130026 ...	01.1130	15.59	140063 ...	01.3452	19.00
110001 ...	01.2556	15.46	110083 ...	01.6420	20.82	110178 ...	01.4860	17.06	130027 ...	00.8925	16.13	140064 ...	01.1804	15.21
110002 ...	01.2481	14.41	110086 ...	01.0577	14.40	110179 ...	01.1708	19.22	130028 ...	01.1858	15.29	140065 ...	01.4131	21.65
110003 ...	01.3332	12.00	110087 ...	01.2668	17.61	110181 ...	01.0329	08.35	130029 ...	01.0240	14.26	140066 ...	01.1807	13.05
110004 ...	01.2190	15.29	110088 ...	00.8756	12.27	110183 ...	01.2881	18.73	130030 ...	01.0332	12.46	140067 ...	01.7219	16.34
110005 ...	01.1837	15.96	110089 ...	01.2054	14.65	110184 ...	01.0935	18.56	130031 ...	01.0192	11.69	140068 ...	01.4082	15.54
110006 ...	01.2858	16.38	110091 ...	01.3779	19.15	110185 ...	01.1329	12.31	130034 ...	01.0509	14.13	140069 ...	01.0752	13.61
110007 ...	01.4541	15.97	110092 ...	01.0729	11.21	110186 ...	01.3360	15.53	130035 ...	00.9959	13.66	140070 ...	01.2902	14.49
110008 ...	01.1034	14.16	110093 ...	00.9706	08.54	110187 ...	01.1704	16.81	130036 ...	01.2485	08.52	140074 ...	01.0194	14.20
110009 ...	01.0167	14.23	110094 ...	01.0195	11.02	110188 ...	01.4346	17.33	130037 ...	01.1261	14.67	140075 ...	01.4173	18.23
110010 ...	02.0011	20.95	110095 ...	01.2492	13.02	110189 ...	01.0969	19.00	130043 ...	01.0444	13.65	140077 ...	01.2251	13.35
110011 ...	01.1821	14.71	110096 ...	01.0935	12.76	110190 ...	01.0867	12.93	130044 ...	00.9725	12.73	140079 ...	01.2689	21.34
110013 ...	01.1076	13.50	110097 ...	01.1032	16.29	110191 ...	01.2378	17.33	130045 ...	00.9056	11.43	140080 ...	01.7910	17.20
110014 ...	01.1944	11.39	110098 ...	01.0389	13.41	110192 ...	01.3453	19.60	130048 ...	01.1126	10.87	140081 ...	01.1106	10.92
110015 ...	01.1391	15.78	110100 ...	01.0995	11.22	110193 ...	01.1414	16.99	130049 ...	01.2253	15.55	140082 ...	01.4026	19.71
110016 ...	01.2956	13.84	110101 ...	01.0725	09.49	110194 ...	00.9753	12.31	130054 ...	00.9348	14.10	140083 ...	01.2849	15.35
110017 ...	00.9338	10.40	110103 ...	00.9623	08.82	110195 ...	01.2032	10.66	130056 ...	00.9454	11.94	140084 ...	01.2094	17.72
110018 ...	01.1783	15.88	110104 ...	01.1365	12.86	110198 ...	01.3710	21.77	130058 ...	00.9163	11.59	140086 ...	01.1079	11.72
110020 ...	01.2001	16.49	110105 ...	01.1331	13.47	110200 ...	01.9920	14.43	130060 ...	01.1839	.....	140087 ...	01.4134	13.47
110023 ...	01.2550	17.01	110107 ...	01.6426	17.03	110201 ...	01.3910	14.99	140001 ...	01.2552	14.19	140088 ...	01.5041	21.90
110024 ...	01.3810	15.58	110108 ...	01.0257	10.19	110203 ...	00.9973	15.78	140002 ...	01.2503	15.22	140089 ...	01.2489	13.84
110025 ...	01.3110	15.02	110109 ...	01.1223	11.30	110204 ...	00.8082	13.88	140003 ...	01.0438	13.21	140090 ...	01.4535	26.53
110026 ...	01.1592	12.82	110111 ...	01.1291	12.36	110205 ...	01.0556	11.10	140004 ...	00.9869	13.64	140091 ...	01.6832	15.96
110027 ...	01.0364	15.43	110112 ...	00.9915	15.95	110207 ...	01.1408	.....	140005 ...	00.9628	09.64	140093 ...	01.1907	14.60
110028 ...	01.6330	14.95	110113 ...	01.0259	13.67	110208 ...	00.9511	12.61	140007 ...	01.4628	19.18	140094 ...	01.3196	15.67
110029 ...	01.3254	16.69	110114 ...	01.0579	14.00	120001 ...	01.7407	22.04	140008 ...	01.4351	19.25	140095 ...	01.2220	17.48

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
140097 ...	00.9791	13.23	140184 ...	01.1712	12.95	150007 ...	01.2318	16.00	150084 ...	01.8372	20.84	160034 ...	00.9808	12.48
140098 ...	01.2746	18.87	140185 ...	01.4027	14.80	150008 ...	01.3200	17.15	150085 ...	00.9594	10.27	160035 ...	00.9182	10.60
140100 ...	01.4568	18.43	140186 ...	01.1937	17.96	150009 ...	01.2890	15.82	150086 ...	01.2674	14.97	160036 ...	01.1018	12.62
140101 ...	01.1878	16.70	140187 ...	01.4084	14.44	150010 ...	01.1625	16.81	150088 ...	01.1619	16.44	160037 ...	01.1005	13.20
140102 ...	01.0169	13.47	140188 ...	00.9954	10.46	150011 ...	01.2281	16.35	150089 ...	01.3818	17.35	160039 ...	01.0959	13.56
140103 ...	01.3066	15.26	140189 ...	01.1429	14.82	150012 ...	01.6231	17.37	150090 ...	01.3008	18.44	160040 ...	01.3003	14.92
140105 ...	01.3383	18.62	140190 ...	01.1585	12.46	150013 ...	01.1922	12.66	150091 ...	01.0805	14.68	160041 ...	01.1337	10.87
140107 ...	01.1328	11.58	140191 ...	01.4009	22.19	150014 ...	01.3802	17.11	150092 ...	01.0350	13.77	160043 ...	01.0150	11.81
140108 ...	01.3305	19.18	140192 ...	01.0739	16.18	150015 ...	01.2578	14.80	150094 ...	01.0092	15.63	160044 ...	01.1775	12.06
140109 ...	01.0517	11.80	140193 ...	01.0185	12.72	150017 ...	01.7801	16.19	150095 ...	01.0820	13.62	160045 ...	01.6657	15.84
140110 ...	01.2889	12.82	140197 ...	01.3049	18.59	150018 ...	01.3147	15.79	150096 ...	01.0517	17.17	160046 ...	01.0096	11.17
140112 ...	01.0816	12.81	140199 ...	01.0385	13.34	150019 ...	01.0784	14.92	150097 ...	01.0921	15.62	160047 ...	01.3667	14.34
140113 ...	01.4240	16.37	140200 ...	01.3994	20.01	150020 ...	01.0988	11.59	150098 ...	01.1536	11.43	160048 ...	01.0676	12.01
140114 ...	01.2753	17.35	140202 ...	01.2611	18.76	150021 ...	01.6021	16.77	150099 ...	01.2551	15.68	160049 ...	00.9371	11.45
140115 ...	01.1709	16.67	140203 ...	01.2234	15.95	150022 ...	01.1271	17.24	150100 ...	01.7076	17.00	160050 ...	01.0221	12.47
140116 ...	01.2906	17.61	140205 ...	00.8429	11.22	150023 ...	01.4118	15.52	150101 ...	01.1150	13.32	160051 ...	01.2040	12.25
140117 ...	01.2995	18.69	140206 ...	01.0688	17.10	150024 ...	01.2090	13.89	150102 ...	01.0600	13.18	160052 ...	01.0482	12.05
140118 ...	01.6000	20.68	140207 ...	01.3987	18.78	150025 ...	01.5400	16.21	150103 ...	01.0248	13.14	160054 ...	01.1041	12.01
140119 ...	01.6599	20.07	140208 ...	01.4899	22.91	150026 ...	01.1922	16.04	150104 ...	01.0818	13.64	160055 ...	00.9470	11.27
140120 ...	01.4135	13.85	140209 ...	01.6465	14.84	150027 ...	01.0151	14.08	150105 ...	01.1638	15.14	160056 ...	01.0686	12.76
140121 ...	01.5618	08.74	140210 ...	01.0426	11.29	150029 ...	01.2539	17.48	150106 ...	01.0490	17.80	160057 ...	01.3496	13.92
140122 ...	01.4707	20.02	140211 ...	01.1981	17.90	150030 ...	01.0811	15.16	150109 ...	01.3696	14.70	160058 ...	01.7009	16.69
140123 ...	01.2304	15.10	140212 ...	01.1686	20.58	150031 ...	01.0977	14.78	150110 ...	00.9317	13.42	160059 ...	01.2637	16.34
140124 ...	01.1384	19.67	140213 ...	01.2004	19.50	150032 ...	01.7458	17.72	150111 ...	01.0977	12.33	160060 ...	01.0314	12.31
140125 ...	01.2373	13.29	140215 ...	01.1466	10.48	150033 ...	01.5916	18.01	150112 ...	01.2074	16.18	160061 ...	00.9508	13.54
140127 ...	01.2957	15.43	140217 ...	01.2331	19.16	150034 ...	01.2852	17.20	150113 ...	01.1462	15.45	160062 ...	00.9618	10.53
140128 ...	01.0440	15.50	140218 ...	00.9554	13.96	150035 ...	01.4059	17.05	150114 ...	00.9923	12.31	160063 ...	01.1404	10.67
140129 ...	01.0657	12.58	140220 ...	01.1751	13.57	150036 ...	01.0196	16.08	150115 ...	01.3254	13.92	160064 ...	01.5961	15.57
140130 ...	01.1624	19.25	140223 ...	01.5048	22.80	150037 ...	01.1976	17.77	150122 ...	01.1137	17.31	160065 ...	01.0734	13.89
140132 ...	01.5296	17.61	140224 ...	01.3260	19.20	150038 ...	01.1996	15.85	150123 ...	01.0974	12.57	160066 ...	01.0808	13.35
140133 ...	01.3520	19.24	140228 ...	01.6052	16.14	150039 ...	00.9143	12.82	150124 ...	01.1228	14.04	160067 ...	01.3100	15.77
140135 ...	01.2363	14.27	140229 ...	00.9407	09.86	150042 ...	01.1860	14.72	150125 ...	01.3770	16.98	160068 ...	00.9997	13.07
140137 ...	01.0275	12.24	140230 ...	00.9519	13.17	150043 ...	01.0836	15.00	150126 ...	01.5072	18.30	160069 ...	01.3779	13.62
140138 ...	01.0230	11.15	140231 ...	01.5344	19.84	150044 ...	01.2715	14.96	150127 ...	01.2073	11.94	160070 ...	01.0467	11.90
140139 ...	01.0515	12.47	140233 ...	01.7207	14.89	150045 ...	01.1628	15.40	150128 ...	01.2183	17.22	160072 ...	01.1165	11.93
140140 ...	01.1266	11.90	140234 ...	01.2036	14.46	150046 ...	01.5483	16.63	150129 ...	01.2138	18.69	160073 ...	01.0381	11.15
140141 ...	00.9828	12.26	140236 ...	01.0093	12.56	150047 ...	01.6825	17.65	150130 ...	01.1189	13.18	160074 ...	01.0287	14.05
140143 ...	01.0752	14.62	140239 ...	01.5754	16.58	150048 ...	01.1687	15.11	150132 ...	01.3674	19.15	160075 ...	01.0542	13.37
140144 ...	00.9982	13.14	140240 ...	01.4164	20.64	150049 ...	01.1209	12.76	150133 ...	01.1742	14.00	160076 ...	01.0078	13.71
140145 ...	01.1474	14.17	140242 ...	01.5349	19.78	150050 ...	01.1417	13.85	150134 ...	01.1513	15.65	160077 ...	00.9898	09.72
140146 ...	00.9718	14.22	140245 ...	01.0567	12.26	150051 ...	01.3401	15.58	150136 ...	00.8476	18.39	160079 ...	01.3235	13.50
140147 ...	01.1893	12.55	140246 ...	01.0445	11.22	150052 ...	01.0967	10.31	150137 ...	03.5965	.....	160080 ...	01.1524	14.09
140148 ...	01.6523	16.06	140250 ...	01.2052	19.71	150053 ...	01.0011	16.74	150897 ...	04.9520	.....	160081 ...	01.1063	13.36
140150 ...	01.4667	20.76	140251 ...	01.3102	16.26	150054 ...	01.0911	12.38	160001 ...	01.1851	15.08	160082 ...	01.6689	15.84
140151 ...	01.1067	15.02	140252 ...	01.3435	20.39	150056 ...	01.7030	18.99	160002 ...	01.1626	12.09	160083 ...	01.5067	16.06
140152 ...	01.0760	21.93	140253 ...	01.3680	24.54	150057 ...	02.3835	13.49	160003 ...	01.0532	11.80	160085 ...	01.0135	11.42
140155 ...	01.1692	15.83	140258 ...	01.3897	19.92	150058 ...	01.6377	18.17	160005 ...	01.0842	12.28	160086 ...	00.9890	11.97
140158 ...	01.4052	19.65	140271 ...	00.9892	12.27	150059 ...	01.1917	17.35	160007 ...	00.9470	11.53	160088 ...	01.1125	12.79
140159 ...	01.2391	14.82	140275 ...	01.2742	14.62	150060 ...	01.1339	15.24	160008 ...	01.1458	13.05	160089 ...	01.2182	15.64
140160 ...	01.1842	14.33	140276 ...	02.0641	18.92	150061 ...	01.1944	12.43	160009 ...	01.2457	13.34	160090 ...	01.0496	13.51
140161 ...	01.1034	15.66	140280 ...	01.2359	15.41	150062 ...	01.0306	12.77	160012 ...	01.1231	12.70	160091 ...	01.0971	11.91
140162 ...	01.6836	15.64	140281 ...	01.5894	19.47	150063 ...	01.0814	13.91	160013 ...	01.2460	13.60	160092 ...	00.9912	13.58
140164 ...	01.2776	13.78	140285 ...	01.3046	14.03	150064 ...	01.0623	15.32	160014 ...	00.9484	11.72	160093 ...	01.1434	11.33
140165 ...	01.0581	12.51	140286 ...	01.1259	15.67	150065 ...	01.0835	15.64	160016 ...	01.2668	14.26	160094 ...	01.1070	14.65
140166 ...	01.2118	14.64	140288 ...	01.6350	20.42	150066 ...	01.0441	12.68	160018 ...	00.8947	11.86	160095 ...	01.1374	14.50
140167 ...	01.1182	12.82	140289 ...	01.2672	14.49	150067 ...	01.0977	13.31	160020 ...	01.0939	12.14	160097 ...	01.1379	12.11
140168 ...	01.1811	14.17	140290 ...	01.3143	19.19	150069 ...	01.2295	14.39	160021 ...	01.0810	12.04	160098 ...	00.9934	12.47
140170 ...	01.0149	10.98	140291 ...	01.3049	20.19	150070 ...	01.0205	13.03	160023 ...	01.0726	12.61	160099 ...	01.0448	10.99
140171 ...	00.9273	12.22	140292 ...	01.1654	19.76	150071 ...	01.1204	12.39	160024 ...	01.5235	15.43	160101 ...	01.1499	15.34
140172 ...	01.4866	18.33	140294 ...	01.1318	14.61	150072 ...	01.2197	14.26	160025 ...	01.8369	15.04	160102 ...	01.4216	15.23
140173 ...	01.0401	13.57	140297 ...	01.2311	20.74	150073 ...	00.9874	16.29	160026 ...	01.1259	13.21	160103 ...	00.9621	12.62
140174 ...	01.4906	16.75	140299 ...	00.8525	22.50	150074 ...	01.5503	19.36	160027 ...	01.1481	12.49	160104 ...	01.2144	15.40
140176 ...	01.2723	18.62	150001 ...	01.0574	15.39	150075 ...	01.2023	12.67	160028 ...	01.2129	16.44	160106 ...	01.0838	12.86
140177 ...	01.5162	15.14	150002 ...	01.3527	16.25	150076 ...	01.0757	15.74	160029 ...	01.5220	15.57	160107 ...	01.2059	12.64
140179 ...	01.2505	18.13	150003 ...	01.6861	15.65	150077 ...	01.2356	14.59	160030 ...	01.3263	14.98	160108 ...	01.0881	12.98
140180 ...	01.5116	19.11	150004 ...	01.4976	18.00	150078 ...	01.1053	15.23	160031 ...	01.1528	12.06	160109 ...	00.9666	09.86
140181 ...	01.2713	17.32	150005 ...	01.1840	17.30	150079 ...	01.1046	12.83	160032 ...	01.1889	13.93	160110 ...	01.4793	16.07
140182 ...	01.2655	18.80	150006 ...	01.2392	14.67	150082 ...	01.4669	16.73	160033 ...	01.4596	14.99	160111 ...	01.0547	09.59

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
160112 ...	01.4113	13.17	170051 ...	00.9991	13.38	170134 ...	01.0170	11.44	180049 ...	01.3997	13.11	190010 ...	01.0796	14.19
160113 ...	01.0156	11.03	170052 ...	01.0907	10.94	170137 ...	01.1563	15.62	180050 ...	01.2711	14.68	190011 ...	01.1174	12.19
160114 ...	01.0339	13.68	170053 ...	00.8734	10.41	170139 ...	01.0590	11.31	180051 ...	01.3043	12.81	190013 ...	01.2335	13.20
160115 ...	01.0563	12.36	170054 ...	01.0950	11.90	170140 ...	01.0446	11.09	180053 ...	01.2874	13.26	190014 ...	01.0883	12.69
160116 ...	01.1445	12.61	170055 ...	00.9663	13.55	170142 ...	01.3007	15.41	180054 ...	01.0039	12.50	190015 ...	01.1613	16.30
160117 ...	01.2812	14.07	170056 ...	00.9755	10.54	170143 ...	01.1380	11.86	180055 ...	01.0488	12.65	190017 ...	01.2184	12.10
160118 ...	01.0402	12.14	170057 ...	01.0704	13.53	170144 ...	01.4733	14.19	180056 ...	01.0708	15.74	190018 ...	01.2776	14.25
160120 ...	00.9891	08.34	170058 ...	01.0792	13.89	170145 ...	01.1872	13.04	180058 ...	00.8952	12.36	190019 ...	01.4676	15.85
160122 ...	01.1598	13.40	170060 ...	01.0608	11.99	170146 ...	01.3467	16.72	180059 ...	00.8662	12.17	190020 ...	01.1858	14.53
160123 ...	01.0397	13.08	170061 ...	01.1210	11.60	170147 ...	01.1342	16.47	180063 ...	01.0480	09.78	190025 ...	01.2411	11.69
160124 ...	01.2475	13.81	170062 ...	00.9459	11.58	170148 ...	01.4002	17.53	180064 ...	01.0967	10.97	190026 ...	01.3902	15.09
160126 ...	01.0582	11.21	170063 ...	00.9011	10.43	170150 ...	01.0802	12.81	180065 ...	00.9647	09.28	190027 ...	01.4599	15.99
160129 ...	01.0286	12.08	170064 ...	00.9869	11.33	170151 ...	01.0014	10.84	180066 ...	01.2927	16.62	190029 ...	01.1633	13.12
160130 ...	01.0393	11.62	170066 ...	00.9312	11.45	170152 ...	00.9702	12.21	180067 ...	01.8619	15.59	190033 ...	00.9144	07.96
160131 ...	01.1439	11.67	170067 ...	00.8618	12.46	170159 ...	00.9310	.....	180069 ...	01.0208	14.41	190034 ...	01.2090	13.01
160133 ...	01.0977	16.39	170068 ...	01.2512	14.20	170160 ...	00.9845	10.63	180070 ...	01.0470	12.77	190035 ...	01.4040	17.47
160134 ...	01.0733	10.74	170069 ...	01.0356	12.27	170164 ...	00.9554	13.38	180072 ...	01.0754	14.38	190036 ...	01.6426	17.28
160135 ...	00.9879	10.91	170070 ...	00.9728	11.79	170166 ...	01.0100	13.17	180075 ...	00.9831	10.68	190037 ...	01.0946	17.85
160138 ...	01.1152	12.46	170072 ...	00.9193	10.58	170168 ...	00.9152	08.28	180078 ...	01.0778	15.71	190039 ...	01.4726	16.44
160140 ...	01.0691	13.24	170073 ...	01.1042	12.78	170171 ...	01.0976	10.91	180079 ...	00.9809	12.61	190040 ...	01.4131	17.30
160141 ...	00.8389	10.05	170074 ...	01.0966	11.30	170172 ...	00.9710	.....	180080 ...	01.1033	12.85	190041 ...	01.5242	16.54
160142 ...	01.0835	11.71	170075 ...	00.8448	09.47	170174 ...	00.8374	10.81	180081 ...	01.5083	17.66	190043 ...	01.0969	10.44
160143 ...	01.0662	12.59	170076 ...	01.1225	10.14	170175 ...	01.2775	15.08	180085 ...	01.3138	16.18	190044 ...	01.0850	15.51
160145 ...	01.0361	11.04	170077 ...	00.9366	11.31	170176 ...	01.4835	18.26	180087 ...	01.0826	12.45	190045 ...	01.2844	17.63
160146 ...	01.3598	14.81	170079 ...	01.0751	09.81	180001 ...	01.2077	15.10	180088 ...	01.6481	18.61	190046 ...	01.5064	16.01
160147 ...	01.1838	13.17	170080 ...	01.0304	11.45	180002 ...	01.0572	14.95	180092 ...	01.1071	13.45	190047 ...	01.1529	15.23
160151 ...	01.1023	12.32	170081 ...	01.0284	10.30	180004 ...	01.1815	12.90	180093 ...	01.3857	14.17	190048 ...	01.0974	13.35
160152 ...	00.9977	12.73	170082 ...	01.0264	10.91	180005 ...	01.0416	14.66	180094 ...	00.9476	11.59	190049 ...	01.0517	13.59
160153 ...	01.6467	16.13	170084 ...	00.8766	10.03	180006 ...	00.9024	11.80	180095 ...	01.1208	11.81	190050 ...	01.0986	13.67
170001 ...	01.2086	14.25	170085 ...	00.9608	11.57	180007 ...	01.4578	13.73	180099 ...	01.0748	10.13	190053 ...	01.0891	11.08
170004 ...	01.0588	12.68	170086 ...	01.7002	17.38	180009 ...	01.2762	16.51	180101 ...	01.2300	19.85	190054 ...	01.4422	12.13
170006 ...	01.1783	13.00	170087 ...	01.3951	18.90	180010 ...	01.8129	15.34	180102 ...	01.4438	12.80	190059 ...	00.9497	17.29
170008 ...	01.0815	11.61	170088 ...	00.8815	08.09	180011 ...	01.2037	14.69	180103 ...	01.9626	16.39	190060 ...	01.4071	14.77
170009 ...	01.2528	15.16	170089 ...	01.0410	13.16	180012 ...	01.3631	15.91	180104 ...	01.4442	14.71	190064 ...	01.5049	16.13
170010 ...	01.2140	14.80	170090 ...	01.0886	09.53	180013 ...	01.3290	14.46	180105 ...	00.9250	15.54	190065 ...	01.4841	15.65
170011 ...	01.4358	14.07	170092 ...	00.8092	11.32	180014 ...	01.5180	17.45	180106 ...	00.8972	11.57	190071 ...	00.8860	11.25
170012 ...	01.3653	15.44	170093 ...	00.9266	11.25	180015 ...	01.1322	14.27	180108 ...	00.8945	12.67	190075 ...	01.4394	19.38
170013 ...	01.3310	14.02	170094 ...	01.0829	13.06	180016 ...	01.2643	12.65	180115 ...	01.0928	13.33	190077 ...	00.9570	10.49
170014 ...	01.0483	14.36	170095 ...	01.1164	12.20	180017 ...	01.3054	12.52	180116 ...	01.3606	14.86	190078 ...	01.2344	10.47
170015 ...	01.0032	12.48	170097 ...	00.9929	12.19	180018 ...	01.1545	12.82	180117 ...	01.1925	12.53	190079 ...	01.2564	14.38
170016 ...	01.5902	18.86	170098 ...	01.0691	13.99	180019 ...	01.3038	15.60	180118 ...	01.0348	10.98	190081 ...	00.8959	09.79
170017 ...	01.1823	15.65	170099 ...	01.2531	10.05	180020 ...	01.0551	14.24	180120 ...	00.9608	11.55	190083 ...	00.9142	11.31
170018 ...	01.0319	11.85	170100 ...	00.9230	13.52	180021 ...	01.2226	12.05	180121 ...	01.1327	12.12	190086 ...	01.2979	13.80
170019 ...	01.1689	14.86	170101 ...	00.9627	12.60	180023 ...	00.8355	10.45	180122 ...	01.0105	12.03	190088 ...	01.2466	15.55
170020 ...	01.2793	14.70	170102 ...	01.0024	12.59	180024 ...	01.3175	14.92	180123 ...	01.4820	17.52	190089 ...	01.0499	09.57
170022 ...	01.2493	11.71	170103 ...	01.2729	14.43	180025 ...	01.1234	13.86	180124 ...	01.3518	14.80	190090 ...	01.2115	14.18
170023 ...	01.3878	15.44	170104 ...	01.4209	18.83	180026 ...	01.1979	10.47	180125 ...	01.0243	14.88	190092 ...	01.2831	16.62
170024 ...	01.1864	11.73	170105 ...	00.9760	14.10	180027 ...	01.1238	12.56	180126 ...	01.0141	10.88	190095 ...	01.0352	12.77
170025 ...	01.2580	13.63	170106 ...	00.9172	12.06	180028 ...	01.0343	15.42	180127 ...	01.2163	16.76	190098 ...	01.4296	16.69
170026 ...	01.0138	14.25	170108 ...	00.9109	10.27	180029 ...	01.2894	14.35	180128 ...	01.1231	14.91	190099 ...	01.1067	14.71
170027 ...	01.1819	15.09	170109 ...	01.0816	13.77	180030 ...	01.1328	11.60	180129 ...	01.1161	11.56	190102 ...	01.5012	14.99
170030 ...	00.9624	13.61	170110 ...	00.9250	12.28	180031 ...	00.9982	11.68	180130 ...	01.4178	16.58	190103 ...	00.8566	09.80
170031 ...	00.9049	11.54	170112 ...	00.8893	11.19	180032 ...	01.0611	13.47	180132 ...	01.2001	15.26	190106 ...	01.1654	15.56
170032 ...	01.0373	13.75	170113 ...	01.1303	13.45	180033 ...	01.0621	10.45	180133 ...	01.2501	17.98	190109 ...	01.1975	13.91
170033 ...	01.2529	14.38	170114 ...	01.0938	12.12	180034 ...	00.9942	13.98	180134 ...	00.9838	11.34	190110 ...	00.9443	10.81
170034 ...	00.9688	13.48	170115 ...	01.0470	11.25	180035 ...	01.5181	16.43	180136 ...	01.3850	15.97	190111 ...	01.5566	15.92
170035 ...	00.9068	12.55	170116 ...	01.0983	12.83	180036 ...	01.1636	16.05	180137 ...	01.6298	17.11	190112 ...	01.3948	16.41
170036 ...	00.8756	11.84	170117 ...	01.0056	11.90	180037 ...	01.2600	17.97	180138 ...	01.2788	17.78	190113 ...	01.3192	16.22
170037 ...	01.1326	14.83	170119 ...	00.9699	10.40	180038 ...	01.3309	14.34	180139 ...	01.0598	13.66	190114 ...	00.9444	12.67
170038 ...	00.9529	11.73	170120 ...	01.3053	14.99	180040 ...	01.9474	18.16	190001 ...	00.9125	14.98	190115 ...	01.3570	21.52
170039 ...	01.0578	12.85	170121 ...	00.9078	10.42	180041 ...	01.0430	13.18	190002 ...	01.5696	14.50	190116 ...	01.2136	12.23
170040 ...	01.4622	16.84	170122 ...	01.8175	19.22	180042 ...	01.0832	11.66	190003 ...	01.4246	17.42	190118 ...	01.0406	11.05
170041 ...	01.0467	10.30	170123 ...	01.7339	18.31	180043 ...	01.1218	13.52	190004 ...	01.3225	13.12	190120 ...	00.9204	14.66
170043 ...	00.9950	12.13	170124 ...	00.9306	12.74	180044 ...	01.0438	12.64	190005 ...	01.4287	14.98	190122 ...	01.2237	13.84
170044 ...	01.1498	14.13	170126 ...	00.9080	10.31	180045 ...	01.1992	15.05	190006 ...	01.1812	13.93	190124 ...	01.4596	18.09
170045 ...	01.0100	12.52	170128 ...	00.9733	12.98	180046 ...	01.0799	16.50	190007 ...	01.0342	12.14	190125 ...	01.3178	13.88
170049 ...	01.3269	17.19	170131 ...	01.1254	10.65	180047 ...	01.0479	12.20	190008 ...	01.5379	16.58	190127 ...	01.4309	16.72
170050 ...	00.8093	10.65	170133 ...	01.1814	13.81	180048 ...	01.1443	14.45	190009 ...	01.3008	13.82	190128 ...	00.9169	15.49

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
190130	00.9897	11.19	190227	00.7615	.....	210032	01.2550	17.31	220066	01.3017	18.54	230020	01.6500	18.94
190131	01.2764	13.59	200001	01.2675	15.09	210033	01.1890	16.07	220067	01.2488	19.66	230021	01.5772	15.00
190133	01.0466	09.24	200002	01.0959	15.46	210034	01.3009	17.26	220068	00.5948	16.26	230022	01.3002	17.34
190134	00.9962	09.28	200003	01.0709	15.05	210035	01.1828	15.47	220070	01.1592	18.15	230024	01.5266	22.55
190135	01.3864	16.54	200006	01.1750	14.04	210036	01.2958	16.68	220071	01.8244	23.03	230027	01.0726	15.36
190136	01.0609	12.04	200007	01.0252	15.37	210037	01.2408	15.64	220073	01.3051	22.39	230029	01.5346	20.32
190138	00.7180	19.68	200008	01.2642	17.07	210038	01.4206	17.33	220074	01.2412	20.16	230030	01.2303	16.73
190140	00.9940	11.25	200009	01.6710	17.96	210039	01.1657	16.17	220075	01.1906	20.08	230031	01.4695	17.50
190142	00.9929	12.54	200012	01.1446	14.30	210040	01.3354	21.10	220076	01.2112	22.33	230032	01.7017	17.85
190144	01.1616	13.35	200013	01.0867	14.12	210043	01.2498	20.01	220077	01.6390	20.92	230034	01.1727	14.38
190145	00.9367	14.48	200015	01.2450	16.17	210044	01.2682	19.24	220079	01.1467	20.12	230035	01.1001	14.84
190146	01.5476	16.85	200016	00.9875	14.92	210045	01.0188	09.60	220080	01.2307	17.63	230036	01.2610	17.94
190147	00.9814	12.33	200017	01.2677	16.81	210046	01.1376	11.93	220081	00.9648	19.63	230037	01.2239	15.86
190148	00.9413	11.58	200018	01.1585	13.98	210048	01.1728	20.49	220082	01.2081	19.86	230038	01.5850	18.78
190149	00.9773	10.49	200019	01.2640	16.59	210049	01.1489	15.63	220083	01.1173	18.96	230040	01.2358	15.59
190151	01.0878	11.17	200020	01.1411	18.32	210051	01.2971	12.97	220084	01.2129	21.51	230041	01.1836	17.06
190152	01.3442	19.19	200021	01.1384	16.13	210054	01.2295	19.77	220086	01.5645	22.71	230042	01.1251	16.23
190155	00.9496	10.29	200023	00.8734	15.51	210055	01.2336	20.46	220088	01.5483	20.65	230043	00.5585	.....
190156	00.8924	11.29	200024	01.1932	17.76	210056	01.4385	16.01	220089	01.2499	21.71	230046	01.8358	26.35
190158	01.2691	20.28	200025	01.1765	17.84	210057	01.3054	21.17	220090	01.1879	20.89	230047	01.2912	18.15
190160	01.1628	14.70	200026	01.0475	14.44	210058	01.7964	17.16	220092	01.2699	19.93	230053	01.4884	23.31
190161	00.8949	13.49	200027	01.2543	15.03	210059	01.3202	20.43	220094	01.2251	18.24	230054	01.7259	17.38
190162	01.2766	15.63	200028	00.9586	13.99	210060	01.0637	19.25	220095	01.1906	18.77	230055	01.1914	15.21
190164	01.1569	14.42	200031	01.2786	14.27	210061	00.8578	.....	220097	01.0471	21.81	230056	00.9578	13.41
190165	01.0022	10.72	200032	01.2741	16.82	220001	01.1827	19.03	220098	01.2248	17.36	230058	01.0944	15.65
190166	01.0303	11.98	200033	01.6726	18.43	220002	01.4300	16.57	220099	01.1587	19.90	230059	01.5400	18.06
190167	01.2759	15.31	200034	01.2041	17.47	220003	01.0791	15.29	220100	01.2435	17.81	230060	01.2781	15.46
190170	01.0698	12.52	200037	01.1788	15.05	220004	01.2327	18.34	220101	01.3953	22.74	230062	01.1739	13.45
190173	01.4218	17.94	200038	01.0132	17.44	220006	01.3008	21.22	220102	00.7873	19.91	230063	01.3800	17.52
190175	01.4664	.....	200039	01.2823	15.86	220008	01.1506	17.96	220104	01.2287	22.48	230065	01.4772	17.15
190176	01.5220	17.76	200040	01.1005	14.71	220010	01.2155	19.85	220105	01.1442	19.59	230066	01.3538	17.72
190177	01.5268	19.77	200041	01.1612	16.52	220011	01.1546	25.18	220106	01.1348	21.34	230068	01.3848	18.28
190178	00.9760	10.27	200043	00.6566	15.00	220012	01.3073	26.56	220107	01.1137	17.08	230069	01.1102	16.62
190182	00.9989	20.51	200050	01.1424	15.39	220015	01.1856	18.89	220108	01.1463	19.07	230070	01.4860	18.10
190183	01.1795	11.91	200051	00.9948	17.08	220016	01.2527	19.03	220110	01.9872	28.62	230071	00.6183	19.34
190184	00.9823	12.28	200052	01.0217	13.98	220017	01.2575	22.56	220111	01.1924	18.46	230072	01.2490	17.07
190185	01.2328	22.78	200055	01.0681	12.93	220019	01.0807	18.15	220114	01.0005	18.76	230075	01.4762	17.70
190186	00.9004	10.73	200062	00.9713	14.24	220020	01.1744	17.95	220116	01.8113	21.93	230076	01.2725	19.48
190187	00.8000	14.06	200063	01.2064	16.48	220021	01.2659	20.16	220118	02.0692	23.05	230077	02.0043	17.19
190189	00.4826	15.10	200066	01.1903	14.22	220023	01.1615	16.29	220119	01.3216	22.92	230078	01.1477	14.20
190190	00.9966	19.64	210001	01.3288	16.34	220024	01.1729	18.19	220120	01.1817	18.85	230080	01.1819	16.42
190191	01.2358	18.16	210002	01.9936	14.40	220025	01.1064	17.74	220123	01.0259	22.50	230081	01.2169	15.62
190193	01.2713	21.05	210003	01.5027	20.58	220026	01.3902	18.69	220126	01.2271	19.48	230082	01.1432	14.70
190194	01.1266	17.88	210004	01.3025	23.87	220028	01.3945	19.70	220128	01.0800	21.45	230085	01.1131	16.73
190196	00.8076	16.52	210005	01.2264	15.89	220029	01.1478	19.55	220131	01.1501	18.18	230086	01.0034	12.96
190197	01.2713	16.76	210006	01.1117	15.52	220030	01.0895	18.23	220133	00.6252	30.62	230087	01.0416	14.20
190198	01.1387	19.92	210007	01.5136	17.96	220031	01.6518	24.26	220135	01.1525	22.28	230089	01.3534	21.44
190199	01.3032	12.07	210008	01.3465	19.28	220033	01.3347	19.44	220153	01.0148	16.24	230092	01.2721	17.03
190200	01.5343	18.43	210009	01.6689	17.62	220035	01.2166	18.93	220154	00.9255	19.73	230093	01.2452	16.96
190201	01.4033	17.53	210010	01.2350	14.61	220036	01.5874	22.48	220156	01.3006	19.03	230095	01.2160	15.30
190202	01.4866	18.80	210011	01.2708	18.56	220038	01.2392	23.00	220162	01.4332	.....	230096	01.2437	16.62
190203	01.5366	19.83	210012	01.5499	19.80	220041	01.1767	16.08	220163	01.8442	19.92	230097	01.5407	17.27
190204	01.4977	19.33	210013	01.2868	21.55	220042	01.2723	22.59	220171	01.6777	20.19	230099	01.2429	17.18
190205	01.7938	16.25	210015	01.1959	18.69	220045	01.2586	19.58	220173	00.6310	.....	230100	01.2155	14.52
190206	01.4388	22.87	210016	01.8110	17.94	220046	01.3809	22.07	220897	04.7767	.....	230101	01.1076	16.09
190207*	01.1993	19.24	210017	01.1038	13.97	220049	01.2332	21.24	230001	01.1929	16.33	230103	01.0302	14.19
190208	00.8106	09.75	210018	01.2813	19.36	220050	00.9715	16.18	230002	01.2720	18.31	230104	01.6323	19.80
190211	00.5662	11.07	210019	01.4084	16.07	220051	01.1967	19.14	230003	01.1335	16.51	230105	01.5472	17.41
190212	00.7211	09.55	210022	01.4223	18.96	220052	01.1996	20.35	230004	01.6992	18.57	230106	01.0964	16.22
190213	02.8663	10.83	210023	01.3443	22.25	220053	01.2845	20.22	230005	01.3330	16.98	230107	00.8899	10.39
190214	00.4476	11.33	210024	01.3323	19.78	220055	01.1986	17.22	230006	01.0594	14.61	230108	01.1687	14.76
190216	00.7557	.....	210025	01.3092	15.79	220057	01.2909	17.18	230007	01.1017	16.37	230110	01.2701	14.49
190217	00.9124	.....	210026	01.3090	18.97	220058	01.1254	18.61	230012	00.7063	14.26	230111	00.9755	14.47
190218	00.9222	.....	210027	01.2362	14.83	220060	01.1411	22.02	230013	01.3023	19.75	230113	01.0302	17.37
190219	00.4818	.....	210028	01.0907	14.70	220062	00.7215	18.20	230014	01.2674	13.29	230114	00.6567	20.83
190220	01.9951	.....	210029	01.3210	17.16	220063	01.2126	17.96	230015	01.2414	17.21	230115	00.9755	14.26
190222	01.7805	.....	210030	01.0931	18.05	220064	01.1936	19.68	230017	01.5027	19.59	230116	00.9372	13.79
190223	00.4818	.....	210031	01.7294	21.38	220065	01.2442	18.79	230019	01.4980	20.62	230117	01.9255	20.87

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
230118 ...	01.2338	15.27	230227 ..	01.4185	18.92	240061 ..	01.5618	19.51	240143 ..	00.9224	09.58	250043 ..	00.8798	11.24
230119 ...	01.2396	19.41	230228 ..	01.3352	17.04	240063 ..	01.5302	19.77	240144 ..	00.9453	14.36	250044 ..	01.0316	11.99
230120 ...	01.1168	16.19	230230 ..	01.3544	18.21	240064 ..	01.1880	17.45	240145 ..	01.0421	10.47	250045 ..	01.1840	14.86
230121 ...	01.2757	17.52	230232 ..	01.0272	15.35	240065 ..	00.9609	11.40	240146 ..	00.9853	13.78	250047 ..	00.9729	09.06
230122 ...	01.2990	17.18	230235 ..	00.9284	12.87	240066 ..	01.3773	17.16	240148 ..	00.9416	10.13	250048 ..	01.4259	13.20
230124 ...	01.1103	15.55	230236 ..	01.3262	18.37	240069 ..	01.1320	16.35	240150 ..	00.9284	10.19	250049 ..	00.9219	10.78
230125 ...	01.3711	13.28	230237 ..	01.1209	18.78	240071 ..	01.1271	16.43	240152 ..	00.9627	15.64	250050 ..	01.2364	11.37
230128 ...	01.3686	19.81	230239 ..	01.1761	15.59	240072 ..	01.0464	14.61	240153 ..	01.0299	13.43	250051 ..	00.9057	09.10
230129 ...	01.9341	19.47	230241 ..	01.1425	15.34	240073 ..	00.9857	11.34	240154 ..	00.9839	14.51	250057 ..	01.1363	11.55
230130 ...	01.6172	19.75	230244 ..	01.4433	19.18	240075 ..	01.2239	17.19	240155 ..	00.9697	13.26	250058 ..	01.1767	11.42
230132 ...	01.4457	19.35	230253 ..	01.2208	16.09	240076 ..	01.0824	17.80	240157 ..	01.0301	13.38	250059 ..	01.0248	10.92
230133 ...	01.2087	14.69	230254 ..	01.2122	20.53	240077 ..	00.9540	12.78	240160 ..	01.0309	13.52	250060 ..	00.8100	10.54
230134 ...	01.2076	14.24	230257 ..	01.0270	16.29	240078 ..	01.3948	20.24	240161 ..	00.9932	12.77	250061 ..	00.8715	09.07
230135 ...	01.2866	17.71	230259 ..	01.1927	18.24	240079 ..	01.0466	12.37	240162 ..	01.0422	14.61	250063 ..	00.8593	09.85
230137 ...	01.1486	16.37	230264 ..	01.2970	17.31	240080 ..	01.4242	19.24	240163 ..	00.9293	12.90	250065 ..	00.8981	10.30
230141 ...	01.6035	19.10	230269 ..	01.2248	19.90	240082 ..	01.1763	13.75	240166 ..	01.1619	14.56	250066 ..	00.9727	09.70
230142 ...	01.1774	23.19	230270 ..	01.2471	18.35	240083 ..	01.3177	15.80	240169 ..	00.9598	13.10	250067 ..	00.9676	11.74
230143 ...	01.1740	13.64	230273 ..	01.6899	18.16	240084 ..	01.3442	15.28	240170 ..	01.0625	13.78	250068 ..	00.8957	14.73
230144 ...	01.1892	19.77	230275 ..	00.8457	15.29	240085 ..	00.8891	12.80	240171 ..	00.9856	13.00	250069 ..	01.2046	12.20
230145 ...	01.1500	14.34	230276 ..	00.9638	14.84	240086 ..	01.1768	14.11	240172 ..	01.1054	14.02	250071 ..	01.0549	10.98
230146 ...	01.2775	18.56	230277 ..	01.2066	18.72	240087 ..	01.0607	13.50	240173 ..	00.9813	14.21	250072 ..	01.3410	15.41
230147 ...	01.5686	18.29	230278 ..	01.9299	.....	240088 ..	01.4600	16.70	240176 ..	00.9959	11.09	250073 ..	00.9807	09.92
230149 ...	01.2338	14.09	240001 ..	01.5708	19.57	240089 ..	01.0397	14.41	240179 ..	00.9847	13.73	250076 ..	00.9532	09.20
230150 ...	01.5566	19.01	240002 ..	01.6587	18.05	240090 ..	01.0952	13.05	240180 ..	00.9750	10.20	250077 ..	00.9320	10.22
230151 ...	01.3761	18.80	240003 ..	01.2291	22.55	240091 ..	01.0392	10.83	240184 ..	00.9999	10.98	250078 ..	01.3952	13.04
230153 ...	01.0546	14.86	240004 ..	01.4562	19.95	240093 ..	01.2787	15.33	240187 ..	01.2830	17.00	250079 ..	00.8734	12.23
230154 ...	01.0176	12.31	240005 ..	00.9197	12.75	240094 ..	00.9699	15.34	240192 ..	01.0375	12.40	250081 ..	01.2182	14.37
230155 ...	01.1241	12.02	240006 ..	01.1567	18.19	240096 ..	01.1091	13.37	240193 ..	01.1307	14.01	250082 ..	01.2190	11.07
230156 ...	01.6575	20.20	240007 ..	01.0728	13.16	240097 ..	01.1124	16.27	240196 ..	00.6068	18.87	250083 ..	00.9395	12.40
230157 ...	01.3277	18.63	240008 ..	01.0418	13.25	240098 ..	01.0163	13.46	240200 ..	00.8798	12.53	250084 ..	01.1255	13.12
230159 ...	01.3269	17.40	240009 ..	01.1476	12.81	240099 ..	01.0461	11.38	240205 ..	00.9147	.....	250085 ..	01.0526	11.04
230162 ...	00.9652	13.97	240010 ..	01.9857	18.94	240100 ..	01.2725	16.95	240206 ..	00.8253	.....	250086 ..	00.9820	12.08
230165 ...	01.7368	18.96	240011 ..	01.1006	14.62	240101 ..	01.2197	15.26	240207 ..	01.1892	21.20	250088 ..	00.9881	11.97
230167 ...	01.2135	18.27	240013 ..	01.2257	15.49	240102 ..	01.0627	12.97	240210 ..	01.3000	21.21	250089 ..	01.0414	10.86
230169 ...	01.3466	19.72	240014 ..	01.0882	16.06	240103 ..	01.1331	14.27	250001 ..	01.5439	13.55	250091 ..	00.9638	10.48
230171 ...	01.0397	12.36	240016 ..	01.3880	14.67	240104 ..	01.1691	18.89	250002 ..	00.8123	11.80	250093 ..	01.1498	11.71
230172 ...	01.2647	17.17	240017 ..	01.1279	14.24	240105 ..	00.9308	13.40	250003 ..	00.9311	12.12	250094 ..	01.2734	13.27
230173 ...	01.2687	17.18	240018 ..	01.2097	15.09	240106 ..	01.2295	21.48	250004 ..	01.4300	13.66	250095 ..	01.0353	11.93
230174 ...	01.2969	16.15	240019 ..	01.2969	18.63	240107 ..	00.9025	13.16	250005 ..	00.9925	08.99	250096 ..	01.1196	14.83
230175 ...	02.5647	14.97	240020 ..	01.1770	15.82	240108 ..	01.0177	10.01	250006 ..	00.9777	12.45	250097 ..	01.2122	12.30
230176 ...	01.2071	20.13	240021 ..	01.1178	13.32	240109 ..	00.9590	13.51	250007 ..	01.2267	15.01	250098 ..	00.8720	09.46
230178 ...	01.0559	14.99	240022 ..	01.0736	15.34	240110 ..	00.9597	15.43	250008 ..	00.9902	11.21	250099 ..	01.2539	12.00
230180 ...	01.0827	14.16	240023 ..	01.0969	15.19	240111 ..	01.0346	11.74	250009 ..	01.1391	10.70	250100 ..	01.2467	11.80
230184 ...	01.1328	14.57	240025 ..	01.1515	14.16	240112 ..	00.9898	12.95	250010 ..	01.0724	10.06	250101 ..	00.8793	08.70
230186 ...	01.0965	14.08	240027 ..	01.0245	11.62	240114 ..	01.0412	10.60	250012 ..	00.9567	11.79	250102 ..	01.4922	13.33
230188 ...	01.1139	15.94	240028 ..	01.1006	14.99	240115 ..	01.6079	21.44	250015 ..	01.0553	09.37	250104 ..	01.3327	14.08
230189 ...	00.9190	13.54	240029 ..	01.2108	14.23	240116 ..	00.9269	12.14	250017 ..	00.9426	13.08	250105 ..	00.8970	11.28
230190 ...	01.3785	18.04	240030 ..	01.3302	15.33	240117 ..	01.1176	15.35	250018 ..	00.9031	10.20	250107 ..	00.9562	13.72
230191 ...	00.8901	13.06	240031 ..	01.0538	13.01	240119 ..	00.8906	14.25	250019 ..	01.3868	14.82	250109 ..	00.9654	10.30
230193 ...	01.2619	16.40	240036 ..	01.4905	17.88	240121 ..	00.9077	16.37	250020 ..	00.9789	09.05	250112 ..	00.9612	11.79
230194 ...	01.1975	13.91	240037 ..	01.1006	15.67	240122 ..	01.0992	15.27	250021 ..	00.9398	07.83	250117 ..	01.0646	12.06
230195 ...	01.2950	18.03	240038 ..	01.4951	21.20	240123 ..	01.0605	13.47	250023 ..	00.8531	09.86	250119 ..	01.0949	10.32
230197 ...	01.2615	19.21	240040 ..	01.2596	16.06	240124 ..	01.0520	14.28	250024 ..	00.9885	07.74	250120 ..	00.9976	10.44
230199 ...	01.1365	15.53	240041 ..	01.2683	13.37	240125 ..	00.9045	10.46	250025 ..	01.0232	13.92	250122 ..	01.2226	15.54
230201 ...	01.0721	12.87	240043 ..	01.2178	15.65	240127 ..	01.0109	11.10	250027 ..	01.0456	10.39	250123 ..	01.2141	18.71
230204 ...	01.2769	19.02	240044 ..	01.1996	15.06	240128 ..	01.1626	15.73	250029 ..	00.9632	10.16	250124 ..	00.9096	10.51
230205 ...	01.0741	14.68	240045 ..	01.0166	16.58	240129 ..	01.0191	12.94	250030 ..	00.9960	10.01	250125 ..	01.3020	14.95
230207 ...	01.2234	18.62	240047 ..	01.4088	15.84	240130 ..	00.9815	13.39	250031 ..	01.2568	16.18	250126 ..	01.0613	11.53
230208 ...	01.1985	13.74	240048 ..	01.3250	20.23	240132 ..	01.1821	22.17	250032 ..	01.2296	14.64	250127 ..	00.7846	.....
230211 ...	00.9788	12.38	240049 ..	01.7175	19.30	240133 ..	01.1217	15.04	250033 ..	00.9742	11.82	250128 ..	00.9391	11.77
230212 ...	01.0550	18.73	240050 ..	01.1360	18.32	240135 ..	00.9377	11.11	250034 ..	01.4973	11.58	250131 ..	01.0142	09.78
230213 ...	01.0806	11.66	240051 ..	00.9231	15.59	240136 ..	00.8433	12.11	250035 ..	00.8641	12.15	250134 ..	00.9954	13.69
230216 ...	01.3347	15.22	240052 ..	01.2111	15.63	240137 ..	01.1811	14.41	250036 ..	01.0005	10.69	250136 ..	00.8317	14.79
230217 ...	01.1540	16.17	240053 ..	01.4962	18.22	240138 ..	00.8843	09.63	250037 ..	00.9018	10.43	250138 ..	01.2888	16.00
230219 ...	01.0239	11.59	240056 ..	01.2453	19.37	240139 ..	00.9723	14.31	250038 ..	00.9987	09.69	250140 ..	00.9049	08.90
230221 ...	01.2870	20.08	240057 ..	01.7395	20.10	240140 ..	00.9074	11.48	250039 ..	00.9788	08.23	250141 ..	01.2795	14.72
230222 ...	01.3017	16.28	240058 ..	01.0076	09.62	240141 ..	00.9912	18.54	250040 ..	01.2974	14.79	250144 ..	00.9225	.....
230223 ...	01.3383	18.13	240059 ..	01.2110	17.26	240142 ..	01.0446	13.02	250042 ..	01.1616	13.22	250145 ..	00.7146	.....

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
250146 ...	01.0102	.....	260091 ..	01.6253	18.26	270006 ..	00.9746	10.56	280023 ..	01.3516	13.27	280110 ..	00.9955	10.65
260001 ...	01.6634	14.89	260092 ..	01.0280	13.62	270007 ..	00.9529	11.48	280024 ..	00.9846	11.66	280111 ..	01.2922	14.82
260002 ...	01.3747	18.64	260094 ..	01.0736	12.66	270009 ..	01.0671	18.52	280025 ..	01.0234	10.02	280114 ..	00.9900	10.45
260003 ...	01.0260	12.20	260095 ..	01.3807	15.45	270011 ..	01.1025	14.76	280026 ..	01.0493	12.16	280115 ..	01.0191	12.67
260004 ...	01.0538	12.77	260096 ..	01.4959	19.36	270012 ..	01.4698	16.27	280028 ..	01.0097	11.92	280117 ..	01.0875	13.19
260005 ...	01.5572	17.00	260097 ..	01.1380	14.13	270013 ..	01.2727	15.02	280029 ..	00.8928	09.58	280118 ..	01.0483	14.77
260006 ...	01.5091	15.71	260100 ..	01.0571	12.23	270014 ..	01.6079	14.95	280030 ..	01.6599	21.75	280119 ..	00.8992	.....
260007 ...	01.3639	15.19	260102 ..	01.0839	14.83	270016 ..	00.8118	09.83	280031 ..	01.0550	12.06	280123 ..	00.8286	13.91
260008 ...	01.2405	14.14	260103 ..	01.3972	16.34	270017 ..	01.2367	15.69	280032 ..	01.2476	14.22	290001 ..	01.6571	20.33
260009 ...	01.2538	14.91	260104 ..	01.6549	17.70	270019 ..	00.9646	11.57	280033 ..	01.1094	13.61	290002 ..	00.9120	16.20
260011 ...	01.5681	16.81	260105 ..	01.8607	17.57	270021 ..	01.1244	13.12	280034 ..	01.1968	13.55	290003 ..	01.6607	20.74
260012 ...	01.0775	10.76	260107 ..	01.4024	16.71	270023 ..	01.3326	16.04	280035 ..	00.9251	11.06	290005 ..	01.2603	18.60
260013 ...	01.1781	13.00	260108 ..	01.7807	17.07	270024 ..	00.9937	12.25	280037 ..	00.9898	10.57	290006 ..	01.0426	17.56
260014 ...	01.7028	17.03	260109 ..	01.0318	10.83	270026 ..	00.9270	14.52	280038 ..	01.0970	12.32	290007 ..	01.8614	19.49
260015 ...	01.1463	13.06	260110 ..	01.6186	13.38	270027 ..	01.0071	11.19	280039 ..	01.1476	11.46	290008 ..	01.2834	19.77
260017 ...	01.2235	13.75	260111 ..	00.9193	10.33	270028 ..	01.0211	14.70	280040 ..	01.5884	17.67	290009 ..	01.5081	20.23
260018 ...	00.9472	08.71	260112 ..	01.4051	17.17	270029 ..	01.0373	14.41	280041 ..	01.0365	10.18	290010 ..	01.1540	16.04
260019 ...	01.0163	12.36	260113 ..	01.1657	11.99	270030 ..	00.7612	.....	280042 ..	01.0350	12.45	290011 ..	00.8320	11.94
260020 ...	01.6650	18.13	260115 ..	01.1918	13.38	270031 ..	00.9295	10.86	280043 ..	01.1274	13.48	290012 ..	01.3572	18.72
260021 ...	01.4522	16.18	260116 ..	01.1505	12.40	270032 ..	01.0832	15.20	280045 ..	01.1318	12.49	290013 ..	00.9998	15.06
260022 ...	01.3955	12.21	260119 ..	01.2584	13.25	270033 ..	00.9110	15.18	280046 ..	01.0010	10.16	290014 ..	01.0364	15.84
260023 ...	01.2384	14.14	260120 ..	01.2393	14.57	270035 ..	01.0121	13.97	280047 ..	01.0944	14.84	290015 ..	00.9331	14.63
260024 ...	01.0522	11.04	260122 ..	01.1817	12.00	270036 ..	00.9135	11.20	280048 ..	01.0423	10.70	290016 ..	01.2080	13.62
260025 ...	01.2423	13.10	260123 ..	01.0260	10.37	270039 ..	00.9348	17.94	280049 ..	01.0269	12.20	290018 ..	01.2956	17.15
260027 ...	01.5736	17.97	260127 ..	00.9731	13.39	270040 ..	01.0844	15.30	280050 ..	00.9529	11.49	290019 ..	01.2279	17.04
260029 ...	01.1928	18.54	260128 ..	00.9679	08.66	270041 ..	00.9693	10.47	280051 ..	00.9747	12.15	290020 ..	01.2483	16.81
260030 ...	01.1710	10.05	260129 ..	01.0667	12.87	270044 ..	01.2568	12.26	280052 ..	01.0435	10.45	290021 ..	01.5747	20.63
260031 ...	01.4919	17.49	260131 ..	01.2852	13.97	270046 ..	00.9215	14.21	280054 ..	01.2397	15.23	290022 ..	01.6050	20.10
260032 ...	01.6994	18.87	260134 ..	01.2865	13.25	270047 ..	01.1692	09.98	280055 ..	00.9080	11.10	290027 ..	01.0024	16.54
260033 ...	01.3247	14.53	260137 ..	01.1776	13.58	270048 ..	01.1014	13.40	280056 ..	01.0481	09.44	290029 ..	00.9610	.....
260034 ...	01.0205	13.13	260138 ..	01.8672	16.90	270049 ..	01.7111	15.71	280057 ..	01.0131	15.03	290032 ..	01.3954	19.64
260035 ...	01.1365	11.06	260141 ..	01.9446	15.87	270050 ..	01.0065	15.42	280058 ..	01.2678	12.49	300001 ..	01.3414	19.02
260036 ...	01.0804	14.55	260142 ..	01.2021	13.51	270051 ..	01.3094	16.46	280060 ..	01.5767	17.64	300003 ..	01.7495	19.71
260037 ...	01.2511	13.74	260143 ..	01.0398	10.03	270052 ..	01.0258	19.34	280061 ..	01.3436	15.01	300005 ..	01.2775	17.05
260039 ...	01.1978	10.70	260146 ..	01.5255	14.81	270053 ..	01.1220	08.14	280062 ..	01.1863	11.55	300006 ..	01.1299	15.08
260040 ...	01.4880	14.03	260147 ..	01.0243	11.64	270055 ..	00.7016	.....	280064 ..	01.0380	11.38	300007 ..	01.1477	19.46
260042 ...	01.1845	15.65	260148 ..	00.9980	14.12	270057 ..	01.1710	15.06	280065 ..	01.2349	15.65	300008 ..	01.2673	15.50
260044 ...	01.0654	13.62	260158 ..	01.0835	10.90	270058 ..	00.9576	10.74	280066 ..	01.0717	10.40	300009 ..	01.1600	16.54
260047 ...	01.2900	13.30	260159 ..	01.1822	18.22	270059 ..	00.8646	12.91	280068 ..	00.8976	08.61	300010 ..	01.2410	16.90
260048 ...	01.2923	16.57	260160 ..	01.1296	12.91	270060 ..	00.9063	11.63	280070 ..	01.0418	11.22	300011 ..	01.2872	20.39
260050 ...	01.0960	12.53	260162 ..	01.1213	16.85	270063 ..	00.8744	13.29	280073 ..	00.9927	13.90	300012 ..	01.2920	20.73
260051 ...	01.0852	13.22	260163 ..	01.1730	12.84	270067 ..	01.1181	.....	280074 ..	01.0971	10.62	300013 ..	01.2094	15.98
260052 ...	01.2549	15.53	260164 ..	01.0734	11.11	270068 ..	00.8749	11.69	280075 ..	01.2244	11.19	300014 ..	01.2542	16.93
260053 ...	01.1330	09.80	260166 ..	01.2098	17.16	270072 ..	00.8859	15.52	280076 ..	01.0942	13.66	300015 ..	01.1507	16.69
260054 ...	01.2850	15.62	260172 ..	00.9893	11.99	270073 ..	01.1510	10.27	280077 ..	01.2977	16.26	300016 ..	01.2369	17.23
260055 ...	01.0642	12.73	260173 ..	00.9923	10.22	270074 ..	00.8805	.....	280079 ..	00.9809	09.48	300017 ..	01.1841	18.38
260057 ...	01.2088	13.64	260175 ..	01.1918	13.15	270075 ..	00.9436	.....	280080 ..	01.2379	10.27	300018 ..	01.2221	18.26
260059 ...	01.1065	11.93	260176 ..	01.5465	15.91	270076 ..	00.7562	.....	280081 ..	01.4820	16.98	300019 ..	01.2495	17.09
260061 ...	01.1426	09.82	260177 ..	01.2941	18.12	270079 ..	00.9326	12.66	280082 ..	01.3050	09.86	300020 ..	01.2377	18.13
260062 ...	01.1629	15.45	260178 ..	01.5048	19.22	270080 ..	01.1032	13.60	280083 ..	01.0240	11.97	300021 ..	01.1597	14.84
260063 ...	01.1454	13.06	260179 ..	01.5311	20.18	270081 ..	00.9698	10.11	280084 ..	01.0470	09.83	300022 ..	01.1177	15.00
260064 ...	01.3850	15.64	260180 ..	01.5518	17.26	270082 ..	00.9072	14.85	280085 ..	00.8963	13.22	300023 ..	01.2391	19.05
260065 ...	01.6779	14.32	260183 ..	01.6363	15.05	270083 ..	01.0378	12.97	280088 ..	01.6710	17.18	300024 ..	01.2318	15.72
260066 ...	01.1342	12.00	260186 ..	01.1638	14.14	270084 ..	00.9212	13.03	280089 ..	01.0477	12.85	300028 ..	01.2081	16.12
260067 ...	00.9175	12.05	260188 ..	01.3866	15.00	280001 ..	01.0391	12.18	280090 ..	00.9980	11.70	300029 ..	01.3292	20.57
260068 ...	01.7836	17.91	260189 ..	00.8964	09.49	280003 ..	01.8969	16.43	280091 ..	01.0899	13.49	300033 ..	01.0766	13.25
260070 ...	01.2315	10.32	260190 ..	01.2049	20.62	280005 ..	01.4381	16.26	280092 ..	00.9157	11.14	300034 ..	01.7999	20.13
260073 ...	01.0263	10.98	260191 ..	01.2302	17.70	280009 ..	01.5328	15.40	280094 ..	01.1517	12.59	310001 ..	01.6349	21.91
260074 ...	01.2177	13.00	260193 ..	01.2600	16.35	280011 ..	00.9727	10.71	280097 ..	00.9588	12.01	310002 ..	01.7714	22.69
260077 ...	01.5203	15.46	260195 ..	01.1426	14.93	280012 ..	01.2184	12.69	280098 ..	00.9679	09.84	310003 ..	01.2152	20.51
260078 ...	01.1311	13.62	260197 ..	01.2209	20.81	280013 ..	01.9819	20.17	280101 ..	01.1395	12.16	310005 ..	01.1891	19.16
260079 ...	01.0080	10.71	260198 ..	01.2177	14.62	280014 ..	01.0454	10.76	280102 ..	00.9735	10.22	310006 ..	01.2276	18.73
260080 ...	01.0833	09.00	260200 ..	01.2017	19.15	280015 ..	01.1047	13.75	280104 ..	01.0008	11.74	310008 ..	01.3004	18.98
260081 ...	01.4061	17.40	260202 ..	01.2953	16.81	280017 ..	01.1113	12.92	280105 ..	01.2967	14.83	310009 ..	01.1509	20.10
260082 ...	01.1213	13.27	260204 ..	00.8499	.....	280018 ..	00.9974	12.01	280106 ..	01.0583	12.09	310010 ..	01.2746	19.78
260085 ...	01.5101	17.37	270002 ..	01.1900	12.64	280020 ..	01.4359	16.53	280107 ..	01.0335	10.56	310011 ..	01.2395	18.15
260086 ...	01.0323	12.04	270003 ..	01.1873	16.85	280021 ..	01.1348	13.34	280108 ..	01.0946	12.16	310012 ..	01.5444	21.45
260089 ...	01.0034	12.53	270004 ..	01.6495	16.14	280022 ..	00.9490	10.53	280109 ..	00.8511	11.14	310013 ..	01.2946	17.62

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
310014	01.5742	22.63	310111	01.2869	17.58	330016	01.0329	14.50	330119	01.7325	27.28	330224	01.2544	19.24
310015	01.6880	23.19	310112	01.2792	17.81	330019	01.2647	22.42	330121	01.0030	14.55	330225	01.1937	23.33
310016	01.2138	20.50	310113	01.2522	18.18	330020	01.0867	14.84	330122	01.2333	19.59	330226	01.2657	17.69
310017	01.3453	20.51	310115	01.1820	18.75	330023	01.1973	19.85	330125	01.6953	18.97	330229	01.3237	13.56
310018	01.2142	23.43	310116	01.2895	19.88	330024	01.8216	26.75	330126	01.2041	18.28	330230	01.5357	24.76
310019	01.6478	19.13	310118	01.2904	23.38	330025	01.1062	14.30	330127	01.3851	24.83	330231	01.1533	25.13
310020	01.2427	17.60	310119	01.5696	29.88	330027	01.5206	28.98	330128	01.3925	25.66	330232	01.2537	14.83
310021	01.3396	18.25	310120	01.0901	17.21	330028	01.3460	22.68	330132	01.1420	12.27	330233	01.5248	27.01
310022	01.2335	18.31	310121	01.1334	18.72	330029	01.1440	15.76	330133	01.3637	26.33	330234	02.0302	25.92
310024	01.2387	20.69	310898	00.4649	.....	330030	01.1835	14.98	330135	01.2408	16.49	330235	01.1396	16.14
310025	01.1841	19.58	320001	01.4496	16.86	330033	01.1756	13.16	330136	01.2608	21.77	330236	01.3256	25.41
310026	01.3100	20.16	320002	01.3049	20.26	330034	01.0216	28.07	330140	01.6509	16.38	330238	01.1250	14.95
310027	01.3074	17.63	320003	01.2595	13.22	330036	01.2544	20.09	330141	01.3081	22.13	330239	01.2379	13.84
310028	01.1817	18.28	320004	01.1589	15.58	330037	01.0940	13.75	330144	01.0838	12.78	330240	01.3051	26.44
310029	01.7744	19.95	320005	01.2295	16.12	330038	01.1633	14.14	330148	00.9882	13.44	330241	01.8399	20.10
310031	02.5295	22.82	320006	01.3783	13.69	330039	00.8375	13.46	330151	01.0959	12.81	330242	01.3653	19.96
310032	01.2728	19.09	320009	01.5035	15.54	330041	01.3278	24.26	330152	01.4062	26.09	330245	01.2087	15.62
310034	01.2211	18.59	320011	00.9916	15.22	330043	01.2506	23.92	330153	01.6330	16.75	330246	01.2171	22.26
310036	01.2241	17.56	320012	01.0247	14.52	330044	01.1678	16.27	330154	01.4949	.....	330247	00.6914	24.34
310037	01.2154	23.45	320013	01.0743	15.84	330045	01.4026	22.01	330157	01.2590	15.89	330249	01.2322	15.40
310038	01.7502	21.86	320014	00.9564	13.73	330046	01.5346	25.92	330158	01.3171	21.63	330250	01.2624	16.08
310039	01.2946	18.56	320016	01.1382	14.59	330047	01.2742	15.31	330159	01.3197	17.11	330252	00.9602	14.59
310040	01.2409	20.49	320017	01.1782	17.22	330048	01.2382	14.59	330160	01.4179	24.63	330254	01.0002	16.38
310041	01.2753	20.49	320018	01.4560	16.07	330049	01.2828	16.98	330161	00.9685	15.29	330258	01.3281	23.94
310042	01.1661	21.01	320019	01.3960	17.39	330053	01.1361	13.82	330162	01.3003	22.13	330259	01.4208	21.72
310043	01.1877	19.14	320021	01.6877	17.70	330055	01.4198	27.67	330163	01.1410	15.59	330261	01.2805	22.00
310044	01.3090	18.52	320022	01.2569	16.29	330056	01.4146	24.73	330164	01.3323	17.75	330263	01.0476	15.05
310045	01.2948	22.96	320023	01.0783	11.67	330057	01.6239	16.34	330166	00.9793	13.39	330264	01.1805	17.85
310047	01.2846	20.40	320030	01.0596	15.83	330058	01.2707	14.94	330167	01.5606	24.15	330265	01.2982	15.23
310048	01.2237	15.96	320031	00.9342	12.53	330059	01.5561	26.37	330169	01.4148	28.56	330267	01.3094	21.01
310049	01.3131	19.63	320032	00.9508	15.92	330061	01.3472	21.49	330171	01.2972	22.03	330268	01.1150	14.37
310050	01.1859	19.96	320033	01.1065	17.04	330062	01.0602	14.93	330175	01.0774	13.20	330270	01.9180	28.30
310051	01.2774	21.27	320035	01.3382	13.24	330064	01.4069	25.74	330177	00.9995	13.24	330273	01.3518	20.59
310052	01.2121	20.20	320037	01.1481	13.11	330065	01.1926	16.20	330179	00.8930	12.97	330275	01.2238	16.62
310054	01.2732	21.24	320038	01.2389	14.38	330066	01.2273	17.39	330180	01.1892	14.87	330276	01.2167	16.70
310056	01.1774	17.32	320046	01.0729	15.91	330067	01.3189	19.22	330181	01.2261	27.37	330277	01.1777	15.22
310057	01.2768	16.38	320048	01.2320	13.09	330072	01.3404	26.08	330182	02.3673	25.86	330279	01.2864	16.73
310058	01.1326	20.45	320056	00.9285	.....	330073	01.2135	12.91	330183	01.3603	17.43	330281	00.5686	20.00
310060	01.1741	15.89	320057	01.0146	.....	330074	01.2478	15.68	330184	01.3576	22.64	330285	01.7443	20.83
310061	01.1664	18.01	320058	00.7388	.....	330075	01.0779	15.62	330185	01.1944	22.90	330286	01.3377	21.72
310062	01.3059	24.81	320059	01.0347	.....	330078	01.3808	15.94	330186	01.0663	19.28	330288	01.0510	15.73
310063	01.3360	20.38	320060	00.9396	.....	330079	01.2508	14.89	330188	01.2364	16.63	330290	01.7023	26.56
310064	01.2505	20.41	320061	01.3158	.....	330080	01.3156	23.40	330189	00.7710	13.00	330293	01.1870	13.94
310067	01.2732	18.65	320062	00.8686	.....	330082	01.2583	16.58	330191	01.2972	16.96	330304	01.2664	25.07
310069	01.1770	18.53	320063	01.2972	15.07	330084	00.9774	15.00	330193	01.3641	24.94	330306	01.4010	23.49
310070	01.3208	20.67	320065	01.1953	15.47	330085	01.3537	17.17	330194	01.8095	25.78	330307	01.2200	16.06
310072	01.2416	18.95	320067	00.9079	10.33	330086	01.2408	22.49	330195	01.5594	26.38	330308	01.2840	24.28
310073	01.4691	19.99	320068	00.9861	15.10	330088	01.1075	22.93	330196	01.3816	24.47	330309	01.2121	22.70
310074	01.2527	19.27	320069	01.0207	12.54	330090	01.6337	15.36	330197	01.0421	14.66	330314	01.2931	21.13
310075	01.3011	20.64	320070	00.8934	.....	330091	01.3710	17.28	330198	01.3539	26.02	330315	01.1666	21.49
310076	01.3398	24.98	320074	01.1252	17.10	330092	01.0355	13.86	330199	01.2781	23.00	330316	01.3004	23.18
310077	01.5661	20.65	320076	01.1991	14.58	330094	01.1760	14.68	330201	01.4416	24.55	330327	00.9282	14.93
310078	01.2659	21.69	320079	01.1341	18.51	330095	01.1924	15.53	330202	01.4057	25.07	330331	01.2040	24.79
310081	01.2485	18.24	320080	00.5832	.....	330096	01.0555	13.82	330203	01.3473	18.97	330332	01.2508	22.24
310083	01.2342	20.23	330001	01.1730	19.91	330097	01.1752	14.78	330204	01.3366	23.41	330333	01.3186	23.12
310084	01.2000	18.73	330002	01.4515	22.56	330100	00.7012	22.60	330205	01.1999	17.97	330336	01.3713	26.05
310085	01.1170	17.90	330003	01.2833	17.47	330101	01.7094	30.13	330208	01.2026	21.83	330338	01.1705	20.43
310086	01.1935	18.94	330004	01.3082	17.83	330102	01.3047	15.59	330209	01.2335	18.89	330339	00.8063	17.43
310087	01.2476	18.41	330005	01.7510	18.22	330103	01.1854	15.52	330211	01.1957	15.21	330340	01.1799	24.08
310088	01.1615	19.42	330006	01.3413	21.67	330104	01.3488	23.56	330212	01.2172	18.85	330350	01.7967	26.28
310090	01.2313	20.13	330007	01.3744	15.51	330106	01.5771	29.39	330213	01.1345	15.33	330353	01.2966	24.84
310091	01.2164	18.22	330008	01.1638	15.29	330107	01.1838	21.23	330214	01.7319	27.58	330354	01.4081	.....
310092	01.3774	18.31	330009	01.2724	26.03	330108	01.2091	16.18	330215	01.1507	15.94	330357	01.3654	29.57
310093	01.1869	18.84	330010	01.2299	13.72	330111	01.1419	13.22	330218	01.2015	15.84	330359	00.9245	19.30
310096	01.8732	21.76	330011	01.2145	16.37	330114	00.9960	15.08	330219	01.6161	18.33	330372	01.2703	20.79
310105	01.3449	19.82	330012	01.5853	26.43	330115	01.2293	13.79	330221	01.2905	25.37	330381	01.2390	23.70
310108	01.3067	20.29	330013	01.9866	16.97	330116	00.9653	16.94	330222	01.2073	14.02	330383	01.5122	.....
310110	01.1782	17.88	330014	01.3938	25.19	330118	01.5909	16.14	330223	01.0720	13.45	330385	01.4133	29.11

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
330386 ...	01.1675	17.11	340069 ..	01.7588	16.62	340166 ..	01.3189	17.47	360018 ..	01.5088	17.63	360094 ..	01.1823	16.44
330387 ...	00.8490	23.22	340070 ..	01.2708	15.30	340168 ..	00.5454	14.80	360019 ..	01.2284	17.21	360095 ..	01.2750	14.92
330389 ...	01.8866	27.58	340071 ..	01.0354	13.49	350001 ..	01.0250	10.83	360020 ..	01.4276	16.47	360096 ..	01.0974	14.95
330390 ...	01.2979	24.47	340072 ..	01.1017	13.40	350002 ..	01.6920	16.15	360021 ..	01.2159	16.31	360098 ..	01.3840	17.84
330393 ...	01.6149	22.41	340073 ..	01.4658	18.47	350003 ..	01.1473	14.23	360024 ..	01.2408	17.03	360099 ..	01.0579	15.49
330394 ...	01.4095	16.96	340075 ..	01.1544	14.80	350004 ..	01.8625	17.07	360025 ..	01.1873	17.00	360100 ..	01.2965	13.69
330395 ...	01.3571	25.96	340080 ..	01.1430	09.88	350005 ..	01.1031	11.21	360026 ..	01.1842	15.01	360101 ..	01.7545	19.63
330396 ...	01.2335	26.91	340084 ..	01.0572	13.62	350006 ..	01.2701	17.95	360027 ..	01.5365	17.37	360102 ..	01.2631	17.18
330397 ...	01.5073	26.69	340085 ..	01.1941	14.33	350007 ..	01.0067	09.21	360028 ..	01.3755	15.02	360103 ..	01.3973	17.82
330398 ...	01.2600	24.07	340087 ..	01.1721	14.86	350008 ..	01.0632	13.30	360029 ..	01.1183	14.74	360104 ..	00.9613	16.76
330399 ...	01.3657	28.62	340088 ..	01.1241	14.92	350009 ..	01.1441	14.36	360030 ..	01.1725	14.51	360106 ..	01.1505	12.63
340001 ...	01.3622	17.90	340089 ..	00.9772	10.77	350010 ..	01.0950	11.07	360031 ..	01.2762	16.00	360107 ..	01.1847	15.07
340002 ...	01.8205	16.29	340090 ..	01.0761	13.47	350011 ..	01.7147	16.96	360032 ..	01.0787	15.27	360108 ..	01.0229	13.97
340003 ...	01.1762	14.86	340091 ..	01.6470	17.60	350012 ..	01.0658	11.31	360034 ..	01.1989	12.84	360109 ..	01.0473	16.12
340004 ...	01.4821	15.33	340093 ..	01.1219	11.99	350013 ..	01.1213	13.52	360035 ..	01.4870	18.47	360112 ..	01.7694	18.73
340005 ...	01.1959	12.35	340094 ..	01.3299	15.81	350014 ..	01.1292	10.67	360036 ..	01.1943	16.47	360113 ..	01.3410	17.59
340006 ...	01.2424	13.41	340096 ..	01.2368	14.57	350015 ..	01.6105	15.84	360037 ..	02.1138	18.67	360114 ..	01.0941	14.97
340007 ...	01.1646	13.78	340097 ..	01.1140	11.48	350016 ..	00.9573	11.10	360038 ..	01.4851	16.89	360115 ..	01.1422	16.96
340008 ...	01.1839	15.73	340098 ..	01.6430	16.25	350017 ..	01.3380	14.02	360039 ..	01.2839	14.64	360116 ..	01.0719	14.50
340009 ...	01.5128	18.76	340099 ..	01.1396	11.89	350018 ..	01.1529	09.40	360040 ..	01.2237	16.01	360118 ..	01.2795	15.25
340010 ...	01.3154	14.82	340100 ..	01.2221	.....	350019 ..	01.5841	17.16	360041 ..	01.3393	16.68	360119 ..	01.2610	17.14
340011 ...	01.0675	12.63	340101 ..	01.0400	09.36	350020 ..	01.3945	16.19	360042 ..	01.1077	14.26	360120 ..	00.7566	17.54
340012 ...	01.1415	14.03	340104 ..	01.0198	07.49	350021 ..	01.0545	10.29	360044 ..	01.0741	14.22	360121 ..	01.2385	11.33
340013 ...	01.2007	14.24	340105 ..	01.3476	17.54	350023 ..	01.0159	11.13	360045 ..	01.4664	19.21	360122 ..	01.3830	16.72
340014 ...	01.6077	18.79	340106 ..	01.1342	15.13	350024 ..	01.1481	09.39	360046 ..	01.1350	16.35	360123 ..	01.2420	16.80
340015 ...	01.2384	14.74	340107 ..	01.2490	15.74	350025 ..	00.9853	11.59	360047 ..	01.0819	12.46	360124 ..	01.2029	16.36
340016 ...	01.1034	13.82	340109 ..	01.2985	14.37	350027 ..	00.9928	12.22	360048 ..	01.8354	20.28	360125 ..	01.1368	14.91
340017 ...	01.2648	13.87	340111 ..	01.1297	12.76	350029 ..	00.8784	09.62	360049 ..	01.3167	17.96	360126 ..	01.3162	15.84
340018 ...	01.1897	13.17	340112 ..	01.0327	13.95	350030 ..	01.0248	14.92	360050 ..	01.1898	12.14	360127 ..	01.0841	14.17
340019 ...	01.1047	13.32	340113 ..	01.9015	18.50	350033 ..	00.9363	13.57	360051 ..	01.5031	18.53	360128 ..	01.1327	13.72
340020 ...	01.1829	18.53	340114 ..	01.4419	18.30	350034 ..	00.9722	13.40	360052 ..	01.7019	16.61	360129 ..	01.0239	13.03
340021 ...	01.3146	13.89	340115 ..	01.5012	16.01	350035 ..	00.9150	09.26	360054 ..	01.2843	14.56	360130 ..	01.0624	13.04
340022 ...	01.0912	13.65	340116 ..	01.7630	19.73	350036 ..	00.9025	09.81	360055 ..	01.1905	16.33	360131 ..	01.2098	15.01
340023 ...	01.3148	16.32	340119 ..	01.2906	13.80	350038 ..	01.0242	15.62	360056 ..	01.3100	15.51	360132 ..	01.2464	17.42
340024 ...	01.2490	13.00	340120 ..	01.0998	12.06	350039 ..	01.0200	12.62	360057 ..	01.0694	12.44	360133 ..	01.4563	16.50
340025 ...	01.1582	13.18	340121 ..	01.0676	12.96	350041 ..	01.0757	11.57	360058 ..	01.1471	15.01	360134 ..	01.5554	17.39
340027 ...	01.2180	13.68	340122 ..	01.0174	10.85	350042 ..	01.0638	12.64	360059 ..	01.4852	18.80	360135 ..	01.2248	14.57
340028 ...	01.3895	15.42	340123 ..	01.1561	13.69	350043 ..	01.5311	14.64	360062 ..	01.5744	17.01	360136 ..	01.1219	13.65
340030 ...	01.8664	17.35	340124 ..	01.1012	13.00	350044 ..	00.8323	08.90	360063 ..	01.1006	14.42	360137 ..	01.5660	18.00
340031 ...	01.0154	11.45	340125 ..	01.4070	16.81	350047 ..	01.1836	15.32	360064 ..	01.4720	17.53	360139 ..	00.9743	12.05
340032 ...	01.2730	15.54	340126 ..	01.3373	15.32	350049 ..	01.1917	09.83	360065 ..	01.2478	15.01	360140 ..	01.0793	14.54
340034 ...	01.2689	15.97	340127 ..	01.2591	15.55	350050 ..	01.0212	11.38	360066 ..	01.2254	14.92	360141 ..	01.4062	18.14
340035 ...	01.1578	15.17	340129 ..	01.2608	17.74	350051 ..	00.9812	12.48	360067 ..	01.1037	11.39	360142 ..	01.0047	13.89
340036 ...	01.1863	15.00	340130 ..	01.3277	14.86	350053 ..	00.8979	11.10	360068 ..	01.5770	18.67	360143 ..	01.2457	16.82
340037 ...	01.2307	15.38	340131 ..	01.3162	14.95	350055 ..	00.9022	11.18	360069 ..	01.0222	15.61	360144 ..	01.2686	18.65
340038 ...	01.1338	13.31	340132 ..	01.2929	12.54	350056 ..	00.9607	11.87	360070 ..	01.5500	15.73	360145 ..	01.5316	15.26
340039 ...	01.2821	16.55	340133 ..	01.1581	14.11	350058 ..	01.0392	11.33	360071 ..	01.2514	13.91	360147 ..	01.1993	14.87
340040 ...	01.8095	16.34	340136 ..	00.9621	16.24	350060 ..	00.9417	07.24	360072 ..	01.1888	14.87	360148 ..	01.1771	14.28
340041 ...	01.2477	14.67	340137 ..	01.4470	12.18	350061 ..	00.9998	12.32	360074 ..	01.4126	16.37	360149 ..	01.1016	15.84
340042 ...	01.1520	13.14	340138 ..	01.2082	14.43	350063 ..	00.9056	.....	360075 ..	01.4333	19.23	360150 ..	01.2634	16.63
340044 ...	01.0454	10.39	340141 ..	01.5716	17.23	350064 ..	00.7266	.....	360076 ..	01.3244	15.95	360151 ..	01.3429	15.61
340045 ...	01.0313	09.87	340142 ..	01.2183	14.37	350065 ..	00.9497	10.34	360077 ..	01.4127	16.81	360152 ..	01.4841	16.22
340047 ...	01.9026	16.64	340143 ..	01.3561	17.58	350066 ..	00.6282	.....	360078 ..	01.2640	17.46	360153 ..	01.1808	12.99
340048 ...	01.2550	07.91	340144 ..	01.2940	17.53	360001 ..	01.2323	15.84	360079 ..	01.6740	17.96	360154 ..	01.0409	11.51
340049 ...	00.6445	15.08	340145 ..	01.2767	17.27	360002 ..	01.1529	14.33	360080 ..	01.1344	14.11	360155 ..	01.3273	17.47
340050 ...	01.1725	14.78	340146 ..	01.0482	12.21	360003 ..	01.6359	18.41	360081 ..	01.3213	17.76	360156 ..	01.1358	16.04
340051 ...	01.2111	15.20	340147 ..	01.3460	15.44	360006 ..	01.7533	18.70	360082 ..	01.3202	17.76	360159 ..	01.2120	16.45
340052 ...	01.0041	16.81	340148 ..	01.4350	15.52	360007 ..	01.0844	15.64	360083 ..	01.3047	15.91	360161 ..	01.2557	18.08
340053 ...	01.5889	17.14	340151 ..	01.2065	13.47	360008 ..	01.2054	14.53	360084 ..	01.6037	16.81	360162 ..	01.2704	15.67
340054 ...	01.0834	12.08	340153 ..	01.9187	19.72	360009 ..	01.3296	17.41	360085 ..	01.7484	18.24	360163 ..	01.7580	18.19
340055 ...	01.2149	15.33	340154 ..	00.7709	14.62	360010 ..	01.1670	14.28	360086 ..	01.4146	15.83	360164 ..	00.8498	13.58
340060 ...	01.1259	14.49	340155 ..	01.4503	20.53	360011 ..	01.2510	16.40	360087 ..	01.3180	15.92	360165 ..	01.1135	13.53
340061 ...	01.6405	17.49	340156 ..	00.8069	.....	360012 ..	01.2347	17.96	360088 ..	01.1443	14.18	360166 ..	01.1827	15.77
340063 ...	01.0337	11.52	340158 ..	01.1022	15.90	360013 ..	01.1008	15.33	360089 ..	01.0927	15.10	360169 ..	01.0869	16.28
340064 ...	01.1706	14.10	340159 ..	01.1219	14.10	360014 ..	01.1323	14.98	360090 ..	01.2451	17.34	360170 ..	01.1039	16.93
340065 ...	01.1413	13.03	340160 ..	01.1180	11.94	360015 ..	01.4740	17.62	360091 ..	01.2659	17.38	360172 ..	01.3416	15.90
340067 ...	01.1663	12.63	340162 ..	01.1545	16.42	360016 ..	01.5331	17.03	360092 ..	01.1827	16.42	360174 ..	01.2014	14.63
340068 ...	01.3545	12.17	340164 ..	01.3555	17.07	360017 ..	01.7120	18.91	360093 ..	01.2196	15.15	360175 ..	01.1433	15.64

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
360176 ...	01.2248	12.33	370037 ...	01.5493	15.41	370158 ...	01.0610	12.52	380069 ...	01.1795	15.99	390059 ...	01.3066	15.15
360177 ...	01.2818	16.76	370038 ...	00.9813	10.14	370159 ...	01.3940	14.16	380070 ...	01.1738	18.67	390060 ...	01.0939	14.69
360178 ...	01.2340	14.42	370039 ...	01.3153	17.35	370161 ...	01.1890	16.35	380071 ...	01.2559	21.69	390061 ...	01.3822	17.33
360179 ...	01.2719	17.36	370040 ...	01.0392	09.92	370163 ...	00.8707	09.85	380072 ...	01.0025	13.01	390062 ...	01.1696	14.09
360180 ...	02.2227	20.03	370041 ...	00.9755	12.74	370165 ...	01.1611	10.92	380075 ...	01.4450	17.91	390063 ...	01.6600	17.69
360184 ...	00.6849	14.70	370042 ...	00.8848	10.79	370166 ...	01.1740	16.00	380078 ...	01.1599	16.41	390064 ...	01.4458	15.00
360185 ...	01.2022	15.85	370043 ...	00.9379	10.62	370169 ...	01.0425	10.00	380081 ...	01.0894	15.77	390065 ...	01.2254	17.69
360186 ...	01.2431	14.82	370045 ...	01.0427	10.20	370170 ...	00.9535	.....	380082 ...	01.2182	18.63	390066 ...	01.2539	16.74
360187 ...	01.3438	16.03	370046 ...	00.9964	12.64	370171 ...	00.9910	.....	380083 ...	01.1281	16.57	390067 ...	01.7108	17.24
360188 ...	01.0378	14.70	370047 ...	01.2319	12.34	370172 ...	00.8426	.....	380084 ...	01.2184	19.45	390068 ...	01.3492	16.97
360189 ...	01.0691	14.46	370048 ...	01.1252	11.45	370173 ...	01.3753	.....	380087 ...	01.0448	12.17	390069 ...	01.2992	16.98
360192 ...	01.3491	17.97	370049 ...	01.3454	14.08	370176 ...	01.2616	17.68	380088 ...	00.9570	14.76	390070 ...	01.2744	18.70
360193 ...	01.2861	12.74	370051 ...	01.0287	10.47	370177 ...	00.9702	09.39	380089 ...	01.2714	19.78	390071 ...	01.0925	11.99
360194 ...	01.1410	14.46	370054 ...	01.2711	14.68	370178 ...	01.0643	11.44	380090 ...	01.2971	18.73	390072 ...	01.0780	14.85
360195 ...	01.1565	16.45	370056 ...	01.4481	14.44	370179 ...	00.9595	12.90	380091 ...	01.1836	22.18	390073 ...	01.5312	17.40
360197 ...	01.1633	15.43	370057 ...	01.1433	13.92	370180 ...	01.0329	.....	380897 ...	05.0667	.....	390074 ...	01.2080	15.50
360200 ...	01.1548	10.65	370059 ...	01.2120	12.34	370183 ...	01.1452	11.67	390001 ...	01.3135	16.25	390075 ...	01.3115	14.60
360203 ...	01.1407	14.52	370060 ...	01.1721	11.89	370186 ...	00.9872	09.16	390002 ...	01.3144	16.65	390076 ...	01.2674	18.93
360204 ...	01.2206	15.73	370063 ...	01.1624	11.88	370189 ...	01.0572	09.26	390003 ...	01.2008	15.23	390078 ...	01.0362	15.47
360210 ...	01.1403	17.25	370064 ...	01.0040	08.92	370190 ...	01.7487	18.02	390004 ...	01.4013	15.76	390079 ...	01.7080	15.49
360211 ...	01.1989	15.45	370065 ...	01.0748	13.47	380001 ...	01.2783	17.45	390005 ...	01.0346	13.42	390080 ...	01.2068	17.66
360212 ...	01.4239	17.91	370069 ...	01.0292	12.62	380002 ...	01.1869	16.54	390006 ...	01.7576	16.22	390081 ...	01.2676	18.98
360213 ...	01.0787	14.45	370071 ...	01.0867	10.25	380003 ...	01.1786	16.59	390007 ...	01.1965	17.30	390083 ...	01.1644	20.49
360218 ...	01.2594	15.21	370072 ...	00.9446	11.20	380004 ...	01.7910	20.49	390008 ...	01.1377	15.38	390084 ...	01.1687	14.93
360230 ...	01.2992	18.07	370076 ...	01.2250	10.80	380005 ...	01.2181	17.60	390009 ...	01.6017	16.14	390086 ...	01.0781	14.19
360231 ...	01.0940	13.85	370077 ...	01.2835	16.00	380006 ...	01.3041	16.06	390010 ...	01.2448	16.77	390088 ...	01.2592	18.26
360232 ...	01.1276	19.54	370078 ...	01.6119	15.06	380007 ...	01.7992	20.52	390011 ...	01.2140	15.72	390090 ...	01.7237	18.51
360234 ...	01.3202	17.45	370079 ...	00.8642	11.46	380008 ...	01.1223	16.10	390012 ...	01.1716	17.94	390091 ...	01.1489	17.98
360236 ...	01.2249	16.91	370080 ...	00.9664	10.78	380009 ...	01.7368	21.31	390013 ...	01.2016	15.66	390093 ...	01.1614	14.74
360238 ...	00.9391	12.13	370082 ...	01.1372	11.98	380010 ...	01.0468	19.43	390014 ...	01.2126	12.81	390095 ...	01.2000	12.94
360239 ...	01.1661	18.03	370083 ...	01.0324	10.50	380011 ...	01.2304	13.31	390015 ...	01.1710	11.85	390096 ...	01.2556	15.43
360240 ...	00.5874	13.30	370084 ...	01.0576	09.02	380013 ...	01.2228	18.80	390016 ...	01.1682	14.81	390097 ...	01.3062	19.40
360241 ...	00.5767	16.05	370085 ...	00.9076	12.29	380014 ...	01.3457	17.78	390017 ...	01.1837	13.52	390098 ...	01.7393	18.83
360242 ...	01.4531	.....	370086 ...	01.1849	09.55	380017 ...	01.7410	20.25	390018 ...	01.2111	17.81	390100 ...	01.6734	17.60
360243 ...	00.8587	15.30	370089 ...	01.2783	11.60	380018 ...	01.7734	17.51	390019 ...	01.1287	14.54	390101 ...	01.2779	15.00
360244 ...	00.8677	15.00	370091 ...	01.6317	14.59	380019 ...	01.3337	17.00	390022 ...	01.3757	19.40	390102 ...	01.3177	19.48
360245 ...	00.9312	.....	370092 ...	01.1097	11.69	380020 ...	01.4100	17.79	390023 ...	01.2541	18.52	390103 ...	01.0523	14.93
360246 ...	00.7017	.....	370093 ...	01.7807	18.82	380021 ...	01.2025	18.54	390024 ...	00.7674	19.86	390104 ...	01.0682	14.28
370001 ...	01.6742	15.99	370094 ...	01.4221	16.65	380022 ...	01.1506	18.26	390025 ...	00.8488	14.06	390106 ...	00.9776	14.65
370002 ...	01.2432	12.02	370095 ...	00.9134	10.73	380023 ...	01.2567	17.05	390026 ...	01.2268	18.67	390107 ...	01.1971	17.38
370004 ...	01.3488	12.31	370097 ...	01.3486	18.53	380025 ...	01.2654	19.95	390027 ...	01.8595	21.14	390108 ...	01.3358	19.07
370005 ...	01.0848	10.63	370099 ...	01.1990	12.08	380026 ...	01.3532	15.93	390028 ...	01.7396	17.68	390109 ...	01.1643	13.33
370006 ...	01.1965	14.06	370100 ...	01.0402	11.67	380027 ...	01.2557	18.02	390029 ...	01.6963	20.55	390110 ...	01.5632	17.01
370007 ...	01.0943	12.64	370103 ...	00.9220	10.13	380029 ...	01.1864	15.62	390030 ...	01.2227	15.45	390111 ...	01.7371	24.12
370008 ...	01.3601	15.20	370105 ...	02.0584	13.71	380031 ...	01.0185	15.90	390031 ...	01.1572	15.91	390112 ...	01.1465	11.94
370011 ...	01.1202	12.74	370106 ...	01.4756	16.09	380033 ...	01.6644	19.92	390032 ...	01.1998	16.58	390113 ...	01.2458	15.48
370012 ...	00.8876	10.18	370108 ...	01.1799	09.27	380035 ...	01.3248	16.28	390035 ...	01.2755	16.49	390114 ...	01.0999	19.32
370013 ...	01.6766	17.44	370110 ...	00.9905	12.01	380036 ...	01.0851	16.10	390036 ...	01.2422	16.78	390115 ...	01.2944	20.16
370014 ...	01.2974	16.19	370112 ...	01.0396	12.14	380037 ...	01.2723	18.94	390037 ...	01.2070	17.47	390116 ...	01.1704	19.33
370015 ...	01.2134	13.44	370113 ...	01.0878	12.37	380038 ...	01.2241	20.37	390039 ...	01.1191	15.31	390117 ...	01.1667	14.44
370016 ...	01.3670	13.98	370114 ...	01.5707	14.55	380039 ...	01.2874	17.76	390040 ...	00.9433	12.20	390118 ...	01.2335	15.42
370017 ...	01.0433	10.30	370121 ...	01.3274	12.36	380040 ...	01.2957	17.85	390041 ...	01.2547	17.32	390119 ...	01.3588	16.18
370018 ...	01.3079	15.58	370122 ...	01.2328	08.56	380042 ...	01.1274	15.46	390042 ...	01.3011	18.62	390121 ...	01.2671	16.71
370019 ...	01.2293	10.56	370123 ...	01.2574	13.79	380047 ...	01.6528	16.43	390043 ...	01.0180	13.85	390122 ...	01.0577	14.83
370020 ...	01.2820	11.37	370125 ...	01.0120	10.72	380048 ...	01.0343	13.09	390044 ...	01.5507	16.77	390123 ...	01.2262	18.61
370021 ...	00.9875	09.49	370126 ...	01.1444	08.72	380050 ...	01.2490	15.78	390045 ...	01.4345	16.03	390125 ...	01.2525	13.82
370022 ...	01.3014	13.75	370131 ...	00.9852	11.32	380051 ...	01.5054	17.52	390046 ...	01.4391	16.75	390126 ...	01.2662	19.95
370023 ...	01.3318	13.57	370133 ...	01.1343	09.86	380052 ...	01.2264	15.01	390047 ...	01.6983	19.69	390127 ...	01.1644	19.24
370025 ...	01.3973	13.86	370138 ...	01.1207	14.59	380055 ...	01.1956	22.55	390048 ...	01.1614	14.69	390128 ...	01.1296	16.84
370026 ...	01.3731	15.30	370139 ...	01.0268	11.63	380058 ...	01.1050	14.28	390049 ...	01.5118	18.00	390130 ...	01.1441	15.37
370028 ...	01.6725	15.88	370140 ...	01.0131	10.01	380060 ...	01.4528	20.35	390050 ...	02.0235	19.37	390131 ...	01.2126	16.10
370029 ...	01.2138	11.58	370141 ...	01.3868	19.42	380061 ...	01.5793	19.88	390051 ...	02.0975	21.73	390132 ...	01.1890	19.58
370030 ...	01.2942	12.91	370146 ...	01.1216	10.05	380062 ...	01.1231	12.73	390052 ...	01.1504	15.00	390133 ...	01.7108	19.44
370032 ...	01.3970	14.59	370148 ...	01.3444	17.30	380063 ...	01.2107	21.13	390054 ...	01.1256	12.61	390135 ...	01.2409	19.50
370033 ...	01.1186	10.55	370149 ...	01.1819	13.75	380064 ...	01.3004	18.01	390055 ...	01.6914	19.09	390136 ...	01.2243	15.15
370034 ...	01.1527	11.98	370153 ...	01.1515	13.77	380065 ...	01.0301	17.02	390056 ...	01.1092	15.26	390137 ...	01.1478	15.60
370035 ...	01.4806	14.39	370154 ...	00.9920	11.80	380066 ...	01.3889	15.59	390057 ...	01.2594	17.71	390138 ...	01.1888	17.08
370036 ...	00.9836	08.68	370156 ...	01.1498	12.70	380068 ...	01.0179	18.42	390058 ...	01.3011	16.54	390139 ...	01.4318	22.12

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
390142 ...	01.6493	23.01	390229 ...	01.5597	17.58	400106 ...	01.1979	07.10	420062 ...	01.4210	16.13	430062 ...	00.8312	10.11
390145 ...	01.2560	18.61	390231 ...	01.3301	21.13	400109 ...	01.5773	08.48	420064 ...	01.1426	12.08	430064 ...	01.1215	10.40
390146 ...	01.2364	15.78	390233 ...	01.3497	16.52	400110 ...	01.1538	07.68	420065 ...	01.3385	15.64	430065 ...	01.0568	10.46
390147 ...	01.2439	17.19	390235 ...	01.8225	22.16	400111 ...	01.1355	07.53	420066 ...	00.9695	13.59	430066 ...	00.9866	11.12
390148 ...	01.0515	16.31	390236 ...	01.2383	15.25	400112 ...	01.1379	06.25	420067 ...	01.2428	14.80	430073 ...	01.1130	12.81
390149 ...	01.1993	16.23	390237 ...	01.5130	18.07	400113 ...	01.1794	06.20	420068 ...	01.2142	14.59	430076 ...	01.0582	08.32
390150 ...	01.2176	17.11	390238 ...	01.1068	16.03	400114 ...	01.0547	07.18	420069 ...	01.1241	12.28	430077 ...	01.5249	14.81
390151 ...	01.2336	16.00	390242 ...	01.3050	17.49	400115 ...	00.9663	06.66	420070 ...	01.2769	14.64	430079 ...	00.9633	10.06
390152 ...	01.0868	15.09	390244 ...	00.8984	12.14	400117 ...	01.1815	07.29	420071 ...	01.3506	15.13	430080 ...	01.2387	09.20
390153 ...	01.2563	20.26	390245 ...	01.3528	21.26	400118 ...	01.1587	07.27	420072 ...	00.9383	09.89	430081 ...	00.9166	.....
390154 ...	01.1597	13.46	390246 ...	01.1839	15.09	400120 ...	01.3397	08.45	420073 ...	01.3086	17.03	430082 ...	00.8013	.....
390155 ...	01.2563	20.35	390247 ...	01.0549	17.29	400122 ...	01.0084	.....	420074 ...	00.9685	10.42	430083 ...	00.8691	.....
390156 ...	01.3401	20.05	390249 ...	01.0228	11.44	400123 ...	01.1291	.....	420075 ...	00.9846	12.37	430084 ...	00.8696	.....
390157 ...	01.2131	16.84	390256 ...	01.7580	18.11	400124 ...	02.9908	.....	420076 ...	01.2141	20.07	430085 ...	00.8846	.....
390158 ...	01.2801	17.26	390258 ...	01.2812	19.11	410001 ...	01.3209	21.02	420078 ...	01.7180	18.78	430086 ...	00.8381	.....
390159 ...	01.3236	19.13	390260 ...	01.2477	16.81	410002 ...	01.1232	18.61	420079 ...	01.4689	15.84	430087 ...	00.9519	08.98
390160 ...	01.1792	17.04	390262 ...	01.8522	16.06	410004 ...	01.4044	18.86	420080 ...	01.2119	16.23	430088 ...	00.8629	10.78
390161 ...	01.1996	13.09	390263 ...	01.4942	18.36	410005 ...	01.3453	20.92	420081 ...	00.8155	17.83	440001 ...	01.0939	11.94
390162 ...	01.2775	17.98	390265 ...	01.2981	16.95	410006 ...	01.2029	19.91	420082 ...	01.4336	16.58	440002 ...	01.5976	14.74
390163 ...	01.1488	16.57	390266 ...	01.0921	15.78	410007 ...	01.6612	19.87	420083 ...	01.2220	16.12	440003 ...	01.0925	13.69
390164 ...	02.0047	18.51	390267 ...	01.2074	18.58	410008 ...	01.1993	19.67	420084 ...	01.0603	11.81	440006 ...	01.3803	16.17
390166 ...	01.1007	16.02	390268 ...	01.2848	18.08	410009 ...	01.3191	19.81	420085 ...	01.2760	16.15	440007 ...	01.0239	10.86
390167 ...	01.2698	19.78	390270 ...	01.3114	15.08	410010 ...	01.0205	23.33	420086 ...	01.4183	16.19	440008 ...	00.9799	13.98
390168 ...	01.1845	16.49	390272 ...	00.5336	21.19	410011 ...	01.2089	20.92	420087 ...	01.6085	15.15	440009 ...	01.0384	11.29
390169 ...	01.1987	16.06	390275 ...	00.4818	.....	410012 ...	01.6430	18.11	420088 ...	01.2268	14.81	440010 ...	00.9658	11.46
390170 ...	01.8123	19.75	390277 ...	00.5117	17.31	410013 ...	01.2305	22.52	420089 ...	01.3309	19.45	440011 ...	01.2416	14.86
390171 ...	01.1326	15.68	390278 ...	00.8304	15.98	420002 ...	01.3547	19.58	420091 ...	00.5427	.....	440012 ...	01.3028	15.12
390172 ...	01.2496	18.70	390279 ...	01.0851	.....	420004 ...	01.8499	16.90	430004 ...	01.0743	13.84	440014 ...	01.0875	11.29
390173 ...	01.1593	16.62	400001 ...	01.1960	06.55	420005 ...	01.1442	12.82	430005 ...	01.2615	13.13	440015 ...	01.5121	14.85
390174 ...	01.6015	22.20	400002 ...	01.3854	07.95	420006 ...	01.2264	15.90	430007 ...	01.1788	11.22	440016 ...	00.9771	10.44
390176 ...	01.1440	15.39	400003 ...	01.1694	07.81	420007 ...	01.5334	15.37	430008 ...	01.2466	13.24	440017 ...	01.5485	16.57
390178 ...	01.2716	16.67	400004 ...	01.2066	07.64	420009 ...	01.2458	14.71	430009 ...	01.1238	10.57	440018 ...	01.3789	16.57
390179 ...	01.2340	21.06	400005 ...	01.0590	05.93	420010 ...	01.0673	13.19	430010 ...	01.1450	08.61	440019 ...	01.5427	17.86
390180 ...	01.4641	21.46	400006 ...	01.1799	06.55	420011 ...	01.0843	13.76	430011 ...	01.3361	12.88	440020 ...	01.1773	16.04
390181 ...	01.0502	19.17	400007 ...	01.1932	06.70	420014 ...	01.0055	11.42	430012 ...	01.3001	13.57	440022 ...	01.1406	12.73
390183 ...	01.1202	26.56	400008 ...	01.2303	06.13	420015 ...	01.3023	16.41	430013 ...	01.2229	14.39	440023 ...	00.9996	10.57
390184 ...	01.1498	16.80	400009 ...	00.9715	06.80	420016 ...	01.0885	15.23	430014 ...	01.3163	15.40	440024 ...	01.2947	14.98
390185 ...	01.1490	15.23	400010 ...	00.9391	07.03	420018 ...	01.5734	16.53	430015 ...	01.2045	13.41	440025 ...	01.1006	12.43
390186 ...	00.9995	15.14	400011 ...	01.0323	07.66	420019 ...	01.1590	13.94	430016 ...	01.7269	16.10	440026 ...	00.8359	15.50
390189 ...	01.1284	20.06	400012 ...	01.1224	07.74	420020 ...	01.2261	14.85	430018 ...	00.9470	12.97	440029 ...	01.2470	14.99
390191 ...	01.0646	13.79	400013 ...	01.0683	07.16	420022 ...	00.9928	15.20	430022 ...	00.9728	09.90	440030 ...	01.1284	12.38
390192 ...	01.1099	15.96	400014 ...	01.3430	07.16	420023 ...	01.3542	17.43	430023 ...	00.9374	08.41	440031 ...	01.0313	12.09
390193 ...	01.1706	14.51	400015 ...	01.2899	09.68	420026 ...	01.8584	17.53	430024 ...	00.9749	11.02	440032 ...	00.9747	10.65
390194 ...	01.1110	17.87	400016 ...	01.3243	09.18	420027 ...	01.3190	14.02	430025 ...	01.0084	09.69	440033 ...	01.0762	16.12
390195 ...	01.7079	20.83	400017 ...	01.1462	.....	420028 ...	01.1146	11.11	430026 ...	00.9364	10.09	440034 ...	01.4203	17.40
390196 ...	01.2085	.....	400018 ...	01.2633	09.43	420029 ...	01.7580	13.19	430027 ...	01.7464	15.94	440035 ...	01.2694	14.46
390197 ...	01.2695	18.10	400019 ...	01.5561	08.81	420030 ...	01.2053	16.33	430028 ...	01.0483	11.61	440039 ...	01.5723	17.12
390198 ...	01.2348	13.92	400021 ...	01.3612	07.76	420031 ...	01.0216	10.68	430029 ...	01.0118	12.71	440040 ...	00.9616	13.60
390199 ...	01.2443	14.43	400022 ...	01.3135	08.22	420033 ...	01.1545	17.58	430031 ...	00.9741	10.28	440041 ...	00.8480	13.66
390200 ...	01.0160	14.23	400024 ...	01.0605	07.19	420035 ...	00.7681	11.27	430033 ...	01.0813	12.29	440046 ...	01.3210	13.16
390201 ...	01.2887	17.68	400026 ...	00.9117	06.70	420036 ...	01.2337	14.65	430034 ...	01.0273	10.85	440047 ...	00.9167	11.74
390203 ...	01.2616	19.27	400027 ...	01.1374	07.31	420037 ...	01.2435	18.15	430036 ...	00.9902	08.36	440048 ...	01.7468	15.49
390204 ...	01.2898	17.68	400028 ...	01.0796	06.70	420038 ...	01.2236	12.41	430037 ...	00.9860	11.79	440049 ...	01.6463	15.50
390205 ...	01.2590	21.76	400029 ...	01.1194	06.21	420039 ...	01.1026	13.26	430038 ...	00.9967	08.43	440050 ...	01.1715	14.53
390206 ...	01.3254	18.69	400031 ...	01.0063	07.72	420040 ...	01.1984	13.54	430039 ...	01.0133	09.15	440051 ...	00.9327	12.36
390209 ...	01.0000	13.32	400032 ...	01.1308	07.65	420042 ...	01.2081	11.67	430040 ...	00.9164	11.35	440052 ...	01.1899	13.51
390211 ...	01.2337	16.85	400044 ...	01.1772	08.60	420043 ...	01.2471	15.44	430041 ...	00.9265	11.35	440053 ...	01.2499	14.72
390213 ...	00.9994	13.22	400048 ...	01.0208	07.77	420044 ...	01.2187	14.95	430042 ...	01.1139	15.25	440054 ...	01.0354	13.96
390215 ...	01.1305	18.84	400061 ...	01.6026	11.46	420048 ...	01.1489	13.91	430043 ...	01.1531	13.05	440056 ...	01.0828	11.91
390217 ...	01.2153	17.46	400079 ...	01.2889	08.92	420049 ...	01.2240	14.11	430044 ...	00.9339	11.74	440057 ...	01.0210	12.82
390219 ...	01.2176	16.47	400087 ...	01.2064	06.69	420051 ...	01.5558	16.53	430047 ...	01.1189	11.70	440058 ...	01.1717	14.16
390220 ...	01.1618	17.74	400088 ...	00.5413	06.59	420053 ...	01.0975	14.06	430048 ...	01.2329	14.21	440059 ...	01.1602	12.81
390222 ...	01.2537	18.22	400094 ...	01.0019	06.74	420054 ...	01.2228	16.05	430049 ...	00.9178	10.80	440060 ...	01.2069	12.90
390223 ...	01.6707	20.96	400098 ...	01.2598	07.55	420055 ...	01.0796	13.01	430051 ...	00.9670	11.03	440061 ...	01.2179	13.93
390224 ...	00.9309	12.60	400102 ...	01.1275	07.49	420056 ...	01.0988	12.61	430054 ...	00.9900	11.56	440063 ...	01.5118	16.27
390225 ...	01.2201	15.00	400103 ...	01.4683	08.79	420057 ...	01.1818	12.00	430056 ...	00.8828	09.09	440064 ...	01.0944	13.98
390226 ...	01.6953	20.96	400104 ...	01.2502	07.79	420059 ...	01.0068	12.84	430057 ...	00.9116	10.70	440065 ...	01.1869	15.06
390228 ...	01.2050	17.13	400105 ...	01.1836	07.14	420061 ...	01.2152	14.38	430060 ...	00.9919	08.54	440067 ...	01.0942	15.26

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
440068 ...	01.1924	15.49	440184 ...	01.4333	18.42	450081 ...	01.1267	13.12	450188 ...	01.0305	11.94	450337 ...	01.1915	13.85
440069 ...	01.1352	13.16	440185 ...	01.0961	16.67	450082 ...	00.9950	11.00	450190 ...	01.1301	18.27	450340 ...	01.3291	14.37
440070 ...	00.9900	12.32	440186 ...	01.1356	18.57	450083 ...	01.6364	16.12	450191 ...	01.1551	15.56	450341 ...	00.9969	14.42
440071 ...	01.4078	14.54	440187 ...	01.1848	15.17	450085 ...	01.1237	12.96	450192 ...	01.0660	16.37	450346 ...	01.3618	15.28
440072 ...	01.3492	11.32	440189 ...	01.4962	16.74	450087 ...	01.5071	19.75	450193 ...	02.0687	18.20	450347 ...	01.1741	15.06
440073 ...	01.3062	15.18	440192 ...	01.1121	13.88	450090 ...	01.1174	11.65	450194 ...	01.2573	15.44	450348 ...	01.0163	10.55
440074 ...	00.8046	12.15	440193 ...	01.2591	17.17	450092 ...	01.1998	13.55	450195 ...	01.3166	17.30	450349 ...	01.1022	23.66
440078 ...	01.0167	11.32	440194 ...	01.3015	18.28	450094 ...	01.3927	19.86	450196 ...	01.4344	14.92	450351 ...	01.2671	22.84
440079 ...	00.7294	.....	440196 ...	00.9419	14.86	450096 ...	01.4510	16.16	450197 ...	01.1705	16.99	450352 ...	01.2159	15.55
440081 ...	01.1648	12.12	440197 ...	01.3731	19.01	450097 ...	01.4266	17.31	450200 ...	01.4866	14.68	450353 ...	01.2255	15.17
440082 ...	01.8422	19.28	440200 ...	01.1180	16.36	450098 ...	01.2099	12.67	450201 ...	00.9941	13.72	450355 ...	01.0862	12.14
440083 ...	01.2565	09.96	440203 ...	00.9907	13.79	450099 ...	01.2034	17.76	450203 ...	01.2823	14.24	450358 ...	02.0362	17.60
440084 ...	01.1792	09.97	440205 ...	01.2429	12.39	450101 ...	01.3505	14.37	450209 ...	01.4285	15.63	450362 ...	01.0606	10.60
440087 ...	01.0550	12.47	440206 ...	00.9048	07.60	450102 ...	01.6868	17.28	450210 ...	01.1085	13.40	450365 ...	00.9335	.....
440090 ...	01.0419	12.38	450002 ...	01.4879	15.52	450104 ...	01.2728	12.51	450211 ...	01.2519	13.86	450366 ...	01.4727	17.50
440091 ...	01.5427	15.71	450004 ...	01.1356	11.11	450107 ...	01.5365	16.38	450213 ...	01.3483	13.57	450369 ...	01.1119	11.81
440095 ...	01.0850	19.37	450005 ...	01.1437	14.76	450108 ...	00.9963	11.41	450214 ...	01.4106	17.51	450370 ...	01.2054	12.06
440100 ...	01.1012	12.24	450007 ...	01.2579	12.30	450109 ...	01.2270	13.96	450217 ...	01.0888	10.11	450371 ...	01.1528	10.89
440102 ...	01.0848	12.02	450008 ...	01.3856	14.03	450110 ...	01.2151	12.04	450219 ...	01.0391	11.49	450372 ...	01.3496	16.37
440103 ...	01.2255	16.56	450010 ...	01.3304	13.63	450111 ...	01.2528	17.62	450221 ...	01.0170	13.07	450373 ...	01.1627	11.09
440104 ...	01.5383	16.76	450011 ...	01.5514	15.71	450112 ...	01.2586	12.44	450222 ...	01.6899	22.10	450374 ...	00.9156	11.01
440105 ...	01.2990	16.68	450014 ...	01.1780	12.60	450113 ...	01.2399	13.96	450224 ...	01.3712	18.01	450376 ...	01.4802	10.63
440109 ...	01.1312	11.86	450015 ...	01.5222	13.57	450118 ...	01.4704	15.64	450229 ...	01.4656	14.60	450378 ...	01.1188	17.92
440110 ...	00.9537	13.67	450016 ...	01.7132	15.62	450119 ...	01.3313	14.65	450231 ...	01.5167	14.06	450379 ...	01.6128	19.58
440111 ...	01.2061	18.15	450018 ...	01.5558	18.40	450121 ...	01.4436	16.93	450233 ...	00.9975	12.70	450381 ...	00.9521	10.67
440114 ...	01.0382	11.65	450020 ...	01.0126	13.75	450123 ...	01.0926	19.97	450234 ...	00.9638	10.46	450388 ...	01.6247	16.36
440115 ...	01.0509	13.80	450021 ...	01.9184	17.59	450124 ...	01.4947	16.86	450235 ...	00.9574	11.12	450389 ...	01.2064	15.73
440120 ...	01.4669	15.49	450023 ...	01.3907	13.94	450126 ...	01.4006	16.17	450236 ...	01.1383	15.95	450393 ...	01.2687	18.35
440121 ...	01.0316	11.93	450024 ...	01.3103	12.06	450127 ...	00.9875	09.55	450237 ...	01.4890	14.79	450395 ...	01.0503	15.15
440125 ...	01.4769	15.68	450025 ...	01.4786	11.79	450128 ...	01.2492	12.38	450239 ...	01.1694	12.14	450399 ...	01.0567	12.15
440130 ...	01.1033	13.75	450027 ...	01.4255	18.45	450130 ...	01.5034	14.99	450241 ...	00.8571	13.09	450400 ...	01.1692	14.98
440131 ...	01.0620	12.90	450028 ...	01.4594	16.21	450131 ...	01.2609	18.39	450243 ...	00.8654	10.77	450403 ...	01.2576	18.67
440132 ...	01.1099	12.72	450029 ...	01.4332	11.79	450132 ...	01.4818	14.53	450246 ...	00.9884	13.87	450410 ...	01.1329	17.45
440133 ...	01.4574	17.01	450031 ...	01.6847	16.35	450133 ...	01.5462	15.33	450249 ...	00.9242	.....	450411 ...	00.9858	11.22
440135 ...	01.4142	18.36	450032 ...	01.2429	12.31	450135 ...	01.7045	16.49	450250 ...	01.0123	15.96	450417 ...	01.0278	12.26
440136 ...	01.0699	15.73	450033 ...	01.6427	14.59	450137 ...	01.4311	18.08	450253 ...	01.1356	10.67	450418 ...	01.3519	15.53
440137 ...	01.0092	11.19	450034 ...	01.5016	15.36	450140 ...	00.7344	16.53	450258 ...	01.1194	10.75	450419 ...	01.2387	16.21
440141 ...	01.1491	11.96	450035 ...	01.4607	16.70	450142 ...	01.3693	18.81	450259 ...	01.1507	17.45	450422 ...	00.6548	24.82
440142 ...	01.0856	09.45	450037 ...	01.5301	16.15	450143 ...	01.0250	10.41	450264 ...	00.8415	11.39	450423 ...	01.3000	.....
440143 ...	01.0555	15.56	450039 ...	01.4291	16.82	450144 ...	01.1483	14.30	450269 ...	01.0799	13.62	450424 ...	01.2537	15.64
440144 ...	01.1983	16.68	450040 ...	01.5737	16.30	450145 ...	00.8845	14.64	450270 ...	01.0762	08.60	450429 ...	01.0341	12.10
440145 ...	01.0552	10.86	450042 ...	01.6099	15.48	450146 ...	00.9848	15.24	450271 ...	01.1226	14.20	450431 ...	01.5897	15.79
440146 ...	01.0442	11.21	450043 ...	01.4581	12.46	450147 ...	01.3446	17.43	450272 ...	01.2134	15.57	450438 ...	01.0859	16.17
440147 ...	00.8996	14.36	450044 ...	01.5896	21.42	450148 ...	01.2058	17.15	450276 ...	01.0078	08.60	450446 ...	00.9648	11.85
440148 ...	01.2042	17.31	450046 ...	01.3861	12.38	450149 ...	01.3434	16.64	450278 ...	01.0542	10.91	450447 ...	01.3192	16.08
440149 ...	01.2333	14.70	450047 ...	01.1028	10.47	450150 ...	00.9529	12.20	450280 ...	01.2975	15.07	450450 ...	01.0270	12.30
440150 ...	01.2405	16.92	450050 ...	01.2011	13.96	450151 ...	01.1434	12.24	450283 ...	01.0786	11.56	450451 ...	01.0230	15.22
440151 ...	01.2866	15.49	450051 ...	01.5610	17.57	450152 ...	01.2882	14.74	450286 ...	01.0253	12.11	450457 ...	01.6927	16.01
440152 ...	01.5898	15.64	450052 ...	01.1106	12.62	450153 ...	01.5697	16.68	450288 ...	01.2285	12.61	450460 ...	01.0146	13.30
440153 ...	01.2676	14.17	450053 ...	01.0770	12.87	450154 ...	01.1375	11.46	450289 ...	01.3342	15.80	450462 ...	01.8283	16.43
440154 ...	00.7750	.....	450054 ...	01.6860	18.29	450155 ...	01.0677	14.52	450292 ...	01.3450	15.96	450464 ...	00.9906	16.00
440156 ...	01.4968	18.20	450055 ...	01.1119	10.81	450157 ...	01.0367	12.65	450293 ...	00.9793	14.15	450465 ...	01.2348	15.09
440157 ...	01.0510	11.50	450056 ...	01.6735	16.56	450160 ...	00.8887	16.83	450296 ...	01.2606	18.17	450467 ...	01.0235	12.74
440159 ...	01.2081	15.33	450058 ...	01.5112	13.63	450162 ...	01.2822	16.42	450297 ...	01.1630	12.08	450469 ...	01.3055	15.75
440160 ...	00.8975	12.59	450059 ...	01.3682	12.34	450163 ...	01.0860	15.46	450299 ...	01.4736	16.11	450473 ...	00.9937	14.40
440161 ...	01.5956	18.01	450060 ...	01.3953	20.85	450164 ...	01.0303	12.98	450303 ...	00.8890	09.86	450475 ...	01.1083	12.45
440166 ...	01.4674	16.87	450063 ...	01.0644	09.22	450165 ...	01.0299	13.46	450306 ...	01.0605	11.18	450484 ...	01.5565	18.13
440168 ...	01.0251	13.13	450064 ...	01.5477	15.22	450166 ...	01.0477	10.59	450307 ...	00.9588	12.42	450488 ...	01.2262	17.64
440170 ...	01.2996	17.76	450065 ...	01.0185	14.74	450169 ...	00.8598	13.97	450309 ...	01.0837	10.76	450489 ...	00.9447	14.79
440173 ...	01.4961	15.39	450068 ...	01.7485	17.99	450170 ...	01.0853	11.40	450315 ...	01.2025	18.72	450497 ...	01.1794	10.99
440174 ...	00.9329	13.46	450070 ...	01.1750	15.54	450176 ...	01.2765	12.94	450320 ...	01.4029	15.82	450498 ...	01.0338	11.09
440175 ...	01.1863	16.89	450072 ...	01.2483	16.10	450177 ...	01.1260	12.07	450321 ...	00.8595	11.25	450508 ...	01.5985	14.80
440176 ...	01.2955	16.07	450073 ...	01.1646	11.84	450178 ...	01.1507	14.80	450322 ...	00.9685	16.67	450514 ...	01.1152	16.87
440178 ...	01.2240	18.45	450074 ...	01.2961	15.77	450179 ...	00.9483	12.39	450324 ...	01.5439	15.52	450517 ...	00.9483	11.05
440180 ...	01.0623	15.48	450076 ...	01.4760	.....	450181 ...	00.9540	13.38	450325 ...	01.2659	08.99	450518 ...	01.4148	16.16
440181 ...	01.0116	10.47	450078 ...	01.0118	12.03	450184 ...	01.4931	19.38	450327 ...	01.0095	10.48	450523 ...	01.5408	19.98
440182 ...	00.9546	14.12	450079 ...	01.4836	19.22	450185 ...	01.0401	08.32	450330 ...	01.1748	15.70	450530 ...	01.3057	23.01
440183 ...	01.5116	16.14	450080 ...	01.2476	14.23	450187 ...	01.3040	14.52	450334 ...	00.9993	11.28	450534 ...	00.9862	13.79

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
450535 ...	01.2010	14.83	450666 ...	01.2579	17.39	450775 ...	01.2483	15.68	490001 ...	01.1080	17.17	490095 ...	01.2300	15.14
450537 ...	01.3977	16.04	450668 ...	01.5902	16.93	450776 ...	00.8654	.....	490002 ...	01.0324	13.41	490097 ...	01.1434	12.72
450538 ...	01.1933	19.68	450669 ...	01.2433	18.67	450777 ...	01.0252	.....	490003 ...	00.6498	15.73	490098 ...	01.3158	10.87
450539 ...	01.2074	15.30	450670 ...	01.2989	15.92	450778 ...	00.8639	.....	490004 ...	01.2172	15.40	490099 ...	00.9645	13.59
450544 ...	01.2983	19.62	450672 ...	01.6454	18.49	450779 ...	01.2592	.....	490005 ...	01.4575	15.40	490100 ...	01.3164	14.13
450545 ...	01.2482	16.20	450673 ...	01.0977	09.93	450780 ...	01.8496	.....	490006 ...	01.1436	11.75	490101 ...	01.1140	20.90
450546 ...	01.2735	.....	450674 ...	00.8239	19.25	450781 ...	01.4437	.....	490007 ...	02.0141	15.29	490104 ...	00.9634	14.01
450547 ...	00.9882	12.78	450675 ...	01.3922	18.32	450782 ...	01.3920	.....	490008 ...	01.0542	20.97	490105 ...	00.7030	14.74
450550 ...	01.0579	19.47	450677 ...	01.3392	14.89	450783 ...	01.1159	.....	490009 ...	01.6730	17.21	490106 ...	00.8216	15.97
450551 ...	01.1708	12.60	450678 ...	01.5634	19.52	450785 ...	00.7492	.....	490010 ...	01.0901	15.40	490107 ...	01.2613	19.56
450558 ...	01.7522	17.98	450681 ...	01.5777	14.98	450786 ...	00.8128	.....	490011 ...	01.3316	16.08	490108 ...	00.8199	15.00
450559 ...	00.8813	11.92	450682 ...	01.2617	17.46	450787 ...	01.0967	.....	490012 ...	01.1120	13.90	490109 ...	00.8839	14.56
450561 ...	01.6573	14.93	450683 ...	01.3232	19.60	450897 ...	04.8995	.....	490013 ...	01.1674	13.67	490110 ...	01.1808	16.61
450563 ...	01.2560	19.54	450684 ...	01.2661	17.89	460001 ...	01.6448	19.60	490014 ...	01.6098	19.87	490111 ...	01.1888	14.35
450565 ...	01.3346	13.56	450686 ...	01.5852	15.83	460003 ...	01.5819	17.26	490015 ...	01.4066	13.85	490112 ...	01.6083	18.29
450570 ...	01.0642	11.27	450688 ...	01.3813	17.47	460004 ...	01.7181	17.97	490017 ...	01.3796	15.60	490113 ...	01.2904	19.16
450571 ...	01.4774	13.89	450690 ...	01.3717	13.94	460005 ...	01.3773	17.46	490018 ...	01.2066	15.56	490114 ...	01.0637	13.79
450573 ...	00.9893	11.89	450691 ...	01.5282	17.57	460006 ...	01.2694	17.06	490019 ...	01.1141	13.78	490115 ...	01.2172	12.44
450574 ...	01.0190	13.95	450694 ...	01.2157	16.02	460007 ...	01.3061	16.89	490020 ...	01.1569	13.14	490116 ...	01.1712	16.25
450575 ...	00.9800	20.31	450696 ...	01.6328	19.75	460008 ...	01.4546	15.99	490021 ...	01.4360	15.75	490117 ...	01.0851	11.43
450578 ...	00.9339	14.41	450697 ...	01.3803	13.76	460009 ...	01.6705	16.97	490022 ...	01.2403	15.68	490118 ...	01.6553	19.99
450580 ...	01.1564	12.24	450698 ...	00.9347	10.48	460010 ...	02.0520	19.06	490023 ...	01.2259	15.65	490119 ...	01.3118	15.33
450583 ...	00.9535	11.81	450700 ...	00.9252	11.65	460011 ...	01.4141	15.56	490024 ...	01.6081	15.30	490120 ...	01.3684	15.93
450584 ...	01.1623	10.95	450702 ...	01.4902	18.26	460013 ...	01.5193	14.87	490027 ...	01.1680	12.49	490122 ...	01.2882	20.07
450586 ...	01.0132	12.39	450703 ...	01.4734	19.40	460014 ...	01.0277	11.67	490028 ...	01.3351	17.29	490123 ...	01.1184	14.53
450587 ...	01.2756	17.28	450704 ...	01.4047	17.61	460015 ...	01.2618	17.61	490030 ...	01.2464	10.92	490124 ...	01.1835	15.29
450591 ...	01.1456	13.04	450705 ...	00.7935	15.32	460016 ...	00.8759	12.40	490031 ...	01.0948	11.91	490126 ...	01.2574	13.61
450596 ...	01.2553	16.69	450706 ...	01.2186	21.01	460017 ...	01.3138	15.18	490032 ...	01.6856	19.11	490127 ...	01.0440	13.33
450597 ...	01.0363	14.80	450709 ...	01.1486	17.85	460018 ...	00.9460	11.56	490033 ...	01.1445	14.76	490130 ...	01.1862	14.96
450603 ...	00.8683	13.23	450711 ...	01.6880	16.47	460019 ...	00.9390	13.93	490035 ...	01.1308	11.43	490131 ...	00.9698	12.94
450604 ...	01.2527	12.31	450712 ...	00.9634	12.74	460020 ...	00.9137	12.14	490037 ...	01.1560	11.92	500001 ...	01.2923	18.93
450605 ...	01.2779	18.23	450713 ...	01.4156	17.31	460021 ...	01.3933	17.13	490038 ...	01.2779	12.36	500002 ...	01.4081	17.35
450607 ...	00.9751	14.12	450715 ...	01.2985	21.28	460022 ...	00.9647	17.88	490040 ...	01.3651	19.78	500003 ...	01.2750	18.17
450609 ...	00.9018	09.27	450716 ...	01.2054	16.91	460023 ...	01.1799	18.70	490041 ...	01.2138	14.32	500005 ...	01.7725	21.33
450610 ...	01.4548	16.20	450717 ...	01.2345	20.68	460024 ...	00.9251	13.00	490042 ...	01.3575	14.34	500007 ...	01.3302	18.70
450614 ...	01.0623	11.94	450718 ...	01.2043	19.69	460025 ...	00.7849	11.54	490043 ...	01.2384	17.27	500008 ...	01.9158	20.34
450615 ...	00.9587	09.07	450723 ...	01.2865	17.31	460026 ...	00.9363	17.49	490044 ...	01.3124	15.46	500009 ...	01.2950	19.68
450617 ...	01.3526	17.98	450724 ...	01.2186	18.65	460027 ...	00.9938	16.41	490045 ...	01.1795	16.83	500011 ...	01.3334	18.64
450620 ...	01.1012	08.97	450725 ...	01.0629	17.55	460029 ...	01.0725	16.94	490046 ...	01.4632	16.26	500012 ...	01.5003	18.44
450623 ...	01.1697	16.27	450726 ...	00.9058	11.21	460030 ...	01.1697	18.98	490047 ...	01.0849	14.15	500014 ...	01.7367	20.69
450626 ...	01.0495	14.93	450727 ...	00.8975	08.79	460032 ...	01.0006	15.30	490048 ...	01.4870	15.77	500015 ...	01.3113	20.68
450628 ...	00.9443	11.42	450728 ...	00.9029	15.06	460033 ...	00.9457	20.50	490050 ...	01.3532	19.03	500016 ...	01.3509	20.11
450630 ...	01.5457	23.91	450730 ...	01.4172	19.15	460035 ...	00.9211	15.04	490052 ...	01.5250	14.03	500019 ...	01.2904	18.38
450631 ...	01.6436	16.75	450732 ...	01.1630	16.76	460036 ...	00.9040	17.97	490053 ...	01.2464	12.69	500021 ...	01.4452	18.44
450632 ...	01.0114	09.73	450733 ...	01.3782	16.49	460037 ...	00.9987	15.82	490054 ...	01.0612	16.12	500023 ...	01.1885	17.72
450633 ...	01.5528	16.84	450734 ...	01.5058	15.76	460039 ...	00.9376	19.39	490057 ...	01.4240	15.34	500024 ...	01.6275	20.14
450634 ...	01.3909	20.07	450735 ...	00.7508	10.25	460041 ...	01.2069	17.85	490059 ...	01.5158	16.77	500025 ...	01.8013	20.57
450637 ...	01.4227	18.37	450742 ...	01.3086	20.55	460042 ...	01.5113	14.35	490060 ...	01.0745	17.38	500026 ...	01.3592	20.11
450638 ...	01.5903	21.27	450743 ...	01.4084	18.11	460043 ...	01.4203	19.43	490063 ...	01.5913	21.01	500027 ...	01.5284	20.29
450639 ...	01.4527	19.59	450745 ...	00.9400	17.81	460044 ...	01.1393	18.06	490066 ...	01.2265	16.33	500028 ...	01.1173	13.44
450641 ...	00.9828	09.51	450746 ...	00.9637	12.33	460046 ...	01.3442	10.37	490067 ...	01.2791	13.99	500029 ...	00.9711	11.90
450643 ...	01.1399	16.08	450747 ...	01.3086	15.66	460047 ...	01.6639	17.76	490069 ...	01.4013	13.22	500030 ...	01.3182	20.51
450644 ...	01.6088	20.13	450749 ...	01.0677	12.76	460049 ...	01.9514	.....	490071 ...	01.4827	17.01	500031 ...	01.3004	18.25
450646 ...	01.5824	18.06	450750 ...	00.9694	10.69	470001 ...	01.1507	16.20	490073 ...	01.3370	22.24	500033 ...	01.2651	16.60
450647 ...	02.0219	20.54	450751 ...	01.2764	15.02	470003 ...	01.9342	18.36	490074 ...	01.3077	15.49	500035 ...	01.4790	20.14
450648 ...	01.0880	10.99	450754 ...	01.0882	10.22	470004 ...	01.0472	13.47	490075 ...	01.2757	14.78	500036 ...	01.2636	16.85
450649 ...	01.0221	14.87	450755 ...	01.1710	14.46	470005 ...	01.1866	17.44	490077 ...	01.1984	16.35	500037 ...	01.1272	16.09
450651 ...	01.8225	19.22	450757 ...	00.9495	13.00	470006 ...	01.1352	12.40	490079 ...	01.3414	13.39	500039 ...	01.2969	17.66
450652 ...	00.9740	12.60	450758 ...	01.7735	18.93	470008 ...	01.1864	15.30	490083 ...	00.6505	13.89	500041 ...	01.2711	20.31
450653 ...	01.2219	16.37	450760 ...	01.2035	18.66	470010 ...	01.0838	16.66	490084 ...	01.2007	14.87	500042 ...	01.3457	18.95
450654 ...	00.9870	11.17	450761 ...	01.1076	12.48	470011 ...	01.1222	18.12	490085 ...	01.1274	11.80	500043 ...	01.1929	16.80
450656 ...	01.3267	15.64	450763 ...	01.0949	13.74	470012 ...	01.2087	15.18	490088 ...	01.2401	13.15	500044 ...	01.9294	19.80
450658 ...	01.0107	11.01	450765 ...	00.9207	16.55	470013 ...	01.1467	18.22	490089 ...	01.0498	14.04	500045 ...	01.0758	17.06
450659 ...	01.4488	18.74	450766 ...	01.9990	20.12	470015 ...	01.1414	18.87	490090 ...	01.1883	13.06	500048 ...	00.9024	14.27
450660 ...	01.6132	18.85	450769 ...	00.9496	09.57	470018 ...	01.1288	18.12	490091 ...	01.1775	18.85	500049 ...	01.3098	17.10
450661 ...	01.2530	18.21	450770 ...	01.0683	12.57	470020 ...	01.0126	12.85	490092 ...	01.1790	13.48	500050 ...	01.4162	19.09
450662 ...	01.3966	17.00	450771 ...	01.7335	15.16	470023 ...	01.2355	16.33	490093 ...	01.2851	14.13	500051 ...	01.6664	20.33
450665 ...	00.9821	10.88	450774 ...	00.7194	.....	470024 ...	01.1330	16.23	490094 ...	01.2223	15.14	500052 ...	01.2459	.....

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
500053	01.2011	17.77	510016	01.0306	.....	520029	00.9356	13.66	520120	01.0549	16.55			
500054	01.8414	19.04	510018	01.0635	13.12	520030	01.6630	17.90	520121	00.9566	13.17			
500055	01.0545	17.78	510020	01.0645	09.18	520031	01.0977	13.75	520122	00.9921	12.50			
500057	01.3022	14.98	510022	01.6731	16.04	520032	01.1459	13.19	520123	01.0355	14.99			
500058	01.5191	17.59	510023	01.0358	15.15	520033	01.2335	15.10	520124	01.1686	13.76			
500059	01.1318	18.35	510024	01.3729	16.07	520034	01.1894	16.57	520130	01.0130	11.54			
500060	01.3448	19.19	510025	00.9358	10.47	520035	01.2608	14.62	520131	01.0285	14.68			
500061	01.0334	17.95	510026	00.9756	11.32	520037	01.6206	16.75	520132	01.1499	12.68			
500062	00.9969	13.74	510027	01.0578	14.24	520038	01.3648	16.08	520134	01.0816	13.78			
500064	01.5477	19.70	510028	01.1631	15.98	520039	00.9879	15.17	520135	00.9958	12.99			
500065	01.3263	16.39	510029	01.2526	15.30	520040	01.4142	16.73	520136	01.5003	17.75			
500068	01.0253	14.82	510030	01.1206	15.72	520041	01.2128	13.13	520138	01.8382	18.83			
500069	01.0526	16.11	510031	01.3039	14.14	520042	01.1115	15.88	520139	01.2251	16.83			
500071	01.3303	18.34	510033	01.2757	13.57	520044	01.3413	15.51	520140	01.4922	17.20			
500072	01.1532	18.80	510035	00.9763	15.60	520045	01.6487	16.77	520141	01.1391	15.13			
500073	00.9973	17.71	510036	00.9689	11.73	520047	01.0137	13.50	520142	00.9776	11.46			
500074	01.1769	13.37	510038	01.0385	13.95	520048	01.3805	15.97	520144	01.0601	14.49			
500075	01.1943	18.49	510039	01.3985	14.67	520049	01.9376	15.82	520145	01.0163	14.95			
500076	01.3655	.....	510043	01.0483	10.44	520051	01.8682	17.94	520146	01.1569	12.32			
500077	01.2935	20.09	510046	01.2254	15.91	520053	01.0616	14.07	520148	01.1022	13.98			
500079	01.2866	17.92	510047	01.1675	15.81	520054	01.0524	15.31	520149	00.9330	11.73			
500080	00.8630	11.55	510048	01.0785	14.71	520056	01.3233	17.02	520151	01.1306	13.59			
500084	01.1285	17.71	510050	01.2940	13.72	520057	01.0868	14.88	520152	01.1344	15.70			
500085	01.0811	15.46	510053	01.0201	12.16	520058	01.0839	16.79	520153	00.9402	11.67			
500086	01.4099	16.28	510055	01.2071	16.99	520059	01.2503	16.21	520154	01.1091	14.96			
500088	01.2684	20.73	510058	01.2183	15.08	520060	01.2999	14.92	520156	01.0589	15.29			
500089	01.0373	13.23	510059	01.3416	12.59	520062	01.2041	14.41	520157	00.9530	12.75			
500090	00.9397	13.62	510060	01.0623	12.88	520063	01.1849	15.91	520159	00.8973	15.47			
500092	01.1574	13.51	510061	01.0467	12.53	520064	01.6355	18.60	520160	01.7831	16.13			
500094	00.8988	13.52	510062	01.2592	14.06	520066	01.2646	16.81	520161	01.0448	14.06			
500096	00.9675	16.16	510063	01.0303	11.09	520068	00.9547	14.38	520170	01.2356	17.02			
500097	01.1526	14.74	510065	00.9731	12.11	520069	01.2078	15.49	520171	01.0174	12.53			
500098	00.8519	14.51	510066	01.1091	12.88	520070	01.4142	15.29	520173	01.1189	17.29			
500101	00.9811	14.48	510067	01.1612	16.64	520071	01.0992	15.10	520174	01.4126	19.12			
500102	00.9767	14.87	510068	01.0710	13.52	520074	01.1149	14.32	520176	00.7496	14.08			
500104	01.2490	18.17	510070	01.1784	14.68	520075	01.4699	16.16	520177	01.5483	17.91			
500106	01.0010	12.54	510071	01.2712	14.60	520076	01.0966	14.78	520178	01.0875	13.06			
500107	01.1098	13.54	510072	01.0450	12.56	520077	00.9945	13.17	520180	00.9439	.....			
500108	01.6208	19.87	510076	01.0756	.....	520078	01.4355	14.81	530001	01.4675	13.50			
500110	01.2003	17.29	510077	01.1413	13.24	520082	01.2824	14.80	530002	01.1585	15.32			
500118	01.1182	18.17	510080	01.1329	10.16	520083	01.5777	19.35	530003	00.9243	08.81			
500119	01.3361	19.79	510081	00.9920	12.98	520084	01.0819	15.01	530004	00.9555	12.56			
500122	01.2703	17.54	510082	01.0732	10.95	520087	01.5706	15.92	530005	01.0749	12.06			
500123	00.9858	13.48	510084	00.9838	11.17	520088	01.2564	16.27	530006	01.1664	14.95			
500124	01.2764	19.76	510085	01.2731	17.35	520089	01.5021	17.22	530007	01.0341	11.54			
500125	00.9817	11.02	510086	01.0079	11.50	520090	01.1723	14.69	530008	01.1909	16.73			
500127	00.5815	14.25	520002	01.2811	15.62	520091	01.2647	15.62	530009	01.0330	14.78			
500129	01.6456	19.35	520003	01.1372	13.96	520092	01.1141	15.12	530010	01.2997	15.83			
500132	00.9544	15.33	520004	01.1943	15.11	520094	01.0966	15.78	530011	01.1438	14.63			
500134	00.7358	16.03	520006	01.0362	15.92	520095	01.3727	16.94	530012	01.6828	15.20			
500137	00.6391	16.87	520007	01.0592	12.43	520096	01.5421	15.50	530014	01.2755	13.73			
500138	11.7584	.....	520008	01.4746	17.90	520097	01.2858	16.40	530015	01.1352	15.80			
500139	01.4083	21.58	520009	01.6341	16.23	520098	01.7645	18.16	530016	01.1970	11.83			
500140	00.7623	14.50	520010	01.1246	16.81	520100	01.2513	14.73	530017	00.9299	13.78			
500141	01.3002	19.75	520011	01.1700	16.58	520101	01.1174	14.26	530018	01.0116	13.10			
500143	00.9927	17.55	520013	01.3238	16.24	520102	01.2034	16.89	530019	00.9962	15.03			
500898	00.7881	.....	520014	01.2286	14.17	520103	01.2829	16.41	530022	01.1654	15.74			
510001	01.6358	16.68	520015	01.1845	15.42	520107	01.2809	15.17	530023	01.0053	15.88			
510002	01.3741	16.27	520016	01.1159	13.09	520109	01.0403	14.86	530024	01.0512	12.11			
510004	00.9722	10.17	520017	01.2080	15.10	520110	01.1018	15.27	530025	01.2788	16.17			
510005	00.9383	13.99	520018	01.0659	14.58	520111	01.1017	12.09	530026	01.1205	13.08			
510006	01.2076	15.75	520019	01.2888	14.27	520112	01.1632	16.29	530027	00.9454	09.41			
510007	01.4198	15.97	520021	01.2952	16.83	520113	01.1975	15.62	530029	00.9396	13.04			
510008	01.1015	15.33	520024	01.0655	11.87	520114	01.1537	12.45	530031	00.8884	13.78			
510009	00.9452	10.45	520025	01.1316	14.34	520115	01.3141	14.47						
510012	01.0842	14.87	520026	01.0683	15.67	520116	01.2563	16.13						
510013	01.1873	14.27	520027	01.1591	17.08	520117	01.0813	14.87						
510015	00.9551	11.69	520028	01.3516	16.26	520118	00.9872	09.46						

Note: Case mix indexes do not include discharges from PPS-exempt units.
Note: Case mix indexes include cases received in HCFA central office through Dec. 1993.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index	GAF
Abilene, TX	0.8624	0.9036
Taylor, TX		
Aguadilla, PR	0.4662	0.5930
Aguada, PR		
Aguadilla, PR		
Moca, PR		
Akron, OH	0.9694	0.9789
Portage, OH		
Summit, OH		
Albany, GA	0.8861	0.9205
Dougherty, GA		
Lee, GA		
Albany-Schenectady-Troy, NY	0.8908	0.9239
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
Albuquerque, NM	0.9362	0.9559
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
Alexandria, LA	0.8313	0.8812
Rapides, LA		
Allentown-Bethlehem-Easton, PA	1.0158	1.0108
Carbon, PA		
Lehigh, PA		
Northampton, PA		
Altoona, PA	0.9244	0.9476
Blair, PA		
Amarillo, TX	0.8084	0.8645
Potter, TX		
Randall, TX		
Anchorage, AK	1.3147	1.2061
Anchorage, AK		
Ann Arbor, MI	1.2661	1.1754
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
Anniston, AL	0.7990	0.8576
Calhoun, AL		
Appleton-Oshkosh-Neenah, WI	0.8882	0.9220
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
Arecibo, PR	0.3815	0.5169
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
Asheville, NC	0.9212	0.9453
Buncombe, NC		
Madison, NC		
Athens, GA	0.9093	0.9370
Clarke, GA		
Madison, GA		
Oconee, GA		
*Atlanta, GA	1.0289	1.0197
Barrow, GA		
Bartow, GA		
Carroll, 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		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
Atlantic City-Cape May, NJ	1.0919	1.0621
Atlantic City, NJ		
Cape May, NJ		
Augusta-Aiken, GA-SC	0.8649	0.9054
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
Austin-San Marcos, TX	0.9031	0.9326
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
Bakersfield, CA	1.0966	1.0652
Kern, CA		
*Baltimore, MD	0.9912	0.9940
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Annes, MD		
Bangor, ME	0.9527	0.9674
Penobscot, ME		
Barnstable-Yarmouth, MA	1.3875	1.2514
Barnstable, MA		
Baton Rouge, LA	0.8656	0.9059
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
Beaumont-Port Arthur, TX	0.8673	0.9071
Hardin, TX		
Jefferson, TX		
Orange, TX		
Bellingham, WA	1.1282	1.0861
Whatcom, WA		
Benton Harbor, MI	0.8209	0.8736
Berrien, MI		
*Bergen-Passaic, NJ	1.1316	1.0884
Bergen, NJ		
Passaic, NJ		
Billings, MT	0.8758	0.9132
Yellowstone, MT		
Biloxi-Gulfport-Pascagoula, MS	0.8282	0.8789
Hancock, MS		
Harrison, MS		
Jackson, MS		
Binghamton, NY	0.9220	0.9459
Broome, NY		
Tioga, NY		
Birmingham, AL	0.8772	0.9142
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
Bismarck, ND	0.8684	0.9079
Burleigh, ND		
Morton, ND		
Bloomington, IN	0.8567	0.8995
Monroe, IN		
Bloomington-Normal, IL	0.8528	0.8967
McLean, IL		
Boise City, ID	0.9067	0.9351
Ada, ID		
Canyon, ID		
*Boston-Brockton-Nashua, MA-NH	1.1564	1.1046
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
Boulder-Longmont, CO	0.8020	0.8598
Boulder, CO		
Brazoria, TX	0.8300	0.8802
Brazoria, TX		
Bremerton, WA	0.9666	0.9770
Kitsap, WA		
Brownsville-Harlingen-San Benito, TX	0.8288	0.8793
Cameron, TX		
Bryan-College Station, TX	0.8712	0.9099
Brazos, TX		
*Buffalo-Niagara Falls, NY	0.9184	0.9434
Erie, NY		
Niagara, NY		
Burlington, VT	0.9983	0.9988
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
Caguas, PR	0.4392	0.5692
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
Canton-Massillon, OH	0.8683	0.9078
Carroll, OH		
Stark, OH		
Casper, WY	0.8431	0.8897
Natrona, WY		
Cedar Rapids, IA	0.8165	0.8704
Linn, IA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Champaign-Urbana, IL	0.8888	0.9224
Champaign, IL		
Charleston-North		
Charleston, SC	0.8885	0.9222
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
Charleston, WV	0.8622	0.9035
Kanawha, WV		
Putnam, WV		
*Charlotte-Gastonia-Rock Hill, NC-SC	0.9593	0.9719
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
Charlottesville, VA	0.9402	0.9587
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
Chattanooga, TN-GA	0.8998	0.9302
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
Cheyenne, WY	0.7490	0.8204
Laramie, WY		
*Chicago, IL	1.0716	1.0485
Cook, IL		
De Kalb, IL		
Du Page, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
Chico-Paradise, CA	1.0302	1.0206
Butte, CA		
*Cincinnati, OH-KY-IN	0.9469	0.9633
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
Clarksville-Hopkinsville, TN-KY	0.7542	0.8243
Christian, KY		
Montgomery, TN		
*Cleveland-Lorain-Elyria, OH	0.9870	0.9911
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
Colorado Springs, CO	0.9338	0.9542
El Paso, CO		
Columbia, MO	0.9254	0.9483
Boone, MO		
Columbia, SC	0.8999	0.9303
Lexington, SC		
Richland, SC		
Columbus, GA-AL	0.7797	0.8433
Russell, AL		
Chattanoochee, GA		
Harris, GA		
Muscogee, GA		
*Columbus, OH	0.9807	0.9867
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
Corpus Christi, TX	0.8366	0.8850
Nueces, TX		
San Patricio, TX		
Cumberland, MD-WV	0.8280	0.8788
Allegany, MD		
Mineral, WV		
*Dallas, TX	0.9600	0.9724
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
Danville, VA	0.8129	0.8677
Danville City, VA		
Pittsylvania, VA		
Davenport-Rock Island-Moline, IA-IL	0.8263	0.8775
Scott, IA		
Henry, IL		
Rock Island, IL		
Dayton-Springfield, OH	0.9199	0.9444
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
Daytona Beach, FL	0.8642	0.9049
Flagler, FL		
Volusia, FL		
Decatur, AL	0.8029	0.8604
Lawrence, AL		
Morgan, AL		
Decatur, IL	0.7948	0.8545
Macon, IL		
*Denver, CO	1.0659	1.0447
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
Des Moines, IA	0.8669	0.9068
Dallas, IA		
Polk, IA		
Warren, IA		
*Detroit, MI	1.0871	1.0589
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
Dothan, AL	0.8010	0.8590
Dale, AL		
Houston, AL		
Dover, DE	0.9143	0.9405
Kent, DE		
Dubuque, IA	0.7573	0.8267
Dubuque, IA		
Duluth-Superior, MN-WI	0.9303	0.9517
St. Louis, MN		
Douglas, WI		
Dutchess County, NY	1.0586	1.0398
Dutchess, NY		
Eau Claire, WI	0.8516	0.8958
Chippewa, WI		
Eau Claire, WI		
El Paso, TX	0.8518	0.8960
El Paso, TX		
Elkhart-Goshen, IN	0.8730	0.9112
Elkhart, IN		
Elmira, NY	0.8615	0.9029
Chemung, NY		
Enid, OK	0.8250	0.8766
Garfield, OK		
Erie, PA	0.8969	0.9282
Erie, PA		
Eugene-Springfield, OR	1.0632	1.0429
Lane, OR		
Evansville-Henderson, IN-KY	0.9071	0.9354
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
Fargo-Moorhead, ND-MN	0.9259	0.9486
Clay, MN		
Cass, ND		
Fayetteville, NC	0.8694	0.9086
Cumberland, NC		
Fayetteville-Springdale-Rogers, AR	0.7274	0.8042
Benton, AR		
Washington, AR		
Flint, MI	1.0411	1.0280
Genesee, MI		
Florence, AL	0.7916	0.8521
Colbert, AL		
Lauderdale, AL		
Florence, SC	0.8565	0.8994
Florence, SC		
Fort Collins-Loveland, CO	0.9772	0.9843
Larimer, CO		
*Ft. Lauderdale, FL	1.0637	1.0432
Broward, FL		
Fort Myers-Cape Coral, FL	0.9613	0.9733
Lee, FL		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Fort Pierce-Port St. Lucie, FL	1.0118	1.0081
Martin, FL		
St. Lucie, FL		
Fort Smith, AR-OK	0.7716	0.8373
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
Fort Walton Beach, FL	0.8895	0.9229
Okaloosa, FL		
Fort Wayne, IN	0.8875	0.9215
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
*Forth Worth-Arlington, TX	0.9169	0.9423
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
Fresno, CA	1.0368	1.0251
Fresno, CA		
Madera, CA		
Gadsden, AL	0.8196	0.8726
Etowah, AL		
Gainesville, FL	0.8867	0.9210
Alachua, FL		
Galveston-Texas City, TX	1.0133	1.0091
Galveston, TX		
Gary, IN	0.9376	0.9568
Lake, IN		
Porter, IN		
Glens Falls, NY	0.9309	0.9521
Warren, NY		
Washington, NY		
Goldsboro, NC	0.8491	0.8940
Wayne, NC		
Grand Forks, ND-MN	0.9038	0.9331
Polk, MN		
Grand Forks, ND		
Grand Rapids-Muskegon-Holland, MI	0.9863	0.9906
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
Great Falls, MT	0.9018	0.9317
Cascade, MT		
Greeley, CO	1.0531	1.0361
Weld, CO		
Green Bay, WI	0.8857	0.9202
Brown, WI		
*Greensboro-Winston-Salem-High Point, NC	0.9206	0.9449
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
Greenville, NC	0.8988	0.9295
Pitt, NC		
Greenville-Spartanburg-Anderson, SC	0.9149	0.9409
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
Hagerstown, MD	0.8987	0.9295
Washington, MD		
Hamilton-Middletown, OH	0.8137	0.8683
Butler, OH		
Harrisburg-Lebanon-Carlisle, PA	0.9667	0.9771
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
*Hartford, CT	1.2429	1.1606
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
Hickory-Morganton, NC	0.7827	0.8455
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
Honolulu, HI	1.1736	1.1159
Honolulu, HI		
Houma, LA	0.7732	0.8385
Lafourche, LA		
Terrebonne, LA		
*Houston, TX	0.9829	0.9883
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
Huntington-Ashland, WV-KY-OH	0.8989	0.9296
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
Huntsville, AL	0.8118	0.8669
Limestone, AL		
Madison, AL		
*Indianapolis, IN	0.9865	0.9907
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
Iowa City, IA	0.9100	0.9375
Johnson, IA		
Jackson, MI	0.9211	0.9453
Jackson, MI		
Jackson, MS	0.7669	0.8338
Hinds, MS		
Madison, MS		
Rankin, MS		
Jackson, TN	0.8299	0.8801
Madison, TN		
Jacksonville, FL	0.9043	0.9334
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
Jacksonville, NC	0.7229	0.8007
Onslow, NC		
Jamestown, NY	0.7565	0.8261
Chautaqua, NY		
Janesville-Beloit, WI	0.8638	0.9046
Rock, WI		
Jersey City, NJ	1.1100	1.0741
Hudson, NJ		
Johnson City-Kingsport-Bristol, TN-VA	0.8667	0.9067
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
Johnstown, PA	0.8654	0.9057
Cambria, PA		
Somerset, PA		
Joplin, MO	0.7828	0.8456
Jasper, MO		
Newton, MO		
Kalamazoo-Battlecreek, MI	1.0507	1.0344
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
Kankakee, IL	0.9423	0.9601
Kankakee, IL		
*Kansas City, KS-MO	0.9513	0.9664
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
Kenosha, WI	0.8849	0.9197
Kenosha, WI		
Killeen-Temple, TX	0.9711	0.9801
Bell, TX		
Coryell, TX		
Knoxville, TN	0.8588	0.9010
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
Kokomo, IN	0.9075	0.9357
Howard, IN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Tipton, IN		
La Crosse, WI-MN	0.8552	0.8984
Houston, MN		
La Crosse, WI		
Lafayette, LA	0.8011	0.8591
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
Lafayette, IN	0.8348	0.8837
Clinton, IN		
Tippecanoe, IN		
Lake Charles, LA	0.8274	0.8783
Calcasieu, LA		
Lakeland-Winter Haven, FL	0.8137	0.8683
Polk, FL		
Lancaster, PA	0.9387	0.9576
Lancaster, PA		
Lansing-East Lansing, MI	1.0067	1.0046
Clinton, MI		
Eaton, MI		
Ingham, MI		
Laredo, TX	0.6998	0.7831
Webb, TX		
Las Cruces, NM	0.8837	0.9188
Dona Ana, NM		
Las Vegas, NV-AZ	1.0723	1.0490
Mohave, AZ		
Clark, NV		
Nye, NV		
Lawrence, KS	0.8593	0.9014
Douglas, KS		
Lawton, OK	0.8532	0.8970
Comanche, OK		
Lewiston-Auburn, ME	0.9705	0.9797
Androscoggin, ME		
Lexington, KY	0.8471	0.8926
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
Lima, OH	0.8703	0.9093
Allen, OH		
Auglaize, OH		
Lincoln, NE	0.9026	0.9322
Lancaster, NE		
Little Rock-North Little Rock, AR	0.8327	0.8822
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
Longview-Marshall, TX	0.8752	0.9128
Gregg, TX		
Harrison, TX		
Upshur, TX		
*Los Angeles-Long Beach, CA	1.2592	1.1710
Los Angeles, CA		
Louisville, KY-IN	0.9474	0.9637
Clark, IN		
Floyd, IN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
Lubbock, TX	0.8717	0.9103
Lubbock, TX		
Lynchburg, VA	0.8347	0.8836
Amherst, VA		
Bedford City, VA		
Bedford, VA		
Campbell, VA		
Lynchburg City, VA		
Macon, GA	0.9032	0.9327
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
Madison, WI	0.9954	0.9968
Dane, WI		
Mansfield, OH	0.8238	0.8757
Crawford, OH		
Richland, OH		
Mayaguez, PR	0.4472	0.5763
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
McAllen-Edinburg-Mission, TX	0.8059	0.8626
Hidalgo, TX		
Medford-Ashland, OR	0.9944	0.9962
Jackson, OR		
Melbourne-Titusville-Palm Bay FL	0.8994	0.9300
Brevard, FL		
*Memphis, TN-AR-MS	0.8519	0.8960
Crittenden, AR		
De Soto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
Merced, CA	1.0250	1.0171
Merced, CA		
*Miami, FL	0.8543	0.8978
Dade, FL		
*Middlesex-Somerset-Hunterdon, NJ	1.0743	1.0503
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
*Milwaukee, WI	0.9649	0.9758
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
*Minneapolis-St Paul, MN-WI	1.0889	1.0601
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
Mobile, AL	0.7383	0.8124
Baldwin, AL		
Mobile, AL		
Modesto, CA	1.1292	1.0868
Stanislaus, CA		
Monmouth-Ocean, NJ	1.0724	1.0490
Monmouth, NJ		
Ocean, NJ		
Monroe, LA	0.7758	0.8404
Ouachita, LA		
Montgomery, AL	0.8082	0.8643
Autauga, AL		
Elmore, AL		
Montgomery, AL		
Muncie, IN	0.9543	0.9685
Delaware, IN		
Myrtle Beach, SC	0.7976	0.8565
Horry, SC		
Naples, FL	0.9770	0.9842
Collier, FL		
*Nashville, TN	0.9379	0.9570
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
*Nassau-Suffolk, NY	1.2908	1.1910
Nassau, NY		
Suffolk, NY		
*New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT	1.2289	1.1516
Fairfield, CT		
New Haven, CT		
New London-Norwich, CT	1.1752	1.1169
New London, CT		
*New Orleans, LA	0.9532	0.9677
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
*New York, NY	1.4200	1.2714
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
*Newark, NJ	1.1146	1.0771

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
Newburgh, NY-PA	0.8759	0.9133
Orange, NY		
Pike, PA		
*Norfolk-Virginia Beach-Newport News, VA-NC	0.8313	0.8812
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
*Oakland, CA	1.4690	1.3013
Alameda, CA		
Contra Costa, CA		
Ocala, FL	0.8820	0.9176
Marion, FL		
Odessa-Midland, TX	0.8436	0.8901
Ector, TX		
Midland, TX		
Oklahoma City, OK	0.8499	0.8946
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
Olympia, WA	1.1179	1.0793
Thurston, WA		
Omaha, NE-IA	0.9825	0.9880
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
*Orange County, CA	1.4029	1.2609
Orange, CA		
*Orlando, FL	0.9472	0.9635
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
Owensboro, KY	0.7877	0.8492
Daviess, KY		
Panama City, FL	0.7543	0.8244
Bay, FL		
Parkersburg-Marietta, WV-OH	0.7957	0.8551
Washington, OH		
Wood, WV		
Pensacola, FL	0.8248	0.8764
Escambia, FL		
Santa Rosa, FL		
Peoria-Pekin, IL	0.8447	0.8909
Peoria, IL		
Tazewell, IL		
Woodford, IL		
*Philadelphia, PA-NJ	1.1115	1.0751
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
*Phoenix-Mesa, AZ	1.0125	1.0085
Maricopa, AZ		
Pinal, AZ		
Pine Bluff, AR	0.8643	0.9050
Jefferson, AR		
*Pittsburgh, PA	0.9847	0.9895
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
Pittsfield, MA	1.1383	1.0928
Berkshire, MA		
Ponce, PR	0.4415	0.5713
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
Portland, ME	0.9487	0.9646
Cumberland, ME		
Sagadahoc, ME		
York, ME		
*Portland-Vancouver, OR-WA	1.1231	1.0827
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
*Providence-Warwick, RI	1.1143	1.0769
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
Provo-Orem, UT	1.0334	1.0228
Utah, UT		
Pueblo, CO	0.7805	0.8439
Pueblo, CO		
Punta Gorda, FL	0.8656	0.9059
Charlotte, FL		
Racine, WI	0.8366	0.8850
Racine, WI		
Raleigh-Durham-Chapel Hill, NC	0.9596	0.9722
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
Rapid City, SD	0.8147	0.8691
Pennington, SD		
Reading, PA	0.9199	0.9444
Berks, PA		
Redding, CA	1.1045	1.0704
Shasta, CA		
Reno, NV	1.1129	1.0760
Washoe, NV		
Richland-Kennewick-Pasco, WA	0.9691	0.9787
Benton, WA		
Franklin, WA		
Richmond-Petersburg, VA	0.9381	0.9572
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
*Riverside-San Bernardino, CA	1.1661	1.1110
Riverside, CA		
San Bernardino, CA		
Roanoke, VA	0.8398	0.8873
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
Rochester, MN	1.0500	1.0340
Olmsted, MN		
*Rochester, NY	0.9850	0.9897
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
Rockford, IL	0.8709	0.9097
Boone, IL		
Ogle, IL		
Winnebago, IL		
Rocky Mount, NC	0.8576	0.9001
Edgecombe, NC		
Nash, NC		
*Sacramento, CA	1.1330	1.0893
El Dorado, CA		
Placer, CA		
Sacramento, CA		
Saginaw-Bay City-Midland, MI	0.9419	0.9598
Bay, MI		
Midland, MI		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Saginaw, MI		
St. Cloud, MN	0.9591	0.9718
Benton, MN		
Stearns, MN		
St. Joseph, MO	0.8641	0.9048
Andrews, MO		
Buchanan, MO		
*St. Louis, MO-IL	0.9150	0.9410
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
Salem, OR	0.9595	0.9721
Marion, OR		
Polk, OR		
Salinas, CA	1.3746	1.2434
Monterey, CA		
*Salt Lake City-Ogden, UT	0.9645	0.9756
Davis, UT		
Salt Lake, UT		
Weber, UT		
San Angelo, TX	0.7164	0.7958
Tom Green, TX		
*San Antonio, TX	0.8083	0.8644
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
*San Diego, CA	1.2094	1.1391
San Diego, CA		
*San Francisco, CA	1.4103	1.2655
Marin, CA		
San Francisco, CA		
San Mateo, CA		
*San Jose, CA	1.4353	1.2808
Santa Clara, CA		
*San Juan-Bayamon, PR	0.4379	0.5681
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, 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		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
San Luis Obispo-Atascadero-Paso Robles, CA	1.2308	1.1528
San Luis Obispo, CA		
Santa Barbara-Santa Maria-Lompoc, CA	1.1669	1.1115
Santa Barbara, CA		
Santa Cruz-Watsonville, CA	0.9788	0.9854
Santa Cruz, CA		
Santa Fe, NM	1.0830	1.0561
Los Alamos, NM		
Santa Fe, NM		
Santa Rosa, CA	1.3020	1.1981
Sonoma, CA		
Sarasota-Bradenton, FL	0.9717	0.9805
Manatee, FL		
Sarasota, FL		
Savannah, GA	0.8880	0.9219
Bryan, GA		
Chatham, GA		
Effingham, GA		
Scranton—Wilkes-Barre—Hazleton, PA	0.8668	0.9067
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
*Seattle-Bellevue-Everett, WA	1.1026	1.0692
Island, WA		
King, WA		
Snohomish, WA		
Sharon, PA	0.8965	0.9279
Mercer, PA		
Sheboygan, WI	0.8082	0.8643
Sheboygan, WI		
Sherman-Denison, TX	0.8876	0.9216
Grayson, TX		
Shreveport-Bossier City, LA	0.9077	0.9358
Bossier, LA		
Caddo, LA		
Webster, LA		
Sioux City, IA-NE	0.8530	0.8968
Woodbury, IA		
Dakota, NE		
Sioux Falls, SD	0.8697	0.9088
Lincoln, SD		
Minnehaha, SD		
South Bend, IN	0.9664	0.9769
St. Joseph, IN		
Spokane, WA	1.0665	1.0451
Spokane, WA		
Springfield, IL	0.8764	0.9136
Menard, IL		
Sangamon, IL		
Springfield, MO	0.7922	0.8526
Christian, MO		
Greene, MO		
Webster, MO		
Springfield, MA	1.0600	1.0407
Hampden, MA		
Hampshire, MA		
State College, PA	0.9947	0.9964
Centre, PA		
Steubenville-Weirton, OH-WV	0.8511	0.8955
Jefferson, OH		
Brooke, WV		
Hancock, WV		
Stockton-Lodi, CA	1.1653	1.1104
San Joaquin, CA		
Sumter, SC	0.8052	0.8621
Sumter, SC		
Syracuse, NY	0.9736	0.9818
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
Tacoma, WA	0.9666	0.9770
Pierce, WA		
Tallahassee, FL	0.8244	0.8761
Gadsden, FL		
Leon, FL		
*Tampa-St. Petersburg-Clearwater, FL	0.9319	0.9528
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
Terre Haute, IN	0.8619	0.9032
Clay, IN		
Vermillion, IN		
Vigo, IN		
Texarkana, AR-Texarkana, TX	0.8336	0.8828
Miller, AR		
Bowie, TX		
Toledo, OH	0.9812	0.9871
Fulton, OH		
Lucas, OH		
Wood, OH		
Topeka, KS	0.9928	0.9951
Shawnee, KS		
Trenton, NJ	1.0257	1.0175
Mercer, NJ		
Tucson, AZ	0.9435	0.9610
Pima, AZ		
Tulsa, OK	0.8253	0.8768
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
Tuscaloosa, AL	0.8197	0.8727
Tuscaloosa, AL		
Tyler, TX	0.8594	0.9014
Smith, TX		
Utica-Rome, NY	0.8506	0.8951
Herkimer, NY		
Oneida, NY		
Vallejo-Fairfield-Napa, CA	1.2590	1.1708
Napa, CA		
Solano, CA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Ventura, CA	0.9788	0.9854
Ventura, CA		
Victoria, TX	0.8743	0.9121
Victoria, TX		
Vineland-Millville-Bridgeton, NJ	1.0340	1.0232
Cumberland, NJ		
Visalia-Tulare-Porterville, CA	1.0344	1.0234
Tulare, CA		
Waco, TX	0.8055	0.8623
McLennan, TX		
*Washington, DC-MD-VA-WV	1.1010	1.0681
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpepper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
Waterloo-Cedar Falls, IA	0.8681	0.9077
Black Hawk, IA		
Wausau, WI	0.9847	0.9895
Marathon, WI		
West Palm Beach-Boca Raton, FL	0.9868	0.9909
Palm Beach, FL		
Wheeling, OH-WV	0.7633	0.8311
Belmont, OH		
Marshall, WV		
Ohio, WV		
Wichita, KS	1.0037	1.0025
Butler, KS		
Harvey, KS		
Sedgwick, KS		
Wichita Falls, TX	0.6885	0.7745
Archer, TX		
Wichita, TX		
Williamsport, PA	0.8463	0.8920
Lycoming, PA		
Wilmington-Newark, DE-MD	1.0764	1.0517
New Castle, DE		
Cecil, MD		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Wilmington, NC	0.9179	0.9430
New Hanover, NC		
Brunswick, NC		
Yakima, WA	0.9538	0.9681
Yakima, WA		
Yolo, CA	1.1897	1.1263
Yolo, CA		
York, PA	0.9044	0.9335
York, PA		
Youngstown-Warren, OH	0.9405	0.9589
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
Yuba City, CA	1.0238	1.0162
Sutter, CA		
Yuba, CA		
Yuma, AZ	0.8714	0.9100
Yuma, AZ		

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7051	0.7872
Alaska	1.2556	1.1687
Arizona	0.8315	0.8813
Arkansas	0.6817	0.7692
California	0.9788	0.9854
Colorado	0.8020	0.8598
Connecticut	1.2289	1.1516
Delaware	0.8468	0.8924
Florida	0.8543	0.8978
Georgia	0.7555	0.8253
Hawaii	0.9563	0.9699
Idaho	0.8406	0.8879
Illinois	0.7444	0.8170
Indiana	0.7963	0.8556
Iowa	0.7325	0.8080
Kansas	0.7286	0.8051
Kentucky	0.7520	0.8227
Louisiana	0.7349	0.8098
Maine	0.8429	0.8896
Maryland	0.8504	0.8950
Massachusetts	1.0818	1.0553
Michigan	0.8732	0.9113
Minnesota	0.8154	0.8696
Mississippi	0.6689	0.7593
Missouri	0.7250	0.8023
Montana	0.8191	0.8723
Nebraska	0.7334	0.8087
Nevada	0.9119	0.9388
New Hampshire	0.9809	0.9869
New Jersey[1]		
New Mexico	0.8107	0.8661
New York	0.8759	0.9133
North Carolina	0.7827	0.8455
North Dakota	0.7322	0.8078
Ohio	0.8137	0.8683
Oklahoma	0.6876	0.7738
Oregon	0.9270	0.9494
Pennsylvania	0.8625	0.9037
Puerto Rico	0.4402	0.5701

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Rhode Island[1]		
South Carolina	0.7644	0.8320
South Dakota	0.6981	0.7818
Tennessee	0.7413	0.8147
Texas	0.7485	0.8201
Utah	0.8840	0.9190
Vermont	0.8934	0.9257
Virginia	0.7832	0.8459
Washington	0.9666	0.9770
West Virginia	0.8138	0.8684
Wisconsin	0.8366	0.8850
Wyoming	0.8014	0.8593

[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
Albuquerque, NM	0.9362	0.9559
Alexandria, LA	0.8313	0.8812
Amarillo, TX	0.8084	0.8645
Anchorage, AK	1.3147	1.2061
Appleton-Oshkosh-Neenah, WI	0.8882	0.9220
Asheville, NC	0.9212	0.9453
Atlanta, GA	1.0289	1.0197
Baton Rouge, LA	0.8656	0.9059
Benton Harbor, MI	0.8209	0.8736
Benton Harbor, MI (Rural Michigan Hosp.)	0.8732	0.9133
Bergen-Passaic, NJ	1.1316	1.0884
Biloxi-Gulfport, MS	0.7968	0.8559
Birmingham, AL	0.8772	0.9142
Bismarck, ND	0.8684	0.9079
Boise City, ID	0.9067	0.9351
Boston-Brockton-Nashua, MA-NH	1.1564	1.1046
Brazoria, TX	0.8300	0.8802
Bremerton, WA	0.7557	0.8255
Bremerton, WA (Rural Wahington Hosp.)	0.9666	0.9770
Bryan-College Station, TX	0.8712	0.9099
Casper, WY	0.8431	0.8897
Charlotte-Gastonia-Rock Hill, NC-SC	0.9593	0.9719
Charlottesville, VA	0.9242	0.9475
Chattanooga, TN-GA	0.8998	0.9302
Chicago, IL	1.0716	1.0485
Cincinnati, OH-KY-IN	0.9469	0.9633
Cleveland-Lorain-Elyria, OH	0.9870	0.9911
Columbia, MO	0.8950	0.9268
Columbus, GA-AL	0.7797	0.8433
Columbus, OH	0.9807	0.9867
Cumberland, MD-WV	0.8280	0.8788
Dallas, TX	0.9600	0.9724
Davenport-Rock Island-Moline, IA-IL	0.8263	0.8775
Dayton-Springfield, OH	0.9199	0.9444

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area Reclassified to	Wage index	GAF
Denver, CO	1.0659	1.0447
Des Moines, IA	0.8669	0.9068
Detroit, MI	1.0871	1.0589
Dothan, AL	0.8010	0.8590
Duluth-Superior, MN-WI	0.9303	0.9517
Dutchess County, NY	1.0470	1.0320
Eau Claire, WI	0.8516	0.8958
El Paso, TX	0.8518	0.8960
Eugene-Springfield, OR	1.0632	1.0429
Fargo-Moorhead, ND-MN	0.9091	0.9368
Fayetteville, NC	0.8423	0.8891
Flint, MI	1.0411	1.0280
Florence, AL	0.7916	0.8521
Fort Lauderdale, FL	1.0361	1.0246
Fort Pierce-Port St. Lucie, FL	1.0118	1.0081
Fort Smith, AR	0.7716	0.8373
Fort Walton Beach, FL	0.8747	0.9124
Fort Wayne, IN	0.8875	0.9215
Fort Worth-Arlington, TX	0.9169	0.9423
Gadsden, AL	0.8196	0.8726
Gainesville, FL	0.8867	0.9210
Glens Falls, NY	0.9309	0.9521
Grand Forks, ND-MN	0.9038	0.9331
Great Falls, MT	0.9018	0.9317
Greenville-Spartanburg-Anderson, SC	0.9149	0.9409
Harrisburg-Lebanon-Carlisle, PA	0.9667	0.9771
Hartford, CT	1.2269	1.1503
Houston, TX	0.9829	0.9883
Huntington-Ashland, WV-KY-OH	0.8989	0.9296
Huntsville, AL	0.7933	0.8534
Indianapolis, IN	0.9865	0.9907
Jackson, MS	0.7669	0.8338
Jackson, TN	0.8299	0.8801
Johnson City-Kingsport-Bristol, TN-VA	0.8667	0.9067
Joplin, MO	0.7828	0.8456
Kalamazoo-Battlecreek, MI	1.0507	1.0344
Kansas City, KS-MO	0.9513	0.9664
Knoxville, TN	0.8588	0.9010
Lafayette, LA	0.8011	0.8591
Lansing-East Lansing, MI	1.0067	1.0046
Las Cruces, NM	0.8837	0.9188
Las Vegas, NV-AZ	1.0723	1.0490
Lexington, KY	0.8471	0.8926
Lima, OH	0.8703	0.9093
Lincoln, NE	0.8790	0.9155
Little Rock-North Little Rock, AR	0.8327	0.8822
Longview-Marshall, TX	0.8546	0.8980
Los Angeles-Long Beach, CA	1.2592	1.1710
Louisville, KY-IN	0.9474	0.9637
Lubbock, TX	0.8717	0.9103
Macon, GA	0.8639	0.9047
Madison, WI	0.9954	0.9968
Mansfield, OH	0.8238	0.8757
Medford-Ashland, OR	0.9944	0.9962
Memphis, TN-AR-MS	0.8412	0.8883
Merced, CA	1.0250	1.0171
Middlesex-Somerset-Hunterdon, NJ	1.0579	1.0393
Milwaukee, WI	0.9537	0.9681
Minneapolis-St. Paul, MN-WI	1.0889	1.0601
Modesto, CA	1.1292	1.0868
Monroe, LA	0.7758	0.8404
Montgomery, AL	0.8082	0.8643
Nashville, TN	0.9235	0.9470
New London-Norwich, CT	1.1752	1.1169
New Orleans, LA	0.9532	0.9677
New York, NY	1.4200	1.2714
Newark, NJ	1.0936	1.0632
Newburgh, NY-PA	0.9496	0.9652
Oakland, CA	1.4690	1.3013
Oklahoma City, OK	0.8499	0.8946
Omaha, NE-IA	0.9825	0.9880
Orange County, CA	1.4029	1.2609
Peoria-Pekin, IL	0.8447	0.8909
Philadelphia, PA-NJ	1.1115	1.0751
Pittsburgh, PA	0.9847	0.9895
Portland-Vancouver, OR-WA	1.1231	1.0827
Provo-Orem, UT	0.9858	0.9903
Raleigh-Durham-Chapel Hill, NC	0.9596	0.9722
Roanoke, VA	0.8398	0.8873
Rochester, MN	1.0363	1.0247
Rockford, IL	0.8709	0.9097
Rocky Mount, NC	0.8576	0.9001
Saginaw-Bay City-Midland, MI	0.9419	0.9598
St. Cloud, MN	0.9591	0.9718
St. Louis, MO-IL	0.9150	0.9410
Salem, OR	0.9595	0.9721
Salt Lake City-Ogden, UT	0.9645	0.9756
San Antonio, TX	0.8083	0.8644
San Francisco, CA	1.4103	1.2655
San Jose, CA	1.4353	1.2808
Sarasota-Bradenton, FL	0.9717	0.9805
Scranton-Wilkes-Barre-Hazelton, PA	0.8668	0.9067
Seattle-Bellevue-Everett, WA	1.0839	1.0567
Sherman-Denison, TX	0.8876	0.9216
Sioux City, IA-NE	0.8377	0.8858
Sioux Falls, SD	0.8697	0.9088
South Bend, IN	0.9664	0.9769
Springfield, IL	0.8764	0.9136
Syracuse, NY	0.9736	0.9818
Tampa-St. Petersburg-Clearwater, FL	0.9319	0.9528
Texarkana, TX-Texarkana, AR	0.8336	0.8828
Topeka, KS	0.9928	0.9951
Trenton, NJ	1.2552	1.1684
Tucson, AZ	0.9435	0.9610
Tulsa, OK	0.8253	0.8768
Tyler, TX	0.8594	0.9014
Ventura, CA	1.2864	1.1882
Waco, TX	0.8055	0.8623
Washington, DC-MD-VA-WV	1.1010	1.0681
Waterloo-Cedar Falls, IA	0.8681	0.9077
Wausau, WI	0.9427	0.9604
Wichita, KS	0.9742	0.9823
Rural Alabama	0.7051	0.7872
Rural Louisiana	0.7349	0.8098
Rural Missouri	0.7250	0.8023
Rural New Hampshire	0.9809	0.9869
Rural Ohio	0.8137	0.8683
Rural Virginia	0.7832	0.8459
Rural West Virginia	0.8138	0.8684
Rural Wyoming	0.8014	0.8593

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	15.6799
Aguadilla, PR	8.4764
Akron, OH	17.2298
Albany, GA	16.1099
Albany-Schenectady-Troy, NY	16.1957
Albuquerque, NM	17.0208
Alexandria, LA	15.1130
Allentown-Bethlehem-Easton, PA-NJ	18.4674
Altoona, PA	16.8070
Amarillo, TX	14.6970
Anchorage, AK	23.8324
Ann Arbor, MI	23.0180
Anniston, AL	14.5274
Appleton-Oshkosh-Neenah, WI	16.1474
Arecibo, PR	6.9358
Asheville, NC	16.7477
Athens, GA	16.5317
Atlanta, GA	18.7055
Atlantic City-Cape May, NJ	19.8522
Augusta-Aiken, GA-SC	15.7238
Austin-San Marcos, TX	16.4196
Bakersfield, CA	19.9373
Baltimore, MD	18.0216
Bangor, ME	17.3217
Barnstable-Yarmouth, MA	25.2260
Baton Rouge, LA	15.7376
Beaumont-Port Arthur, TX	15.7684
Bellingham, WA	20.5119
Benton Harbor, MI	14.8759
Bergen-Passaic, NJ	20.5959
Billings, MT	15.9221
Biloxi-Gulfport-Pascagoula, MS	15.0572
Binghamton, NY	16.7629
Birmingham, AL	15.9479
Bismarck, ND	15.7880
Bloomington, IN	15.5760
Bloomington-Normal, IL	15.5045
Boise City, ID	16.4848
Boston-Boston-Nashua, MA-NH	21.0242
Boulder-Longmont, CO	18.1601
Brazoria, TX	15.9482
Bremerton, WA	17.6611
Brownsville-Harlingen-San Benito, TX	15.0688
Bryan-College Station, TX	15.8389
Buffalo-Niagara Falls, NY	16.6972
Burlington, VT	18.1503
Caguas, PR	7.9854

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Canton-Massillon, OH	15.7864
Casper, WY	15.1989
Cedar Rapids, IA	14.8441
Champaign-Urbana, IL	16.1590
Charleston-North Charleston, SC	16.1537
Charleston, WV	15.6757
Charlotte-Gastonia-Rock Hill, NC-SC	17.3740
Charlottesville, VA	17.0943
Chattanooga, TN-GA	16.3584
Cheyenne, WY	13.6175
Chicago, IL	19.4830
Chico-Paradise, CA	18.7297
Cincinnati, OH-KY-IN	17.2034
Clarksville-Hopkinsville, TN-KY	13.7119
Cleveland-Lorain-Elyria, OH	17.9437
Colorado Springs, CO	16.9767
Columbia, MO	16.8243
Columbia, SC	16.3607
Columbus, GA-AL	14.1755
Columbus, OH	17.8306
Corpus Christi, TX	15.2095
Cumberland, MD-WV	14.9137
Dallas, TX	17.4528
Danville, VA	14.7798
Davenport-Moline-Rock Island, IA-IL	15.0227
Dayton-Springfield, OH	17.0612
Daytona Beach, FL	15.7116
Decatur, AL	14.5969
Decatur, IL	14.4506
Denver, CO	19.3789
Des Moines, IA	15.7603
Detroit, MI	19.7641
Dothan, AL	14.5621
Dover, DE	16.6236
Dubuque, IA	13.7683
Duluth-Superior, MN-WI	16.8727
Dutchess County, NY	19.2454
Eau Claire, WI	15.3631
El Paso, TX	15.4859
Elkhart-Goshen, IN	15.8724
Elmira, NY	15.6636
Enid, OK	14.9984
Erie, PA	16.3068
Eugene-Springfield, OR	19.3300
Evansville, Henderson, IN-KY	16.4926
Fargo-Moorhead, ND-MN	16.8334
Fayetteville, NC	15.8069
Fayetteville-Springdale-Rogers, AR	13.2254
Flint, MI	18.9698
Florence, AL	13.9337
Florence, SC	15.5718
Fort Collins-Loveland, CO	17.7671
Fort Lauderdale, FL	19.3381
Fort Myers-Cape Coral, FL	17.4771
Fort Pierce-Fort St. Lucie, FL	18.1523
Fort Smith, AR-OK	14.0151
Fort Walton Beach, FL	16.1725
Fort Wayne, IN	16.1351
Fort Worth-Arlington, TX	16.6281
Fresno, CA	18.8501
Gadsden, AL	14.9006
Gainesville, FL	16.1053
Galveston-Texas City, TX	18.4232
Gary, IN	17.5613
Glens Falls, NY	16.6860
Goldsboro, NC	15.4377

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Grand Forks, ND-MN	16.2914
Grand Rapids-Muskegon-Holland, MI	17.9324
Great Falls, MT	15.7732
Greeley, CO	19.1455
Green Bay, WI	16.1023
Greensboro-Winston-Salem-High Point, NC	16.7368
Greenville, NC	16.3414
Greenville-Spartanburg-Anderson, SC	16.6335
Hagerstown, MD	16.3387
Hamilton-Middletown, OH	16.1746
Harrisburg-Lebanon-Carlisle, PA	17.5461
Hartford, CT	22.5979
Hickory-Morganton, NC	15.9128
Honolulu, HI	21.3363
Houma, LA	14.0576
Houston, TX	17.8660
Huntington-Ashland, WV-KY-OH	16.3419
Huntsville, AL	14.7596
Indianapolis, IN	17.9355
Iowa City, IA	16.5438
Jackson, MI	16.7467
Jackson, MS	13.8228
Jackson, TN	15.0882
Jacksonville, FL	16.4406
Jacksonville, NC	13.1433
Jamestown, NY	13.7544
Janesville-Beloit, WI	15.7055
Jersey City, NJ	20.1808
Johnson City-Kingsport-Bristol, TN-VA	15.7582
Johnstown, PA	15.7335
Joplin, MO	14.1473
Kalamazoo-Battle Creek, MI	19.1022
Kankakee, IL	17.1314
Kansas City, KS-MO	17.2955
Kenosha, WI	16.0882
Killeen-Temple, TX	17.6560
Knoxville, TN	15.6051
Kokomo, IN	16.4989
LaCrosse, WI	15.5484
Lafayette, LA	14.4264
Lafayette, IN	15.1766
Lake Charles, LA	15.0433
Lakeland-Winter Haven, FL	14.7941
Lancaster, PA	17.0658
Lansing-East Lansing, MI	18.3031
Laredo, TX	12.7235
Las Cruces, NM	16.0660
Las Vegas, NV-AZ	19.4913
Lawrence, KS	15.6222
Lawton, OK	15.5118
Lewiston-Auburn, ME	17.6436
Lexington, KY	15.3463
Lima, OH	15.8233
Lincoln, NE	16.4101
Little Rock-North Little Rock, AR	15.1390
Longview-Marshall, TX	15.9127
Los Angeles-Long Beach, CA	22.8969
Louisville, KY-IN	17.2240
Lubbock, TX	15.8490
Lynchburg, VA	15.1754
Macon, GA	16.4206
Madison, WI	18.0981
Mansfield, OH	14.9778
Mayaguez, PR	8.1304
McAllen-Edinburg-Mission, TX	14.6517

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Medford-Ashland, OR	17.6432
Melbourne-Titusville-Palm Bay, FL	16.3510
Memphis, TN-AR-MS	15.4887
Merced, CA	17.9930
Miami, FL	18.5575
Middlesex-Somerset-Hunterdon, NJ	19.5314
Milwaukee-Waukesha, WI	17.5426
Minneapolis-St. Paul, MN-WI	19.7966
Mobile, AL	13.7051
Modesto, CA	20.4129
Monmouth-Ocean, NJ	19.4962
Monroe, LA	13.9777
Montgomery, AL	14.6928
Muncie, IN	17.3507
Myrtle Beach, SC	14.5015
Naples, FL	17.7633
Nashville, TN	17.0518
Nassau-Suffolk, NY	24.6970
New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT	22.5646
New London-Norwich, CT	21.1702
New Orleans, LA	17.3291
New York, NY	25.6447
Newark, NJ	21.7897
Newburgh, NY-PA	18.6043
Norfolk-Virginia Beach-Newport News, VA	15.1146
Oakland, CA	26.6653
Ocala, FL	16.0357
Odessa-Midland, TX	15.3382
Oklahoma City, OK	15.4527
Olympia, WA	20.3246
Omaha, NE-IA	17.8621
Orange County, CA	22.2936
Orlando, FL	17.2217
Owensboro, KY	14.3219
Panama City, FL	13.7129
Parkersburg-Marietta, WV-OH	14.4674
Pensacola, FL	14.9950
Peoria-Pekin, IL	15.3566
Philadelphia, PA-NJ	20.2418
Phoenix-Mesa, AZ	18.4081
Pine Bluff, AR	15.7140
Pittsburgh, PA	17.9035
Pittsfield, MA	20.6961
Ponce, PR	8.0275
Portland, ME	17.2961
Portland-Vancouver, OR-WA	20.4183
Providence-Warwick, RI	20.2583
Provo-Orem, UT	18.7888
Pueblo, CO	14.1899
Punta Gorda, FL	15.9683
Racine, WI	15.7220
Raleigh-Durham-Chapel Hill, NC	17.4465
Rapid City, SD	14.8116
Reading, PA	16.7253
Redding, CA	20.0800
Reno, NV	20.2340
Richland-Kennewick-Pasco, WA	17.6183
Richmond-Petersburg, VA	17.0553
Riverside-San Bernardino, CA	21.3851
Roanoke, VA	15.0995
Rochester, MN	19.0900
Rochester, NY	17.9083
Rockford, IL	15.8339
Rocky Mount, NC	15.5922
Sacramento, CA	20.5987

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Saginaw-Bay City-Midland, MI	17.0890
St. Cloud, MN	17.4372
St. Joseph, MO	15.7097
St. Louis, MO-IL	16.6361
Salem, OR	17.4562
Salinas, CA	24.9907
Salt Lake City-Ogden, UT	17.5358
San Angelo, TX	13.0251
San Antonio, TX	14.6955
San Diego, CA	21.9381
San Francisco, CA	25.6122
San Jose, CA	26.0941
San Juan-Bayamon, PR	7.9610
San Luis Obispo-Atascadero-Paso Robles, CA	22.3764
Santa Barbara-Santa Maria-Lompoc, CA	21.2153
Santa Cruz-Watsonville, CA	24.5190
Santa Fe, NM	19.6904
Santa Rosa, CA	23.4906
Sarasota-Bradenton, FL	17.6658
Savannah, GA	16.1442
Scranton-Wilkes Barre-Hazleton, PA	15.5977
Seattle-Bellevue-Everett, WA	20.0458
Sharon, PA	16.2992
Sheboygan, WI	14.6933
Sherman-Denison, TX	16.1308
Shreveport-Bossier City, LA	16.5027
Sioux City, IA-NE	15.5079
Sioux Falls, SD	15.8117
South Bend, IN	17.5707
Spokane, WA	19.3897
Springfield, IL	15.9339
Springfield, MO	14.4034
Springfield, MA	19.2715
State College, PA	18.0846
Steubenville-Weirton, OH-WV	15.4737
Stockton-Lodi, CA	21.2618
Sumter, SC	14.6395
Syracuse, NY	17.7012
Tacoma, WA	18.9982
Tallahassee, FL	14.9889
Tampa-St. Petersburg-Clearwater, FL	16.9475
Terre Haute, IN	15.6697
Texarkana, TX-Texarkana, AR	14.8819

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Toledo, OH	18.1171
Topeka, KS	18.0500
Trenton, NJ	18.6489
Tucson, AZ	17.1274
Tulsa, OK	15.0046
Tuscaloosa, AL	14.9033
Tyler, TX	15.6242
Utica-Rome, NY	15.4642
Vallejo-Fairfield-Napa, CA	23.8150
Ventura, CA	21.2819
Victoria, TX	15.8948
Vineland-Millville-Bridgeton, NJ	18.7995
Visalia-Tulare-Porterville, CA	18.8058
Waco, TX	14.6442
Washington, DC-MD-VA-WV	20.0174
Waterloo-Cedar Falls, IA	15.7836
Wausau, WI	17.9018
West Palm Beach-Boca Raton, FL	18.3519
Wheeling, WV-OH	13.8778
Wichita, KS	18.2479
Wichita Falls, TX	12.5172
Williamsport, PA	15.3868
Wilmington-Newark, DE-MD	19.5698
Wilmington, NC	16.6887
Yakima, WA	17.3416
Yolo, CA	21.6301
York, PA	16.4426
Youngstown-Warren, OH	17.0986
Yuba City, CA	18.6136
Yuma, AZ	15.8434

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	12.7907
Alaska	22.8273
Arizona	15.1182
Arkansas	12.3940
California	17.7961
Colorado	14.5806
Connecticut	22.3424

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Delaware	15.3947
Florida	15.5317
Georgia	13.7365
Hawaii	17.3871
Idaho	15.2823
Illinois	13.5345
Indiana	14.4777
Iowa	13.3171
Kansas	13.2473
Kentucky	13.6720
Louisiana	13.3198
Maine	15.3246
Maryland	15.4619
Massachusetts	19.6679
Michigan	15.8762
Minnesota	14.8248
Mississippi	12.1611
Missouri	13.1806
Montana	14.8911
Nebraska	13.3346
Nevada	16.5787
New Hampshire	17.8203
New Jersey [1]	
New Mexico	14.7398
New York	15.9245
North Carolina	14.2303
North Dakota	13.3117
Ohio	14.7840
Oklahoma	12.5019
Oregon	16.8541
Pennsylvania	15.6802
Puerto Rico	8.0041
Rhode Island [1]	
South Carolina	13.8973
South Dakota	12.6925
Tennessee	13.4771
Texas	13.6078
Utah	16.0721
Vermont	16.2419
Virginia	14.2279
Washington	17.5732
West Virginia	14.7082
Wisconsin	15.2103
Wyoming	14.4787

[1] All counties within the State are classified urban.

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
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.1583	9.6	13.5	32
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0986	9.8	13.9	32
3	01	SURG	*CRANIOTOMY AGE 0–17	3.0370	12.7	12.7	35
4	01	SURG	SPINAL PROCEDURES	2.3196	7.2	11.0	29
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5615	4.4	5.6	26
6	01	SURG	CARPAL TUNNEL RELEASE	.6360	2.2	3.2	24
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC.	2.3641	9.6	16.7	32
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	.8845	2.8	4.5	25
9	01	MED	SPINAL DISORDERS & INJURIES	1.2468	6.0	8.8	28
10	01	MED	NERVOUS SYSTEM NEOPLASMS WITH CC	1.2626	6.7	9.6	29
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.7736	3.8	5.5	26
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9576	6.3	9.0	28
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7846	5.7	7.2	28

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA.	1.1962	6.4	8.7	28
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS.	.6915	3.8	4.9	26
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC.	1.0468	5.8	7.7	28
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.	.6197	3.5	4.6	26
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC.	.9138	5.5	7.2	27
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC.	.5941	3.7	4.8	26
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS.	2.0898	8.3	11.7	30
21	01	MED	VIRAL MENINGITIS	1.4489	6.5	8.7	28
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.7809	4.2	5.4	26
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8018	4.0	5.6	26
24	01	MED	SEIZURE & HEADACHE AGE >17 WITH CC	.9661	4.8	6.6	27
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5524	3.2	4.1	25
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6294	2.8	4.4	25
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3456	4.0	7.1	26
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC.	1.2155	5.5	8.2	27
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	.6215	3.3	4.6	25
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17.	.3684	2.0	2.0	17
31	01	MED	CONCUSSION AGE >17 WITH CC	.7551	3.9	5.6	26
32	01	MED	CONCUSSION AGE >17 W/O CC	.4598	2.5	3.4	23
33	01	MED	*CONCUSSION AGE 0–17	.2556	1.6	1.6	9
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITH CC.	1.0876	5.3	7.4	28
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5857	3.5	4.9	27
36	02	SURG	RETINAL PROCEDURES	.6000	1.5	1.8	8
37	02	SURG	ORBITAL PROCEDURES	.8124	2.7	3.9	25
38	02	SURG	PRIMARY IRIS PROCEDURES	.3997	2.0	2.7	16
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY.	.5079	1.5	1.9	9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	.6020	2.3	3.6	24
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17.	.3806	1.6	1.6	7
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	.5783	1.7	2.3	13
43	02	MED	HYPHEMA	.3405	3.0	3.6	20
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.5780	5.0	6.0	27
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6214	3.5	4.3	25
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7573	4.5	6.0	26
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4330	3.0	3.9	25
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.4182	2.9	2.9	25
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7155	4.9	6.8	27
50	03	SURG	SIALOADENECTOMY	.7151	1.9	2.3	11
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	.6850	2.0	3.0	22
52	03	SURG	CLEFT LIP & PALATE REPAIR	.9160	2.3	3.0	20
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.8624	2.2	3.4	24
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.7170	3.2	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.6451	1.8	2.8	20
56	03	SURG	RHINOPLASTY	.7719	2.2	3.1	24
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0215	3.4	5.2	25
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.3224	1.5	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.4603	1.5	1.9	9
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2721	1.5	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.0048	2.9	5.1	25
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.3215	1.3	1.3	5

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.1087	3.4	5.1	25
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1440	5.0	6.4	27
65	03	MED	DYSEQUILIBRIUM	.5066	3.0	3.8	22
66	03	MED	EPISTAXIS	.5070	3.1	3.9	24
67	03	MED	EPIGLOTTITIS	.8395	3.8	4.8	26
68	03	MED	OTITIS MEDIA & URI AGE >17 WITH CC	.7109	4.4	5.4	26
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5137	3.5	4.2	22
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.5674	3.5	4.3	25
71	03	MED	LARYNGOTRACHEITIS	.6500	3.5	4.2	22
72	03	MED	NASAL TRAUMA & DEFORMITY	.6037	3.1	4.3	25
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	.7607	4.1	5.5	26
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3568	2.1	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES	3.0728	9.9	12.4	32
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5091	10.0	13.8	32
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.0561	4.0	6.0	26
78	04	MED	PULMONARY EMBOLISM	1.4217	7.8	9.2	30
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC.	1.6968	8.3	10.7	30
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9243	5.9	7.3	28
81	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17.	1.1138	5.6	7.0	28
82	04	MED	RESPIRATORY NEOPLASMS	1.3249	6.3	8.9	28
83	04	MED	MAJOR CHEST TRAUMA WITH CC	.9473	5.5	7.2	28
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.4934	3.2	4.3	25
85	04	MED	PLEURAL EFFUSION WITH CC	1.1910	6.2	8.2	28
86	04	MED	PLEURAL EFFUSION W/O CC	.6744	3.8	4.9	26
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3319	5.5	7.5	27
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0062	5.6	6.9	28
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.1325	6.5	8.0	29
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6923	4.9	5.7	26
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.5790	3.6	4.2	18
92	04	MED	INTERSTITIAL LUNG DISEASE WITH CC	1.2097	6.4	8.1	28
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7706	4.5	5.7	26
94	04	MED	PNEUMOTHORAX WITH CC	1.2406	6.5	8.5	28
95	04	MED	PNEUMOTHORAX W/O CC	.6191	4.0	5.0	26
96	04	MED	BRONCHITIS & ASTHMA AGE >17 WITH CC	.8494	5.2	6.2	27
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.6122	4.1	4.8	24
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.5396	3.1	4.1	25
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS WITH CC	.7034	3.2	4.1	25
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5052	2.3	2.8	15
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC.	.9052	4.6	6.2	27
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5320	3.0	3.9	25
103	05	SURG	HEART TRANSPLANT	13.0713	24.3	34.2	46
104	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.6122	15.1	17.9	37
105	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.7785	11.0	13.0	33
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.6745	12.1	13.6	34
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.2105	9.3	10.4	31
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	6.1158	11.4	14.7	33
109			NO LONGER VALID	.0000	.0	.0	0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES WITH CC	4.0832	9.1	12.2	31
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.3065	6.5	7.5	28
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9910	3.9	5.3	26
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7751	12.7	17.1	35
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5388	7.9	10.9	30
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK.	3.5971	10.4	12.7	32
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GEN PROC.	2.4510	4.7	6.5	27
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.1670	3.3	4.8	25
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5643	2.3	3.5	24
119	05	SURG	VEIN LIGATION & STRIPPING	.9981	3.3	5.6	25
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9541	6.2	10.6	28

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE.	1.6042	7.0	8.6	29
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE.	1.1310	4.9	6.0	27
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4292	2.9	5.1	25
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.2680	4.2	5.5	26
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	.8460	2.4	3.2	23
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.7676	13.6	18.3	36
127	05	MED	HEART FAILURE & SHOCK	1.0244	5.5	7.1	27
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7814	6.7	7.5	29
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1312	2.1	3.8	24
130	05	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	.9089	5.8	7.4	28
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5871	4.6	5.6	27
132	05	MED	ATHEROSCLEROSIS WITH CC	.7295	3.6	4.7	26
133	05	MED	ATHEROSCLEROSIS W/O CC	.5369	2.7	3.5	21
134	05	MED	HYPERTENSION	.5765	3.5	4.4	25
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 WITH CC.	.8488	4.2	5.8	26
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5616	3.0	3.7	23
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	.6572	3.3	3.3	25
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC.	.7971	3.9	5.2	26
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	.4942	2.6	3.3	20
140	05	MED	ANGINA PECTORIS	.6267	3.2	4.0	23
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.7028	3.9	5.1	26
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5178	2.9	3.6	21
143	05	MED	CHEST PAIN	.5173	2.4	3.0	16
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0667	4.5	6.4	27
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6230	2.8	3.7	25
146	06	SURG	RECTAL RESECTION WITH CC	2.5374	10.7	12.2	33
147	06	SURG	RECTAL RESECTION W/O CC	1.5514	7.4	8.0	28
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC.	3.2219	12.2	14.6	34
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.5038	7.6	8.2	26
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.5637	10.5	12.7	32
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.1849	5.5	6.8	27
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC.	1.7740	8.2	9.6	30
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.1154	6.0	6.7	26
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 WITH CC.	4.1774	13.3	17.0	35
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3927	6.1	7.2	28
156	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8724	6.0	6.0	28
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	1.0322	4.4	6.1	26
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5446	2.3	3.0	18
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 WITH CC.	1.1081	4.3	5.6	26
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.6582	2.5	3.1	18
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 WITH CC.	.9060	3.2	4.6	25
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.5169	1.8	2.2	11
163	06	SURG	HERNIA PROCEDURES AGE 0–17	.7290	3.9	4.8	24
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC.	2.1664	8.8	10.2	31
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.2002	5.7	6.3	24
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC.	1.3522	5.2	6.3	27

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	.7843	3.2	3.7	16
168	03	SURG	MOUTH PROCEDURES WITH CC	1.0920	3.5	5.4	26
169	03	SURG	MOUTH PROCEDURES W/O CC	.6176	2.1	2.7	16
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC.	2.7634	9.7	14.4	32
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.0576	4.3	5.8	26
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.3010	6.5	9.4	29
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6325	3.2	4.6	25
174	06	MED	G.I. HEMORRHAGE WITH CC	.9735	4.9	6.2	27
175	06	MED	G.I. HEMORRHAGE W/O CC	.5366	3.3	3.9	19
176	06	MED	COMPLICATED PEPTIC ULCER	1.0447	5.3	6.9	27
177	06	MED	UNCOMPLICATED PEPTIC ULCER WITH CC	.8070	4.6	5.6	27
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.5829	3.3	3.9	19
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.1147	6.4	8.2	28
180	06	MED	G.I. OBSTRUCTION WITH CC	.9134	5.2	6.8	27
181	06	MED	G.I. OBSTRUCTION W/O CC	.4978	3.4	4.2	23
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 WITH CC.	.7687	4.3	5.6	26
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5360	3.1	3.8	22
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.4135	2.6	3.2	18
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8339	4.1	5.7	26
186	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.4278	2.9	2.9	23
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.6465	2.8	3.8	25
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 WITH CC.	1.0203	4.9	6.8	27
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	.5025	2.7	3.7	25
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17 ..	.6263	3.1	4.4	25
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES WITH CC..	4.4048	13.6	18.1	36
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7647	6.8	8.8	29
193	07	SURG	BILIARY TRACT PROC W CC EXCEPT ONLY CHOLECYST W OR W/O C.D.E..	3.1449	12.9	15.6	35
194	07	SURG	BILIARY TRACT PROC W/O CC EXCEPT ONLY CHOLECYST W OR W/O C.D.E.	1.6602	7.3	9.2	29
195	07	SURG	CHOLECYSTECTOMY W C.D.E. WITH CC	2.4631	9.7	11.4	32
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.4811	6.5	7.4	28
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. WITH CC.	2.0800	8.1	9.7	30
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.0967	4.6	5.3	24
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.3638	9.8	13.2	32
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	2.9766	8.4	13.1	30
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.2257	12.1	17.0	34
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3126	6.4	8.7	28
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.2401	6.3	8.8	28
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY ..	1.1365	5.6	7.3	28
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA WITH CC.	1.2275	6.1	8.4	28
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.6075	3.4	4.6	25
207	07	MED	DISORDERS OF THE BILIARY TRACT WITH CC	1.0081	4.9	6.4	27
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.5661	2.9	3.7	23
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - LOWER EXTREMITY.	2.3181	7.7	8.6	29
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC.	1.8427	9.0	10.6	31
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.3000	7.0	7.8	29

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	.8759	3.4	3.8	17
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7182	8.2	11.2	30
214	08	SURG	BACK & NECK PROCEDURES WITH CC	1.9223	6.5	8.2	28
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.0974	3.9	4.8	24
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1005	9.2	13.2	31
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.9904	12.2	18.7	34
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 WITH CC.	1.3959	5.7	7.4	28
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	.9120	3.6	4.4	23
220	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.9618	5.3	5.3	27
221	08	SURG	KNEE PROCEDURES WITH CC	1.7897	6.6	9.3	29
222	08	SURG	KNEE PROCEDURES W/O CC	.9898	3.5	4.7	25
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.8163	2.5	3.2	18
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.6923	2.2	2.7	13
225	08	SURG	FOOT PROCEDURES	.9056	3.4	5.1	25
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3345	5.0	7.6	27
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6994	2.4	3.2	19
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	.8431	2.3	3.5	24
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	.5991	1.9	2.5	15
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	.9155	3.5	5.5	26
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.1300	3.5	5.4	25
232	08	SURG	ARTHROSCOPY	1.1591	3.2	5.8	25
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC.	1.9004	7.4	10.6	29
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	.9497	3.5	4.8	26
235	08	MED	FRACTURES OF FEMUR	.8958	5.7	8.8	28
236	08	MED	FRACTURES OF HIP & PELVIS	.7760	5.5	7.6	27
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	.5538	3.7	5.0	26
238	08	MED	OSTEOMYELITIS	1.4971	9.1	12.4	31
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0333	6.8	9.0	29
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.1883	6.4	8.7	28
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5835	4.0	5.2	26
242	08	MED	SEPTIC ARTHRITIS	1.1433	7.0	9.3	29
243	08	MED	MEDICAL BACK PROBLEMS	.7120	4.9	6.4	27
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC.	.7334	4.9	6.6	27
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	.4814	3.4	4.7	25
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5531	3.8	4.8	26
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5544	3.3	4.5	25
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7124	4.4	5.8	26
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6485	3.4	5.0	25
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 WITH CC.	.6922	4.1	5.7	26
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4521	2.5	3.4	23
252	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	.3638	1.8	1.8	15
253	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 WITH CC.	.7615	5.0	7.0	27
254	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4314	3.2	4.3	25

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
255	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.4827	2.9	2.9	25
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNEC-TIVE TISSUE DIAGNOSES.	.6418	3.4	4.7	25
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY WITH CC ...	.8842	3.5	4.2	20
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6992	2.7	3.1	12
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC.	.8270	2.8	4.1	25
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC.	.5841	1.9	2.2	10
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BI-OPSY & LOCAL EXCISION.	.7428	2.0	2.5	12
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MA-LIGNANCY.	.6475	2.5	3.9	25
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS WITH CC.	2.3497	12.5	17.5	34
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1657	7.1	9.6	29
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.3926	5.3	8.3	27
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.7371	2.9	4.0	25
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.6903	2.6	4.2	25
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	.8341	2.5	3.9	25
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE WITH CC.	1.7009	7.4	10.9	29
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE W/O CC.	.6619	2.5	3.6	25
271	09	MED	SKIN ULCERS	1.1340	7.6	9.9	30
272	09	MED	MAJOR SKIN DISORDERS WITH CC	1.0050	6.3	8.2	28
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.6315	4.6	6.1	27
274	09	MED	MALIGNANT BREAST DISORDERS WITH CC	1.1070	5.9	9.2	28
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.4950	2.6	4.0	25
276	09	MED	NON-MALIGANT BREAST DISORDERS	.6132	4.0	5.4	26
277	09	MED	CELLULITIS AGE >17 WITH CC	.8806	6.2	7.6	28
278	09	MED	CELLULITIS AGE >17 W/O CC	.5853	4.8	5.7	27
279	09	MED	CELLULITIS AGE 0–17	.6514	3.7	4.3	24
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC.	.6734	4.2	5.8	26
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4345	3.0	3.9	25
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17.	.3563	2.2	2.2	19
283	09	MED	MINOR SKIN DISORDERS WITH CC	.7142	4.8	6.3	27
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4358	3.3	4.3	25
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.5371	12.6	17.5	35
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2668	7.6	9.3	30
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	2.1030	11.4	16.3	33
288	10	SURG	O.R. PROCEDURES FOR OBESITY	1.9349	5.8	8.1	28
289	10	SURG	PARATHYROID PROCEDURES	1.0017	3.1	4.6	25
290	10	SURG	THYROID PROCEDURES	.7926	2.4	3.0	15
291	10	SURG	THYROGLOSSAL PROCEDURES	.5115	1.6	2.0	9
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC.	2.7349	10.3	15.0	32
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.1756	4.7	6.7	27
294	10	MED	DIABETES AGE >35	.7458	5.2	6.5	27
295	10	MED	DIABETES AGE 0–35	.7494	4.0	5.2	26
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC.	.9182	5.4	7.3	27
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5300	3.7	4.7	26
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17.	.5367	2.7	4.3	25
299	10	MED	INBORN ERRORS OF METABOLISM	.8087	4.3	6.1	26
300	10	MED	ENDOCRINE DISORDERS WITH CC	1.0989	6.3	8.3	28
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6044	3.7	5.0	26

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
302	11	SURG	KIDNEY TRANSPLANT	4.1738	12.6	14.6	35
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.5762	9.7	11.6	32
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC.	2.3271	8.7	11.6	31
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1348	4.5	5.6	26
306	11	SURG	PROSTATECTOMY WITH CC	1.2108	5.4	7.3	27
307	11	SURG	PROSTATECTOMY W/O CC	.6609	3.0	3.6	18
308	11	SURG	MINOR BLADDER PROCEDURES WITH CC	1.4472	5.4	8.1	27
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.7978	2.6	3.4	22
310	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	.9169	3.5	5.0	25
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5395	2.0	2.5	13
312	11	SURG	URETHRAL PROCEDURES, AGE >17 WITH CC	.8451	3.5	5.2	26
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.4775	1.9	2.6	16
314	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4499	2.3	2.3	24
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES.	2.0361	6.0	10.7	28
316	11	MED	RENAL FAILURE	1.2859	5.9	8.4	28
317	11	MED	ADMIT FOR RENAL DIALYSIS	.5151	2.8	3.9	25
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.1169	5.5	8.1	28
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5531	2.4	3.3	24
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC.	.9452	5.9	7.4	28
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC.	.6109	4.4	5.2	26
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5438	3.8	4.6	25
323	11	MED	URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY.	.7218	2.9	3.9	25
324	11	MED	URINARY STONES W/O CC	.3869	1.9	2.3	11
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC.	.6490	3.9	5.2	26
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4191	2.6	3.4	22
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	.7215	3.1	3.1	25
328	11	MED	URETHRAL STRICTURE AGE >17 WITH CC	.6741	3.5	4.8	26
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4317	1.9	2.5	15
330	11	MED	*URETHRAL STRICTURE AGE 0–17	.2901	1.6	1.6	9
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC.	.9950	5.1	7.0	27
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.5587	2.9	4.1	25
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17.	1.0095	4.8	7.0	27
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.7203	6.8	7.5	24
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.3462	5.6	6.1	19
336	12	SURG	TRANSURETHRAL PROSTATECTOMY WITH CC	.8537	4.0	4.8	23
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6142	3.0	3.3	12
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.9747	3.7	5.6	26
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.8266	3.1	4.4	25
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17.	.4512	2.4	2.4	13
341	12	SURG	PENIS PROCEDURES	1.0214	2.9	3.8	24
342	12	SURG	CIRCUMCISION AGE >17	.6732	2.7	4.2	25
343	12	SURG	*CIRCUMCISION AGE 0–17	.3941	1.7	1.7	6
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	.9940	2.7	3.6	25
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.7528	3.1	4.5	25
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC.	.9616	5.3	7.7	27
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	.4931	2.6	3.7	25
348	12	MED	BENIGN PROSTATIC HYPERTROPHY WITH CC	.6740	3.7	5.1	26
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4112	2.4	3.2	23
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	.6793	4.5	5.4	27
351	12	MED	*STERILIZATION, MALE	.3469	1.3	1.3	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5835	3.2	4.3	25

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8885	8.0	9.8	30
354	13	SURG	UTERINE & ADNEXA PROC FOR NON-OVARIAN/ ADNEXAL MALIG WITH CC.	1.3744	5.9	6.9	28
355	13	SURG	UTERINE & ADNEXA PROC FOR NON-OVARIAN/ ADNEXAL MALIG W/O CC.	.8790	4.0	4.3	12
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7168	3.2	3.6	14
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG.	2.2838	8.9	10.9	31
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC.	1.1045	4.7	5.4	20
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC.	.7993	3.5	3.8	11
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8205	3.5	4.3	22
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION.	1.1147	3.2	4.9	25
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.5184	1.4	1.4	5
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	.6472	2.8	3.7	21
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.6260	2.6	3.7	25
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	1.7149	6.3	9.1	28
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC.	1.2085	5.9	9.1	28
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/ O CC.	.4488	2.3	3.3	24
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.9716	5.6	7.3	28
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5119	2.9	4.0	25
370	14	SURG	CESAREAN SECTION W CC	.9020	4.9	5.8	24
371	14	SURG	CESAREAN SECTION W/O CC	.6323	3.6	3.8	9
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4798	2.7	3.3	16
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES.	.3378	1.9	2.1	8
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6135	2.4	3.2	17
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C.	.7094	4.4	4.4	26
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.3286	2.3	3.2	19
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.9805	3.4	5.8	25
378	14	MED	ECTOPIC PREGNANCY	.7065	2.6	3.0	15
379	14	MED	THREATENED ABORTION	.3197	2.0	2.8	18
380	14	MED	ABORTION W/O D&C	.3515	1.6	2.1	11
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.4061	1.7	2.2	12
382	14	MED	FALSE LABOR	.1860	1.2	1.4	5
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.4039	3.0	4.0	25
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.2947	1.9	2.6	15
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.2729	1.8	1.8	24
386	15	MED	*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	3.7965	17.9	17.9	40
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	1.9011	13.3	13.3	35
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.2042	8.6	8.6	31
389	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	1.2894	5.6	7.7	28
390	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	.5396	3.1	4.8	25
391	15	MED	*NORMAL NEWBORN	.2309	3.1	3.1	11
392	16	SURG	SPLENECTOMY AGE >17	3.2008	10.2	13.2	32
393	16	SURG	*SPLENECTOMY AGE 0–17	1.5824	9.1	9.1	31
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.5735	5.0	8.7	27
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8123	4.3	6.0	26
396	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	.2697	1.6	2.1	13
397	16	MED	COAGULATION DISORDERS	1.2487	5.0	6.9	27
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC.	1.2141	5.8	7.4	28

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	.6756	3.8	4.8	26
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE.	2.5572	7.6	11.7	30
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.4034	9.2	13.6	31
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	.9229	3.2	4.8	25
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6925	7.4	10.7	29
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.7567	3.7	5.2	26
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	1.0830	4.9	4.9	27
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.6478	9.4	12.8	31
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.1314	4.1	5.3	26
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.5561	5.0	8.4	27
409	17	MED	RADIOTHERAPY	.9823	5.4	7.7	27
410	17	MED	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.6762	2.7	3.3	20
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4503	2.7	3.7	25
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4497	2.1	3.0	21
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC.	1.3591	6.8	9.9	29
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.6645	3.7	5.4	26
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	3.5035	13.4	18.6	35
416	18	MED	SEPTECEMIA AGE >17	1.4936	6.9	9.5	29
417	18	MED	SEPTECEMIA AGE 0–17	1.4510	5.2	7.5	27
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9619	6.0	7.6	28
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9263	5.2	6.6	27
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6390	4.0	4.9	26
421	18	MED	VIRAL ILLNESS AGE >17	.6860	4.0	5.1	26
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17.	.5893	3.4	4.3	25
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.5811	7.1	9.9	29
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.5481	13.5	22.3	35
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION.	.7092	4.1	5.7	26
426	19	MED	DEPRESSIVE NEUROSES	.5956	4.6	6.5	27
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5939	4.4	6.4	26
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL.	.7355	5.7	9.2	28
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.9239	7.0	10.3	29
430	19	MED	PSYCHOSES	.8977	8.0	11.4	30
431	19	MED	CHILDHOOD MENTAL DISORDERS	.6358	5.3	7.7	27
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7580	4.7	7.3	27
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA.	.3350	2.8	4.1	25
434	20	MED	ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC.	.7210	4.9	6.6	27
435	20	MED	ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC.	.4364	4.1	5.5	26
436	20	MED	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY.	.9175	14.5	17.2	36
437	20	MED	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.9003	11.5	13.6	33
438	.....		NO LONGER VALID	.0000	.0	.0	0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.3129	5.6	8.8	28
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.7578	7.0	11.2	29
441	21	SURG	HAND PROCEDURES FOR INJURIES	.7762	2.3	3.4	24
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	2.0112	5.8	9.4	28
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.7544	2.4	3.3	24
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7379	4.6	6.2	27
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4621	3.1	4.0	25
446	21	MED	*TRAUMATIC INJURY AGE 0–17	.4991	2.4	2.4	22

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
447	21	MED	ALLERGIC REACTIONS AGE >17	.4693	2.3	3.1	20
448	21	MED	*ALLERGIC REACTIONS AGE 0–17	.3611	2.9	2.9	17
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC.	.7798	3.5	5.1	26
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	.4155	2.0	2.7	17
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17.	1.0332	2.1	2.1	17
452	21	MED	COMPLICATIONS OF TREATMENT WITH CC	.8584	4.0	5.6	26
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4343	2.6	3.4	22
454	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC.	.8879	4.1	6.4	26
455	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC.	.4404	2.3	3.3	24
456	22	MED	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	2.0638	5.3	10.2	27
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	1.7231	3.1	5.6	25
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.5371	14.0	19.8	36
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC.	1.7448	8.4	12.3	30
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0164	5.6	8.0	28
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	.9430	2.5	5.2	24
462	23	MED	REHABILITATION	1.6505	13.3	16.6	35
463	23	MED	SIGNS & SYMPTOMS W CC	.7167	4.5	6.0	26
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4746	3.1	4.1	25
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.4421	2.0	3.2	23
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5346	2.3	4.8	24
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.3726	2.6	5.0	25
468	.....		EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.5712	12.4	17.7	34
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.	3.7407	9.3	10.9	31
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	11.9304	16.2	30.5	38
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.5993	9.3	16.2	31
474	04		NO LONGER VALID	.0000	.0	.0	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6978	9.5	13.7	31
476	.....		PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2306	12.3	15.5	34
477	.....		NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.5262	5.9	9.5	28
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2254	6.3	9.5	28
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.3496	3.9	5.1	26
480	.....	SURG	LIVER TRANSPLANT	17.2203	26.3	33.3	48
481	.....	SURG	BONE MARROW TRANSPLANT	15.0471	34.9	38.7	57
482	.....	SURG	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES.	3.6765	13.0	17.3	35
483	.....	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH AND NECK DIAGNOSES.	16.7255	41.5	53.1	63
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.8382	12.7	20.2	35
485	24	SURG	LIMB REATTACH., HIP AND FEMUR PROCS FOR MULTI SIGN TRAUMA.	3.0833	11.3	14.2	33
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	5.0175	10.7	16.9	33
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9044	6.9	10.1	29
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.3726	15.0	21.1	37
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8234	8.3	12.4	30
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0610	5.1	8.0	27
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES—UPPER EXTREMITY.	1.6254	4.4	5.3	24
492	17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	3.6498	10.7	16.8	33

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—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. WITH CC.	1.5832	4.3	6.1	26
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	.8466	1.7	2.3	14

* Medicare data have been supplemented by data from Maryland and Michigan for low volume DRGS.
** DRGS 469 and 470 contain cases which could not be assigned to valid DRGS.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is used only to determine payment for outlier cases.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
042	Human immunodeficiency virus [HIV] disease	Y	25	489, 490
070.22	Chronic viral hepatitis B with hepatic coma without mention of hepatitis delta	Y	07	205, 206
			15	387, 389[1]
070.23	Chronic viral hepatitis B with hepatic coma with hepatitis delta	Y	07	205, 206
			15	387, 389[1]
070.32	Chronic viral hepatitis B without mention of hepatic coma without mention of hepatitis delta	Y	07	205, 206
			15	387, 389[1]
070.33	Chronic viral hepatitis B without mention of hepatic coma with hepatitis delta	Y	07	205, 206
			15	387, 389[1]
070.44	Chronic hepatitis C with hepatic coma	Y	07	205, 206
			15	387, 389[1]
070.54	Chronic hepatitis C without mention of hepatic coma	Y	07	205, 206
			15	387, 389[1]
312.81	Conduct disorder, childhood onset type	N	19	431
312.82	Conduct disorder, adolescent onset type	N	19	431
312.89	Other specified conduct disorder, not elsewhere classified	N	19	431
333.92	Neuroleptic malignant syndrome	N	01	34, 35
333.93	Benign shuddering attacks	N	01	34, 35
342.00	Flaccid hemiplegia and hemiparesis affecting unspecified side	N	01	12
342.01	Flaccid hemiplegia and hemiparesis affecting dominant side	N	01	12
342.02	Flaccid hemiplegia and hemiparesis affecting nondominant side	N	01	12
342.10	Spastic hemiplegia and hemiparesis affecting unspecified side	N	01	12
342.11	Spastic hemiplegia and hemiparesis affecting dominant side	N	01	12
342.12	Spastic hemiplegia and hemiparesis affecting nondominant side	N	01	12
342.80	Other specified hemiplegia and hemiparesis affecting unspecified side	N	01	12
342.81	Other specified hemiplegia and hemiparesis affecting dominant side	N	01	12
342.82	Other specified hemiplegia and hemiparesis affecting nondominant side	N	01	12
342.90	Unspecified hemiplegia and hemiparesis affecting unspecified side	N	01	12
342.91	Unspecified hemiplegia and hemiparesis affecting dominant side	N	01	12
342.92	Unspecified hemiplegia and hemiparesis affecting nondominant side	N	01	12
344.00	Quadriplegia, unspecified	Y	01	9
344.01	Quadriplegia, C1–C4, complete	Y	01	9
344.02	Quadriplegia, C1–C4, incomplete	Y	01	9
344.03	Quadriplegia, C5–C7, complete	Y	01	9
344.04	Quadriplegia, C5–C7, incomplete	Y	01	9
344.09	Other quadriplegia	Y	01	9
344.30	Monoplegia of lower limb affecting unspecified side	N	01	34, 35
344.31	Monoplegia of lower limb affecting dominant side	N	01	34, 35
344.32	Monoplegia of lower limb affecting nondominant side	N	01	34, 35
344.40	Monoplegia of upper limb affecting unspecified side	N	01	34, 35
344.41	Monoplegia of upper limb affecting dominant side	N	01	34, 35
344.42	Monoplegia of upper limb affecting nondominant side	N	01	34, 35
414.00	Coronary atherosclerosis of unspecified vessel	N	05	132, 133
414.01	Coronary atherosclerosis of native coronary vessel	N	05	132, 133
414.02	Coronary atherosclerosis of autologous vein bypass graft	N	05	132, 133
414.03	Coronary atherosclerosis of nonautologous biological bypass graft	N	05	132, 133
440.30	Atherosclerosis of unspecified bypass graft of the extremities	N	05	130, 131
440.31	Atherosclerosis of autologous vein bypass graft of the extremities	N	05	130, 131
440.32	Atherosclerosis of nonautologous biological bypass graft of the extremities	N	05	130, 131
441.00	Dissecting aortic aneurysm of unspecified site	Y	05	121, 130, 131
441.01	Dissecting thoracic aortic aneurysm	Y	05	121, 130, 131
441.02	Dissecting abdominal aortic aneurysm	Y	05	121, 130, 131

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
441.03	Dissecting thoracoabdominal aortic aneurysm	Y	05	121, 130, 131
512.1	Iatrogenic pneumothorax	Y	04	94, 95
536.3	Gastroparesis	N	06	182, 183, 184
556.0	Ulcerative enterocolitis	N	06	179
556.1	Ulcerative ileocolitis	N	06	179
556.2	Ulcerative proctitis	N	06	179
556.3	Ulcerative proctosigmoiditis	N	06	179
556.4	Pseudopolyposis of colon	N	06	179
556.5	Left-sided ulcerative colitis	N	06	179
556.6	Universal ulcerative colitis	N	06	179
556.8	Other ulcerative colitis	N	06	179
556.9	Ulcerative colitis, unspecified	N	06	179
593.70	Vesicoureteral reflux unspecified or without reflux nephropathy	N	11	331, 332, 333
593.71	Vesicoureteral reflux with reflux nephropathy, unilateral	N	11	331, 332, 333
593.72	Vesicoureteral reflux with reflux nephropathy, bilateral	N	11	331, 332, 333
593.73	Other vesicoureteral reflux with reflux nephropathy	N	11	331, 332, 333
669.43	Other complications of obstetrical surgery and procedures, antepartum condition or complication	N	14	383, 384
677	Late effect of complication of pregnancy, childbirth, the puerperium	N	14	469
702.11	Inflamed seborrheic keratosis	N	09	283, 284
702.19	Other seborrheic keratosis	N	09	283, 284
709.00	Dyschromia, unspecified	N	09	283, 284
709.01	Vitiglio	N	09	283, 284
709.09	Other dyschromia	N	09	283, 284
759.83	Fragile X syndrome	N	15	390
760.76	Diethylstilbestrol (DES) exposure affecting fetus or newborn via placenta or breast milk	N	15	390
781.8	Neurologic neglect syndrome	N	01	34, 35
787.01	Nausea with vomiting	N	06	182, 183, 184
787.02	Nausea alone	N	06	182, 183, 184
787.03	Vomiting alone	N	06	182, 183, 184
789.00	Abdominal pain, unspecified site	N	06	182, 183, 184
789.01	Abdominal pain, right upper quadrant	N	06	182, 183, 184
789.02	Abdominal pain, left upper quadrant	N	06	182, 183, 184
789.03	Abdominal pain, right lower quadrant	N	06	182, 183, 184
789.04	Abdominal pain, left lower quadrant	N	06	182, 183, 184
789.05	Abdominal pain, periumbilic	N	06	182, 183, 184
789.06	Abdominal pain, epigastric	N	06	182, 183, 184
789.07	Abdominal pain, generalized	N	06	182, 183, 184
789.09	Abdominal pain, other specified site	N	06	182, 183, 184
789.30	Abdominal or pelvic swelling, mass, or lump, unspecified site	N	06	182, 183, 184
789.31	Abdominal or pelvic swelling, mass, or lump, right upper quadrant	N	06	182, 183, 184
789.32	Abdominal or pelvic swelling, mass, or lump, left upper quadrant	N	06	182, 183, 184
789.33	Abdominal or pelvic swelling, mass, or lump, right lower quadrant	N	06	182, 183, 184
789.34	Abdominal or pelvic swelling, mass, or lump, left lower quadrant	N	06	182, 183, 184
789.35	Abdominal or pelvic swelling, mass, or lump, periumbilic	N	06	182, 183, 184
789.36	Abdominal or pelvic swelling, mass, or lump, epigastric	N	06	182, 183, 184
789.37	Abdominal or pelvic swelling, mass, or lump, generalized	N	06	182, 183, 184
789.39	Abdominal or pelvic swelling, mass, or lump, other specified site	N	06	182, 183, 184
789.40	Abdominal rigidity, unspecified site	N	06	188, 189, 190
789.41	Abdominal rigidity, right upper quadrant	N	06	188, 189, 190
789.42	Abdominal rigidity, left upper quadrant	N	06	188, 189, 190
789.43	Abdominal rigidity, right lower quadrant	N	06	188, 189, 190
789.44	Abdominal rigidity, left lower quadrant	N	06	188, 189, 190
789.45	Abdominal rigidity, periumbilic	N	06	188, 189, 190
789.46	Abdominal rigidity, epigastric	N	06	188, 189, 190
789.47	Abdominal rigidity, generalized	N	06	188, 189, 190
789.49	Abdominal rigidity, other specified site	N	06	188, 189, 190
789.60	Abdominal tenderness, unspecified site	N	06	182, 183, 184
789.61	Abdominal tenderness, right upper quadrant	N	06	182, 183, 184
789.62	Abdominal tenderness, left upper quadrant	N	06	182, 183, 184
789.63	Abdominal tenderness, right lower quadrant	N	06	182, 183, 184
789.64	Abdominal tenderness, left lower quadrant	N	06	182, 183, 184
789.65	Abdominal tenderness, periumbilic	N	06	182, 183, 184
789.66	Abdominal tenderness, epigastric	N	06	182, 183, 184
789.67	Abdominal tenderness, generalized	N	06	182, 183, 184
789.69	Abdominal tenderness, other specified site	N	06	182, 183, 184
795.71	Nonspecific serologic evidence of human immunodeficiency virus [HIV]	N	16	398, 399
795.79	Other and unspecified nonspecific immunological findings	N	16	398, 399
909.5	Late effect of adverse effect of drug, medicinal or biological substance	N	21	454, 455
996.04	Complications due to automatic implantable cardiac defibrillator	Y	05	138, 139

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
998.81	Emphysema (subcutaneous) resulting from procedure	N	21	452, 453
998.82	Cataract fragments in eye following cataract surgery	N	02	46, 47, 48
998.89	Other specified complications of procedures not elsewhere classified	Y	21	452, 453
V03.81	Prophylactic vaccination against Hemophilus influenza, type B [Hib]	N	23	467
V03.82	Prophylactic vaccination against Streptococcus pneumoniae	N	23	467
V03.89	Other specified prophylactic vaccination against single bacterial disease	N	23	467
V06.5	Prophylactic vaccination against Tetanus-diphtheria [Td]	N	23	467
V06.6	Prophylactic vaccination against Streptococcus pneumoniae and influenza	N	23	467
V07.31	Prophylactic fluoride administration	N	23	467
V07.39	Other prophylactic chemotherapy	N	23	467
V08	Asymptomatic human immunodeficiency virus [HIV] infection status	N	18	421, 422
V12.00	Personal history of other unspecified infectious and parasitic disease	N	23	467
V12.01	Personal history of tuberculosis	N	23	467
V12.02	Personal history of poliomyelitis	N	23	467
V12.03	Personal history of malaria	N	23	467
V12.09	Personal history of other specified infectious and parasitic disease	N	23	467
V12.70	Personal history of unspecified digestive disease	N	23	467
V12.71	Personal history of peptic ulcer disease	N	23	467
V12.72	Personal history of colonic polyps	N	23	467
V12.79	Personal history of other specified digestive system diseases	N	23	467
V13.00	Personal history of unspecified urinary disorder	N	23	467
V13.01	Personal history of urinary calculi	N	23	467
V13.09	Personal history of other specified urinary system disorders	N	23	467
V15.82	History of tobacco use	N	23	467
V29.2	Observation and evaluation of newborn for suspected respiratory condition	N	23	467
V43.60	Unspecified joint replacement status	N	08	256
V43.61	Shoulder joint replacement status	N	08	256
V43.62	Elbow joint replacement status	N	08	256
V43.63	Wrist joint replacement status	N	08	256
V43.64	Hip joint replacement status	N	08	256
V43.65	Knee joint replacement status	N	08	256
V43.66	Ankle joint replacement status	N	08	256
V43.69	Other joint replacement status	N	08	256
V45.00	Unspecified cardiac device in situ	N	23	467
V45.01	Cardiac pacemaker in situ	N	23	467
V45.02	Automatic implantable cardiac defibrillator in situ	N	23	467
V45.09	Other specified cardiac device in situ	N	23	467
V45.51	Presence of intrauterine contraceptive device	N	23	467
V45.52	Presence of subdermal contraceptive implant	N	23	467
V45.59	Presence of other contraceptive device	N	23	467
V45.82	Percutaneous transluminal coronary angioplasty status	N	23	467
V49.60	Unspecified level upper limb amputation status	N	23	467
V49.61	Thumb amputation status	N	23	467
V49.62	Other finger(s) amputation status	N	23	467
V49.63	Hand amputation status	N	23	467
V49.64	Wrist amputation status	N	23	467
V49.65	Below elbow amputation status	N	23	467
V49.66	Above elbow amputation status	N	23	467
V49.67	Shoulder amputation status	N	23	467
V49.70	Unspecified level lower limb amputation status	N	23	467
V49.71	Great toe amputation status	N	23	467
V49.72	Other toe(s) amputation status	N	23	467
V49.73	Foot amputation status	N	23	467
V49.74	Ankle amputation status	N	23	467
V49.75	Below knee amputation status	N	23	467
V49.76	Above knee amputation status	N	23	467
V49.77	Hip amputation status	N	23	467
V50.41	Prophylactic breast removal	N	09	276
V50.42	Prophylactic ovary removal	N	13	358, 359, 369
V50.49	Other prophylactic organ removal	N	23	467
V53.31	Fitting and adjustment of cardiac pacemaker	N	05	144, 145
V53.32	Fitting and adjustment of automatic implantable cardiac defibrillator	N	05	144, 145
V53.39	Fitting and adjustment of other cardiac device	N	05	144, 145
V57.21	Encounter for occupational therapy	N	23	462
V57.22	Encounter to vocational therapy	N	23	462
V58.41	Encounter for planned post-operative wound closure	N	23	465, 466
V58.49	Other specified aftercare following surgery	N	23	465, 466
V58.81	Encounter for removal of vascular catheter	N	23	465, 466
V58.89	Other specified aftercare	N	23	465, 466
V65.40	Other unspecified counseling	N	23	467
V65.41	Exercise counseling	N	23	467

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V65.42	Counseling on substance use and abuse	N	23	467
V65.43	Counseling on injury prevention	N	23	467
V65.44	Human immunodeficiency virus [HIV] counseling	N	23	467
V65.45	Counseling on other sexually transmitted diseases	N	23	467
V65.49	Other specified counseling	N	23	467
V69.0	Lack of physical exercise	N	23	467
V69.1	Inappropriate diet and eating habits	N	23	467
V69.2	High-risk sexual behavior	N	23	467
V69.3	Gambling and betting	N	23	467
V69.8	Other problems related to lifestyle	N	23	467
V69.9	Unspecified problem related to lifestyle	N	23	467

[1] Diagnosis code is classified as a "major problem" in these DRGs.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
34.05	Creation of pleuroperitoneal shunt	N		
41.04	Autologous hematopoietic stem cell transplant	N	Pre	481
99.28	Injection or infusion of biological response modifier [BRM] as an antineoplastic agent	N		

TABLE 6C.—INVALID DIAGNOSIS CODES [1]

Diagnosis code	Description	CC	MDC	DRG
042.0	Human immunodeficiency virus infection with specified infections	Y	25	489, 490
042.1	Human immunodeficiency virus infection causing other specified infections	Y	25	489, 490
042.2	Human immunodeficiency virus infection with specified malignant neoplasms	Y	25	489, 490
042.9	Human immunodeficiency virus infection with acquired immunodeficiency syndrome, unspecified	Y	25	489, 490
043.0	Human immunodeficiency virus infection causing lymphadenopathy	Y	25	489, 490
043.1	Human immunodeficiency virus infection causing specified diseases of the central nervous system	Y	25	489, 490
043.2	Human immunodeficiency virus infection causing other disorders involving the immune mechanism	Y	25	489, 490
043.3	Human immunodeficiency virus infection causing other specified conditions	Y	25	489, 490
043.9	Human immunodeficiency virus infection causing acquired immunodeficiency syndrome-related complex, unspecified	Y	25	489, 490
044.0	Other human immunodeficiency virus infection causing specified acute infections	Y	25	489, 490
044.9	Human immunodeficiency virus infection, unspecified	Y	25	489, 490
312.8	Other specified disturbances of conduct, not elsewhere classified	N	19	431
342.0	Flaccid hemiplegia	N	01	12
342.1	Spastic hemiplegia	N	01	12
342.9	Hemiplegia, unspecified	N	01	12
344.0	Quadriplegia, unspecified	Y	01	9
344.3	Monoplegia of lower limb	N	01	34, 35
344.4	Monoplegia of upper limb	N	01	34, 35
414.0	Coronary atherosclerosis	N	05	132, 133
441.0	Dissecting aortic aneurysm	Y	05	121, 144, 145
556	Idiopathic proctocolitis	N	06	179
593.7	Vesicoureteral reflux	N	11	331, 332, 333
702.1	Seborrheic keratosis	N	09	283, 284
709.0	Dyschromia	N	09	283, 284
787.0	Nausea and vomiting	N	06	182, 183, 184
789.0	Abdominal pain	N	06	182, 183, 184
789.3	Abdominal or pelvic swelling, mass, or lump	N	06	182, 183, 184
789.4	Abdominal rigidity	N	06	188, 189, 190
795.7	Other nonspecific immunological findings	N	16	398, 399
795.8	Positive serological or viral culture findings for human immunodeficiency virus (HIV)	N	18	421, 422
998.8	Other specified complications of procedures, not elsewhere classified	Y	21	452, 453
V03.8	Other specified vaccinations against single bacterial diseases	N	23	467
V07.3	Other prophylactic chemotherapy	N	23	467
V12.0	Personal history of infectious and parasitic diseases	N	23	467
V12.7	Personal history of diseases of the digestive system	N	23	467

TABLE 6C.—INVALID DIAGNOSIS CODES [1]—Continued

Diagnosis code	Description	CC	MDC	DRG
V13.0	Personal history of disorders of the urinary system	N	23	467
V43.6	Joint replacement status	N	08	256
V45.0	Cardiac pacemaker in situ	N	23	467
V45.5	Presence of intrauterine contraceptive device	N	23	467
V53.3	Fitting and adjustment of cardiac pacemaker	N	05	144, 145
V57.2	Occupational therapy and vocational rehabilitation	N	23	462
V58.4	Other aftercare following surgery	N	23	465, 466
V58.8	Other specified aftercare	N	23	465, 466
V65.4	Other counseling	N	23	467

[1] See Table 6a for new diagnosis codes that will be considered valid by the FY 1995 GROUPER.

TABLE 6D.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
070.20	Viral hepatitis B with hepatic coma, acute or unspecified, without mention of hepatitis delta	Y	07	205, 206
			15	387, 389 [1]
070.21	Viral hepatitis B with hepatic coma, acute or unspecified, with hepatitis delta	Y	07	205, 206
			15	387, 389 [1]
070.30	Viral hepatitis B without mention of hepatic coma, acute or unspecified, without mention of hepatitis delta	Y	07	205, 206
			15	387, 389 [1]
070.31	Viral hepatitis B without mention of hepatic coma, acute or unspecified, with hepatitis delta	Y	07	205, 206
			15	387, 389 [1]
070.41	Acute or unspecified hepatitis C with hepatic coma	Y	07	205, 206
			15	387, 389 [1]
070.42	Hepatitis delta without mention of active hepatitis B disease with hepatic coma	Y	07	205, 206
			15	387, 389 [1]
070.43	Hepatitis E with hepatic coma	Y	07	205, 206
			15	387, 389 [1]
070.49	Other specified viral hepatitis with hepatic coma	Y	07	205, 206
			15	387, 389 [1]
070.51	Acute or unspecified hepatitis C without mention of hepatic coma	Y	07	205, 206
			15	387 389 [1]
070.52	Hepatitis delta without mention of active hepatitis B disease or hepatic coma	Y	07	205, 206
			15	387, 389 [1]
070.53	Hepatitis E without mention of hepatic coma	Y	07	205, 206
			15	387, 389 [1]
070.59	Other specified viral hepatitis without mention of hepatic coma	Y	07	205, 206
			15	387, 389 [1]
440.20	Atherosclerosis of native arteries of extremities, unspecified	N	05	130, 131
440.21	Atherosclerosis of native arteries of extremities with intermittent claudication	N	05	130, 131
440.22	Atherosclerosis of native arteries of extremities with rest pain	N	05	130, 131
440.23	Atherosclerosis of native arteries of extremities with ulceration	N	05	130, 131
440.24	Atherosclerosos of native arteries of extremities with gangrene	Y	05	130, 131
440.29	Other atherosclerosos of native arteries of extremities	N	05	130, 131
770.1	Meconium aspiration syndrome	Y	15	387, 389 [1]

[1] Diagnosis code is classified as a "major problem" in these DRGs.

TABLE 6E.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
36.01	Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy without mention of thrombolytic agent	Y	05	106, 112
36.02	Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy with mention of thrombolytic agent	Y	05	106, 112
36.05	Multiple vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy performed during the same operation with or without mention of thrombolytic agent	Y	05	106, 112

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST
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CCs that are added to the list are in Table 6f—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.

*042	07052	*07041	07032	07054	*25072	34402	29583
042	07053	07022	07033	*07989	44100	34403	29584
*0700	07054	07023	07044	07022	44101	34404	29590
07022	07059	07032	07054	07023	44102	34409	29591
07023	0706	07033	*07054	07032	44103	44100	29592
07032	0709	07044	07020	07033	*25073	44101	29593
07033	78001	07054	07021	07044	44100	44102	29594
07044	78003	*07042	07022	07054	44101	44103	29604
07054	*07030	07022	07023	*07998	44102	*25092	29614
*0701	07022	07023	07030	07022	44103	34400	29634
07022	07023	07032	07031	07023	*25080	34401	29644
07023	07032	07033	07032	07032	34400	34402	29654
07032	07033	07044	07033	07033	34401	34403	29664
07033	07044	07054	07041	07044	34402	34404	2980
07044	07054	*07043	07042	07054	34403	34409	2983
07054	*07031	07022	07043	*07999	34404	44100	2984
*07020	07022	07023	07044	07022	34409	44101	29900
07022	07023	07032	07049	07023	44100	44102	29910
07023	07032	07033	07051	07032	44101	44103	29980
07032	07033	07044	07052	07033	44102	*25093	29990
07033	07044	07054	07053	07044	44103	34400	*31282
07044	07054	*07044	07054	07054	*25081	34401	29500
07054	*07032	07020	07059	*1398	34400	34402	29501
*07021	07020	07021	0706	042	34401	34403	29502
07022	07021	07022	0709	07022	34402	34404	29503
07023	07022	07023	78001	07023	34403	34409	29504
07032	07023	07030	78003	07032	34404	44100	29510
07033	07030	07031	*07059	07033	34409	44101	29511
07044	07031	07032	07022	07044	44100	44102	29512
07054	07032	07033	07023	07054	44101	44103	29513
*07022	07033	07041	07032	*25060	44102	*31281	29514
07020	07041	07042	07033	34400	44103	29500	29521
07021	07042	07043	07044	34401	*25082	29501	29522
07022	07043	07044	07054	34402	34400	29502	29523
07023	07044	07049	*0706	34403	34401	29503	29524
07030	07049	07051	07022	34404	34402	29504	29530
07031	07051	07052	07023	34409	34403	29510	29531
07032	07052	07053	07032	*25061	34404	29511	29532
07033	07053	07054	07033	34400	34409	29512	29533
07041	07054	07059	07044	34401	44100	29513	29534
07042	07059	0706	07054	34402	44101	29514	29540
07043	0706	0709	*0709	34403	44102	29521	29541
07044	0709	78001	07022	34404	44103	29522	29542
07049	78001	78003	07023	34409	*25083	29523	29543
07051	78003	*07049	07032	*25062	34400	29524	29544
07052	*07033	07022	07033	34400	34401	29530	29560
07053	07020	07023	07044	34401	34402	29531	29561
07054	07021	07032	07054	34402	34403	29532	29562
07059	07022	07033	*07888	34403	34404	29533	29563
0706	07023	07044	07022	34404	34409	29534	29564
0709	07030	07054	07023	34409	44100	29540	29570
78001	07031	*07051	07032	*25063	44101	29541	29571
78003	07032	07022	07033	34400	44102	29542	29572
*07023	07033	07023	07044	34401	44103	29543	29573
07020	07041	07032	07054	34402	*25090	29544	29574
07021	07042	07033	*07889	34403	34400	29560	29580
07022	07043	07044	07022	34404	34401	29561	29581
07023	07044	07054	07023	34409	34402	29562	29582
07030	07049	*07052	07032	*25070	34403	29563	29583
07031	07051	07022	07033	44100	34404	29564	29584
07032	07052	07023	07044	44101	34409	29570	29590
07033	07053	07032	07054	44102	44100	29571	29591
07041	07054	07033	*07988	44103	44101	29572	29592
07042	07059	07044	07022	*25071	44102	29573	29593
07043	0706	07054	07023	44100	44103	29574	29594
07044	0709	*07053	07032	44101	*25091	29580	29604
07049	78001	07022	07033	44102	34400	29581	29614
07051	78003	07023	07044	44103	34401	29582	29634

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TABLE 6G.—DELETIONS TO THE CC EXCLUSIONS LIST

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CCs that are deleted from the list are in Table 6G–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.

*0420	0433	0429	29540	3440	9582
0420	0439	0430	29541	*3443	9583
0421	0440	0431	29542	3432	9584
0422	0449	0432	29543	3440	9585
0429	*0432	0433	29544	*3444	9587
0430	0420	0439	29560	3432	9954
0431	0421	0440	29561	3440	99600
0432	0422	0449	29562	*3445	99601
0433	0429	*25060	29563	3440	99602
0439	0430	3440	29564	*34460	99603
0440	0431	*25061	29570	3440	99609
0449	0432	3440	29571	*34461	9961
*0421	0433	*25062	29572	3440	9962
0420	0439	3440	29573	*34481	99630
0421	0440	*25063	29574	3440	99639
0422	0449	3440	29580	*34489	9964
0429	*0433	*25070	29581	3440	99660
0430	0420	4410	29582	*3449	99661
0431	0421	*25071	29583	3440	99662
0432	0422	4410	29584	*3488	99663
0433	0429	*25072	29590	3440	99664
0439	0430	4410	29591	*3489	99665
0440	0431	*25073	29592	3440	99666
0449	0432	4410	29593	*34989	99667
*0422	0433	*25080	29594	3440	99669
0420	0439	3440	29604	*3499	99670
0421	0440	4410	29614	3440	99671
0422	0449	*25081	29634	*4410	99672
0429	*0439	3440	29644	4410	99673
0430	0420	4410	29654	4411	99674
0431	0421	*25082	29664	4413	99675
0432	0422	3440	2980	4415	99676
0433	0429	4410	2983	4416	99677
0439	0430	*25083	2984	*4411	99678
0440	0431	3440	29900	4410	99679
0449	0432	4410	29910	*4412	99690
*0429	0433	*25090	29980	4410	99691
0420	0439	3440	29990	*4413	99692
0421	0440	4410	*3420	4410	99693
0422	0449	*25091	3432	*4414	99694
0429	*0440	3440	3440	4410	99695
0430	0420	4410	*3421	*4415	99696
0431	0421	*25092	3432	4410	99699
0432	0422	3440	3440	*4416	9970
0433	0429	4410	7817	4410	9971
0439	0430	*25093	*3429	*4417	9972
0440	0431	3440	3432	4410	9973
0449	0432	4410	3440	*4419	9974
*0430	0433	*3128	*3430	4410	9975
0420	0439	29500	3440	*45989	99762
0421	0440	29501	*3431	4410	9979
0422	0449	29502	3440	*4599	9980
0429	*0449	29503	*3432	4410	9981
0430	0420	29504	3440	*74259	9982
0431	0421	29510	*3433	3440	9983
0432	0422	29511	3440	*7428	9984
0433	0429	29512	*3434	3440	9985
0439	0430	29513	3440	*7429	9986
0440	0431	29514	*3438	3440	9987
0449	0432	29521	3440	*7893	9988
*0431	0433	29522	*3439	7895	9989
0420	0439	29523	3440	*7894	*9989
0421	0440	29524	*3440	7895	9988
0422	0449	29530	3432	*9979	
0429	*1398	29531	3440	9988	
0430	0420	29532	*3441	*9988	
0431	0421	29533	3440	9580	
0432	0422	29534	*3442	9581	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
001	30373	13.5498	3	6	10	17	27
002	5861	13.9686	4	6	10	17	27
003	2	41.5000	17	17	66	66	66
004	5387	11.0787	2	4	7	14	23
005	64233	5.8124	2	3	4	7	11
006	517	3.2128	1	1	2	4	7
007	6847	17.1151	2	5	10	18	35
008	2226	4.5022	1	1	3	5	10
009	1605	9.2299	2	4	6	11	17
010	20587	9.6795	2	4	7	12	20
011	3219	5.5902	1	2	4	7	11
012	21670	9.2853	2	4	6	11	17
013	6125	7.5703	3	4	6	9	13
014	353384	8.9247	2	4	7	11	17
015	131428	5.0837	2	2	4	6	9
016	11066	8.2622	2	4	6	10	15
017	3630	4.7063	1	2	4	6	9
018	18584	7.2969	2	3	6	9	14
019	7122	4.8655	1	2	4	6	9
020	7553	11.7304	3	5	9	15	23
021	1026	8.7320	2	4	7	11	17
022	3809	5.5547	2	3	4	7	10
023	4708	5.8180	1	2	4	7	11
024	55140	6.8617	2	3	5	8	13
025	21162	4.2204	1	2	3	5	8
026	40	4.3750	1	1	2	4	9
027	2974	7.5790	1	1	4	9	17
028	8995	8.4404	2	3	6	10	18
029	3289	4.6722	1	2	3	6	9
031	3616	5.8462	1	2	4	7	12
032	2071	3.4843	1	1	2	4	7
034	14911	7.7272	2	3	5	9	15
035	3437	4.9674	1	2	4	6	9
036	16091	1.8704	1	1	1	2	3
037	2305	4.0638	1	1	3	5	8
038	477	2.7317	1	1	2	3	5
039	5224	2.0312	1	1	1	2	4
040	2126	3.6350	1	1	2	4	8
042	13425	2.3924	1	1	1	3	5
043	145	4.2552	1	2	3	5	8
044	1684	6.0653	2	3	5	8	11
045	2423	4.3120	1	2	4	6	8
046	2954	6.1852	1	3	5	8	12
047	1485	3.8774	1	2	3	5	8
049	2255	6.9929	2	3	5	8	13
050	4034	2.3406	1	1	2	3	4
051	409	3.0831	1	1	2	3	6
052	97	3.3402	1	1	2	4	7
053	4556	3.5435	1	1	2	4	8
054	1	1.0000	1	1	1	1	1
055	2531	3.0217	1	1	1	3	7
056	826	3.1695	1	1	2	4	7
057	617	5.3485	1	2	3	6	11
059	124	2.3468	1	1	1	2	4
060	2	2.5000	2	2	3	3	3
061	297	5.2256	1	1	2	7	12
063	4419	5.3220	1	2	3	6	10
064	3707	8.3663	1	2	5	10	18
065	34105	3.8732	1	2	3	5	7
066	7569	4.0285	1	2	3	5	7
067	458	4.7576	2	3	4	6	9
068	12495	5.4854	2	3	4	7	10
069	3688	4.2573	2	2	4	5	7
070	35	4.2571	1	2	4	5	8
071	138	4.2174	2	2	3	5	8
072	600	4.3200	1	2	3	5	8
073	6282	5.6492	1	2	4	7	11
075	36514	12.6075	5	7	9	15	24
076	38214	14.1313	3	6	11	17	27
077	2808	5.9822	1	2	4	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued
[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
078	26921	9.2896	4	6	8	11	15
079	174836	10.7988	3	5	8	13	20
080	8572	7.4425	3	4	6	9	13
081	10	7.0000	1	4	6	10	13
082	68268	8.9293	2	4	7	11	18
083	7079	7.4091	2	3	6	9	14
084	1576	4.3331	1	2	3	5	8
085	17127	8.2495	2	4	7	10	16
086	1510	4.9192	1	2	4	6	10
087	51460	7.5282	1	3	6	10	14
088	332295	7.0044	3	4	6	8	12
089	410720	8.0987	3	4	7	10	14
090	40769	5.7490	2	3	5	7	10
091	38	4.2105	2	3	4	4	7
092	10341	8.1339	3	4	6	10	15
093	1377	5.9092	2	3	5	7	11
094	9789	8.6530	3	4	7	11	17
095	1095	4.9726	2	3	4	6	9
096	78494	6.3363	2	4	5	8	11
097	28088	4.8754	2	3	4	6	8
098	29	4.1034	1	2	3	4	7
099	27359	4.2464	1	2	3	5	8
100	10912	2.8235	1	1	2	3	5
101	18549	6.3481	2	3	5	8	12
102	3083	4.0642	1	2	3	5	8
103	348	35.3218	9	14	22	43	77
104	20448	18.0558	8	11	15	22	31
105	17984	13.3331	7	8	10	15	23
106	85552	13.8702	7	9	12	16	22
107	56763	10.6400	6	7	9	12	17
108	6318	14.6399	5	8	12	18	27
110	55626	12.2737	3	7	10	15	23
111	5508	7.5882	3	6	7	9	11
112	165207	5.3375	1	2	4	7	11
113	41056	17.3678	5	8	13	21	35
114	8732	11.0470	3	5	8	14	22
115	9395	12.7986	5	7	11	16	23
116	73442	6.5117	2	3	5	8	13
117	3705	4.9970	1	2	3	6	10
118	7591	3.5381	1	1	2	4	8
119	2413	5.7791	1	1	3	7	14
120	36642	10.6624	1	3	6	14	24
121	159546	8.7209	3	5	7	11	15
122	94506	6.0345	2	3	6	8	10
123	53142	5.0944	1	1	3	6	12
124	133965	5.5625	1	2	4	7	11
125	68339	3.2111	1	1	2	4	7
126	4359	18.2292	5	8	14	25	38
127	679157	7.1974	2	4	6	9	14
128	22137	7.6946	4	5	7	9	12
129	5385	3.8375	1	1	1	4	10
130	78977	7.5326	2	4	6	9	13
131	24242	5.6644	1	3	5	7	9
132	16994	4.8000	1	2	4	6	9
133	3780	3.5124	1	2	3	4	6
134	30568	4.4913	1	2	3	5	8
135	6195	5.9711	2	3	4	7	11
136	1205	3.8556	1	2	3	5	7
138	196966	5.3070	2	2	4	6	10
139	67986	3.3770	1	2	3	4	6
140	318042	4.0906	1	2	3	5	7
141	76022	5.2772	2	2	4	6	10
142	35107	3.6827	1	2	3	4	7
143	133200	3.0817	1	2	2	4	6
144	60798	6.5142	1	3	5	8	13
145	7253	3.7740	1	2	3	5	7
146	8127	12.3116	6	8	10	14	20
147	1471	7.9844	4	6	8	9	11
148	145108	14.9089	7	8	12	17	27
149	14666	8.3034	5	6	8	9	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
150	22651	12.8981	5	7	11	15	23
151	4308	6.8271	2	4	6	9	12
152	4894	9.8733	4	6	8	11	16
153	1760	6.7545	3	5	6	8	10
154	36532	17.1556	6	9	13	21	33
155	3705	7.3665	3	4	7	9	12
156	4	11.5000	2	2	9	13	22
157	12499	6.3625	2	3	4	8	13
158	7092	3.0451	1	1	2	4	6
159	17371	5.7938	2	3	4	7	11
160	10912	3.1574	1	2	3	4	6
161	18202	4.8049	1	2	3	6	10
162	11663	2.2115	1	1	2	3	4
163	16	4.7500	2	2	3	6	8
164	4964	10.3342	5	6	9	12	17
165	1512	6.2890	3	4	6	8	10
166	3190	6.4994	2	3	5	8	12
167	2206	3.7040	2	2	3	5	6
168	1851	5.6018	1	2	3	7	12
169	1185	2.6962	1	1	2	3	6
170	12853	14.7068	3	6	10	18	30
171	1199	5.8507	1	3	5	8	11
172	30862	9.4698	2	4	7	12	19
173	2449	4.6991	1	2	3	6	9
174	225891	6.3539	2	3	5	8	12
175	25401	3.9307	2	2	3	5	7
176	14812	7.0485	2	3	5	8	13
177	12916	5.6722	2	3	5	7	10
178	4944	3.9606	2	2	3	5	7
179	9686	8.3931	3	4	6	10	16
180	77950	6.9772	2	3	5	8	13
181	20494	4.2234	1	2	4	5	7
182	231480	5.7533	2	3	4	7	11
183	71521	3.8393	1	2	3	5	7
184	67	3.8358	1	2	3	4	5
185	3615	5.9422	1	2	4	7	12
186	5	4.0000	1	1	3	6	8
187	860	3.8558	1	1	3	5	8
188	53223	6.9469	2	3	5	8	14
189	7789	3.7621	1	1	3	5	8
190	54	4.4074	1	2	3	4	6
191	10304	18.2203	6	8	14	22	35
192	820	8.8305	2	5	8	11	16
193	10321	15.8257	6	9	13	19	28
194	904	9.1040	3	5	8	11	16
195	12380	11.7961	5	7	10	14	20
196	1026	7.3899	4	5	7	9	12
197	33963	9.9541	4	6	8	12	17
198	10346	5.2905	2	3	5	7	9
199	2660	13.3534	4	6	10	17	26
200	1683	13.2133	2	5	10	17	28
201	1677	17.0030	4	7	12	22	35
202	20872	8.7625	2	4	7	11	17
203	29280	8.8699	2	4	7	11	18
204	44310	7.5089	2	4	6	9	14
205	21520	8.4757	2	4	6	10	17
206	1779	4.6549	1	2	4	6	9
207	36615	6.5464	2	3	5	8	12
208	11419	3.6754	1	2	3	5	7
209	303651	8.7652	5	6	8	10	13
210	129230	10.9177	5	6	9	12	18
211	25020	7.9683	4	5	7	9	12
212	10	3.8000	1	3	4	5	5
213	6329	11.6949	3	5	8	14	23
214	48908	8.3508	3	4	6	10	15
215	39409	4.7896	2	3	4	6	8
216	6597	13.2759	3	6	10	17	26
217	17833	18.9865	4	7	13	23	40
218	21393	7.6410	2	4	6	9	14
219	18645	4.4635	2	2	4	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	5	6.2000	2	2	6	7	10
221	4727	9.4007	2	4	7	11	19
222	3985	4.6979	1	2	4	6	9
223	18602	3.3396	1	2	2	4	6
224	8372	2.6646	1	1	2	3	5
225	7483	5.2232	1	2	3	6	12
226	5574	7.8281	2	3	5	9	17
227	5634	3.2157	1	1	2	4	6
228	3492	3.6904	1	1	2	4	8
229	1775	2.5228	1	1	2	3	5
230	2838	5.8439	1	2	3	7	12
231	10537	5.6445	1	2	3	7	13
232	775	5.9277	1	1	3	6	16
233	4860	10.7298	2	4	8	13	22
234	2420	4.8157	1	2	4	6	10
235	6120	8.9845	2	3	6	10	18
236	38386	7.8166	2	3	6	9	15
237	1605	5.3234	1	2	4	6	10
238	6734	12.7251	3	6	9	15	26
239	60904	9.1849	3	4	7	11	18
240	11208	8.9697	2	4	7	11	17
241	3260	5.2215	1	3	4	6	10
242	2281	9.4638	3	4	7	11	18
243	88697	6.5167	2	3	5	8	12
244	11351	6.8297	2	3	5	8	13
245	4564	4.9634	1	2	3	6	9
246	1431	4.8595	2	2	4	6	9
247	9989	4.6786	1	2	3	6	9
248	6510	6.0246	2	3	4	7	11
249	9415	5.2349	1	2	3	6	11
250	3290	6.1280	1	2	4	7	12
251	2507	3.5548	1	1	2	4	7
252	2	6.0000	2	2	10	10	10
253	17261	7.2853	2	3	5	8	14
254	10298	4.4081	1	2	3	5	8
255	1	10.0000	10	10	10	10	10
256	9475	4.7850	1	2	3	6	9
257	26630	4.2972	2	2	3	5	7
258	21946	3.1009	1	2	3	4	5
259	4351	4.3691	1	2	2	4	9
260	5570	2.2197	1	1	2	3	4
261	2585	2.5455	1	1	2	3	4
262	868	3.9124	1	1	2	5	8
263	30392	17.7629	5	7	12	21	36
264	3875	9.7752	3	4	7	12	20
265	4819	8.6777	1	3	6	10	18
266	3324	4.0884	1	1	3	5	8
267	232	4.1595	1	1	2	5	10
268	1219	4.2231	1	1	2	5	9
269	11374	11.0770	2	4	8	14	23
270	4423	3.6878	1	1	2	4	8
271	20737	10.3003	3	5	8	12	19
272	6755	8.3843	3	4	6	10	16
273	1752	6.0736	2	3	5	7	12
274	2582	9.1971	2	3	6	11	18
275	251	4.0956	1	1	2	5	9
276	859	5.7334	1	2	4	7	10
277	74776	7.8329	3	4	6	9	14
278	26182	5.7631	2	3	5	7	10
279	10	4.3000	1	3	4	6	7
280	13247	6.0380	1	3	4	7	11
281	6270	4.0675	1	2	3	5	8
282	1	1.0000	1	1	1	1	1
283	5385	6.5441	2	3	5	8	13
284	1955	4.4123	1	2	3	5	8
285	4930	17.6406	4	8	13	21	34
286	1891	9.7324	4	5	7	11	18
287	6466	16.6157	4	7	11	19	33
288	653	8.3629	3	4	6	8	15
289	4563	4.9001	1	2	3	4	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
290	9202	3.1564	1	2	2	3	5
291	111	1.9730	1	1	1	2	4
292	5170	15.1474	3	6	11	19	31
293	395	6.8557	1	2	5	9	14
294	80666	6.7243	2	3	5	8	12
295	3224	5.4100	2	2	4	6	10
296	227107	7.5655	2	3	5	9	15
297	40135	4.8183	2	2	4	6	9
298	81	4.2963	1	1	2	4	10
299	905	6.3901	1	2	4	8	13
300	12698	8.5099	2	4	6	10	16
301	1891	4.9804	1	2	4	6	10
302	6980	14.9606	7	9	12	18	26
303	18216	11.8073	5	7	9	14	21
304	13382	11.8629	3	5	9	14	23
305	2692	5.6118	2	3	5	7	10
306	11838	7.5201	2	3	5	10	15
307	3299	3.7014	1	2	3	4	6
308	9917	8.2603	2	3	6	10	17
309	3783	3.4335	1	2	3	4	7
310	32915	5.1680	1	2	3	6	10
311	14111	2.5038	1	1	2	3	5
312	2543	5.3917	1	2	4	7	11
313	1154	2.6023	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	29182	10.9542	1	3	7	14	24
316	57588	8.4956	2	3	6	11	17
317	690	4.3174	1	2	3	4	8
318	6220	8.2323	2	3	6	10	17
319	544	3.2831	1	1	2	4	7
320	168207	7.5966	3	4	6	9	14
321	26158	5.3687	2	3	4	6	9
322	72	4.5833	2	2	4	5	9
323	19232	4.0182	1	2	3	5	8
324	10858	2.3119	1	1	2	3	4
325	8572	5.3898	1	2	4	6	10
326	2823	3.4307	1	2	3	4	7
327	3	3.0000	1	1	4	4	4
328	1023	5.0205	1	2	4	6	10
329	197	2.6701	1	1	2	3	5
331	33508	7.1297	2	3	5	9	14
332	4698	4.1350	1	2	3	5	8
333	299	7.0368	1	3	5	10	15
334	28600	7.6310	4	5	7	8	11
335	12704	6.0778	4	5	6	7	9
336	81940	4.9549	2	3	4	6	9
337	58596	3.3036	2	2	3	4	5
338	8839	5.8370	1	2	4	7	13
339	3107	4.7023	1	2	3	5	10
340	3	2.3333	1	1	2	4	4
341	9209	4.0488	1	2	3	4	7
342	307	4.1564	1	1	2	5	10
344	6604	3.8139	1	1	3	4	7
345	1808	4.8623	1	2	3	6	10
346	6645	7.7943	2	3	5	9	16
347	554	3.7365	1	1	3	5	8
348	3661	5.1478	1	2	4	6	10
349	1010	3.3426	1	1	2	4	6
350	7431	5.5438	2	3	5	7	10
352	756	4.6019	1	2	3	6	9
353	2445	10.1877	4	5	8	12	19
354	9943	7.2639	3	4	6	8	12
355	5537	4.3150	3	3	4	5	6
356	34772	3.7010	2	2	3	4	6
357	6736	11.1651	4	6	9	13	21
358	26416	5.5984	3	4	4	6	9
359	26404	3.7891	2	3	4	4	5
360	9475	4.5882	2	3	3	5	8
361	511	5.0431	1	2	3	5	11
362	3	1.3333	1	1	1	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued
[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
363	5120	3.9785	1	2	3	4	7
364	2078	3.7671	1	1	2	5	8
365	2643	9.4813	2	3	6	12	20
366	4656	9.1016	2	3	6	11	19
367	625	3.3776	1	1	2	4	7
368	1750	7.3937	2	4	6	9	15
369	2330	4.0159	1	1	3	5	8
370	857	6.1680	3	3	4	6	10
371	864	3.9699	3	3	3	4	5
372	586	3.5256	1	2	3	4	6
373	3116	2.2073	1	1	2	2	3
374	120	3.2167	1	2	2	3	5
375	4	51.5000	2	2	3	11	190
376	173	3.3410	1	2	2	3	7
377	32	5.7813	1	1	3	10	13
378	137	3.0438	1	2	3	4	5
379	338	2.8639	1	1	2	3	6
380	67	2.1045	1	1	1	3	4
381	225	2.6578	1	1	1	3	5
382	48	1.4167	1	1	1	1	2
383	1178	4.1061	1	2	3	5	8
384	126	2.7619	1	1	2	3	5
385	2	2.5000	1	1	4	4	4
389	12	7.6667	1	2	7	10	15
390	11	4.8182	1	1	3	4	8
391	1	4.0000	4	4	4	4	4
392	2421	13.2978	5	6	10	16	26
393	1	3.0000	3	3	3	3	3
394	1845	9.3176	1	2	6	11	20
395	66925	6.0837	1	3	4	7	12
396	14	2.0714	1	1	1	4	5
397	13735	6.9771	2	3	5	9	14
398	16149	7.4775	3	4	6	9	14
399	1442	4.7961	1	2	4	6	9
400	8087	11.8312	2	4	8	15	26
401	6407	13.6969	3	5	10	17	29
402	1880	4.7899	1	2	3	6	10
403	31756	10.7486	2	4	8	14	22
404	4324	5.1859	1	2	4	7	10
406	3656	13.0126	3	6	9	16	26
407	816	5.3223	1	2	4	7	10
408	3620	8.5298	1	2	5	10	20
409	6885	7.9063	2	4	5	8	17
410	115896	3.4291	1	2	3	4	6
411	89	3.7079	1	1	3	4	6
412	87	3.2299	1	1	2	4	6
413	8628	9.9350	2	4	7	12	20
414	1111	5.4851	1	2	4	7	11
415	34634	18.7088	5	8	14	23	37
416	165302	9.5625	2	5	8	12	18
417	34	7.5294	2	3	5	7	17
418	15792	7.7252	3	4	6	9	14
419	16751	6.7324	2	3	5	8	12
420	3070	4.9896	2	3	4	6	9
421	13327	5.2403	2	3	4	6	10
422	92	4.3261	1	2	3	5	8
423	8045	10.0675	3	4	7	12	20
424	2342	23.0478	3	8	15	26	46
425	17532	5.9067	1	2	4	7	12
426	5260	6.6293	2	3	5	8	13
427	1916	6.4541	1	2	4	8	13
428	1022	9.3875	1	3	6	11	20
429	32989	10.9768	2	4	7	12	21
430	55906	11.5219	2	5	8	15	23
431	185	7.6595	2	3	5	9	17
432	473	7.4038	1	3	5	9	16
433	6970	4.1164	1	1	3	5	9
434	19096	6.8571	2	3	5	8	13
435	13108	5.5738	1	3	4	6	11
436	2435	17.0119	5	10	16	24	38

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 GROUPER V11.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
437	12492	13.5556	5	8	12	18	25
439	862	9.5186	1	3	6	12	21
440	4409	11.5321	2	4	7	14	25
441	660	3.8167	1	1	2	4	7
442	12872	9.6969	1	3	6	12	20
443	4362	3.3304	1	1	2	4	7
444	3259	6.5170	2	3	5	8	12
445	1547	4.1261	1	2	3	5	8
447	3349	3.1400	1	1	2	4	6
448	1	2.0000	2	2	2	2	2
449	28599	5.3042	1	2	4	6	11
450	6390	2.7858	1	1	2	3	5
451	6	2.0000	1	1	1	3	3
452	18951	5.8673	1	2	4	7	12
453	4193	3.4226	1	2	2	4	7
454	4519	6.5499	1	2	4	7	14
455	1093	3.6075	1	1	2	4	7
456	180	10.2056	1	2	5	12	25
457	126	5.6032	1	1	3	8	13
458	1603	19.8047	5	9	15	25	39
459	573	12.2792	3	5	9	15	27
460	2269	8.3486	2	3	6	10	16
461	4302	5.4547	1	1	2	4	14
462	10139	16.5278	6	8	14	21	30
463	9139	6.2674	2	3	5	7	12
464	2247	4.1081	1	2	3	5	8
465	313	3.1502	1	1	2	3	6
466	2816	5.3612	1	1	2	4	9
467	2945	5.0156	1	1	2	5	9
468	64052	17.6626	4	8	13	22	35
471	8311	11.2860	5	7	9	13	18
472	149	30.5101	2	8	21	39	63
473	8348	16.2351	2	4	9	25	39
475	80231	13.6842	2	6	11	18	27
476	8720	15.5812	5	9	13	19	27
477	35266	9.8103	1	3	7	12	20
478	111354	9.6146	2	4	7	12	20
479	16210	5.1031	1	2	4	7	10
480	269	33.8141	12	15	25	44	66
481	115	38.1304	21	26	35	43	58
482	7201	17.6463	6	8	13	20	34
483	35287	52.6801	17	27	42	64	97
484	296	20.1284	3	8	14	26	42
485	2791	14.4643	6	7	11	17	26
486	1960	16.8240	2	7	12	22	34
487	3242	10.1875	2	4	8	13	20
488	876	21.1039	6	9	15	25	39
489	9289	12.4757	3	5	8	15	25
490	3042	8.1190	2	3	5	9	16
491	8218	5.3304	2	3	4	6	9
492	1545	16.7851	3	5	8	27	
493	49835	6.2719	1	2	5	8	13
494	31647	2.3298	1	1	1	3	5
	10544650						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
001	30373	13.5498	3	6	10	17	27
002	5861	13.9686	4	6	10	17	27
003	2	41.5000	17	17	66	66	66
004	5387	11.0787	2	4	7	14	23
005	64233	5.8124	2	3	4	7	11
006	517	3.2128	1	1	2	4	7
007	6847	17.1151	2	5	10	18	35

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
008	2226	4.5022	1	1	3	5	10
009	1605	9.2299	2	4	6	11	17
010	20587	9.6795	2	4	7	12	20
011	3219	5.5902	1	2	4	7	11
012	21670	9.2853	2	4	6	11	17
013	6125	7.5703	3	4	6	9	13
014	353384	8.9247	2	4	7	11	17
015	131428	5.0837	2	2	4	6	9
016	11066	8.2622	2	4	6	10	15
017	3630	4.7063	1	2	4	6	9
018	18584	7.2969	2	3	6	9	14
019	7122	4.8655	1	2	4	6	9
020	7553	11.7304	3	5	9	15	23
021	1026	8.7320	2	4	7	11	17
022	3809	5.5547	2	3	4	7	10
023	4708	5.8180	1	2	4	7	11
024	55140	6.8617	2	3	5	8	13
025	21162	4.2204	1	2	3	5	8
026	40	4.3750	1	1	2	4	9
027	2974	7.5790	1	1	4	9	17
028	8995	8.4404	2	3	6	10	18
029	3289	4.6722	1	2	3	6	9
031	3616	5.8462	1	2	4	7	12
032	2071	3.4843	1	1	2	4	7
034	14911	7.7272	2	3	5	9	15
035	3437	4.9674	1	2	4	6	9
036	16091	1.8704	1	1	1	2	3
037	2305	4.0638	1	1	3	5	8
038	477	2.7317	1	1	2	3	5
039	5224	2.0312	1	1	1	2	4
040	2126	3.6350	1	1	2	4	8
042	13425	2.3924	1	1	1	3	5
043	145	4.2552	1	2	3	5	8
044	1684	6.0653	2	3	5	8	11
045	2423	4.3120	1	2	4	6	8
046	2944	6.1695	1	3	5	7	12
047	1480	3.8770	1	2	3	5	8
049	2255	6.9929	2	3	5	8	13
050	4034	2.3406	1	1	2	3	4
051	409	3.0831	1	1	2	3	6
052	97	3.3402	1	1	2	4	7
053	4556	3.5435	1	1	2	4	8
054	1	1.0000	1	1	1	1	1
055	2531	3.0217	1	1	1	3	7
056	826	3.1695	1	1	2	4	7
057	617	5.3485	1	2	3	6	11
059	124	2.3468	1	1	1	2	4
060	2	2.5000	2	2	3	3	3
061	297	5.2256	1	1	2	7	12
063	4419	5.3220	1	2	3	6	10
064	3707	8.3663	1	2	5	10	18
065	34105	3.8732	1	2	3	5	7
066	7569	4.0285	1	2	3	5	7
067	458	4.7576	2	3	4	6	9
068	12495	5.4854	2	3	4	7	10
069	3688	4.2573	2	2	4	5	7
070	35	4.2571	1	2	4	5	8
071	138	4.2174	2	2	3	5	8
072	600	4.3200	1	2	3	5	8
073	6282	5.6492	1	2	4	7	11
075	36514	12.6075	5	7	9	15	24
076	38214	14.1313	3	6	11	17	27
077	2808	5.9822	1	2	4	8	13
078	26921	9.2896	4	6	8	11	15
079	174836	10.7988	3	5	8	13	20
080	8572	7.4425	3	4	6	9	13
081	10	7.0000	1	4	6	10	13
082	68268	8.9293	2	4	7	11	18
083	7079	7.4091	2	3	6	9	14
084	1576	4.3331	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
085	17127	8.2495	2	4	7	10	16
086	1510	4.9192	1	2	4	6	10
087	51460	7.5282	1	3	6	10	14
088	332295	7.0044	3	4	6	8	12
089	410720	8.0987	3	4	7	10	14
090	40769	5.7490	2	3	5	7	10
091	38	4.2105	2	3	4	4	7
092	10341	8.1339	3	4	6	10	15
093	1377	5.9092	2	3	5	7	11
094	9789	8.6530	3	4	7	11	17
095	1095	4.9726	2	3	4	6	9
096	78494	6.3363	2	4	5	8	11
097	28088	4.8754	2	3	4	6	8
098	29	4.1034	1	2	3	4	7
099	27359	4.2464	1	2	3	5	8
100	10912	2.8235	1	1	2	3	5
101	18549	6.3481	2	3	5	8	12
102	3083	4.0642	1	2	3	5	8
103	348	35.3218	9	14	22	43	77
104	20448	18.0558	8	11	15	22	31
105	17984	13.3331	7	8	10	15	23
106	85552	13.8702	7	9	12	16	22
107	56763	10.6400	6	7	9	12	17
108	6318	14.6399	5	8	12	18	27
110	55626	12.2737	3	7	10	15	23
111	5508	7.5882	3	6	7	9	11
112	165207	5.3375	1	2	4	7	11
113	41056	17.3678	5	8	13	21	35
114	8732	11.0470	3	5	8	14	22
115	9395	12.7986	5	7	11	16	23
116	73442	6.5117	2	3	5	8	13
117	3705	4.9970	1	2	3	6	10
118	7591	3.5381	1	1	2	4	8
119	2413	5.7791	1	1	3	7	14
120	39194	10.8284	1	3	7	14	24
121	159547	8.7209	3	5	7	11	15
122	94506	6.0345	2	3	6	8	10
123	53142	5.0944	1	1	3	6	12
124	133965	5.5625	1	2	4	7	11
125	68339	3.2111	1	1	2	4	7
126	4359	18.2292	5	8	14	25	38
127	679158	7.1974	2	4	6	9	14
128	22137	7.6946	4	5	7	9	12
129	5385	3.8375	1	1	1	4	10
130	78977	7.5326	2	4	6	9	13
131	24242	5.6644	1	3	5	7	9
132	16994	4.8000	1	2	4	6	9
133	3780	3.5124	1	2	3	4	6
134	30568	4.4913	1	2	3	5	8
135	6195	5.9711	2	3	4	7	11
136	1205	3.8556	1	2	3	5	7
138	196966	5.3070	2	2	4	6	10
139	67986	3.3770	1	2	3	4	6
140	318042	4.0906	1	2	3	5	7
141	76022	5.2772	2	2	4	6	10
142	35107	3.6827	1	2	3	4	7
143	133200	3.0817	1	2	2	4	6
144	60798	6.5142	1	3	5	8	13
145	7253	3.7740	1	2	3	5	7
146	8127	12.3116	6	8	10	14	20
147	1471	7.9844	4	6	8	9	11
148	145108	14.9089	7	8	12	17	27
149	14666	8.3034	5	6	8	9	12
150	22651	12.8981	5	7	11	15	23
151	4308	6.8271	2	4	6	9	12
152	4894	9.8733	4	6	8	11	16
153	1760	6.7545	3	5	6	8	10
154	36532	17.1556	6	9	13	21	33
155	3705	7.3665	3	4	7	9	12
156	4	11.5000	2	2	9	13	22

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
157	12499	6.3625	2	3	4	8	13
158	7092	3.0451	1	1	2	4	6
159	17371	5.7938	2	3	4	7	11
160	10912	3.1574	1	2	3	4	6
161	18202	4.8049	1	2	3	6	10
162	11663	2.2115	1	1	2	3	4
163	16	4.7500	2	2	3	6	8
164	4964	10.3342	5	6	9	12	17
165	1512	6.2890	3	4	6	8	10
166	3190	6.4994	2	3	5	8	12
167	2206	3.7040	2	2	3	5	6
168	1851	5.6018	1	2	3	7	12
169	1185	2.6962	1	1	2	3	6
170	12853	14.7068	3	6	10	18	30
171	1199	5.8507	1	3	5	8	11
172	30862	9.4698	2	4	7	12	19
173	2449	4.6991	1	2	3	6	9
174	225891	6.3539	2	3	5	8	12
175	25401	3.9307	2	2	3	5	7
176	14812	7.0485	2	3	5	8	13
177	12916	5.6722	2	3	5	7	10
178	4944	3.9606	2	2	3	5	7
179	9686	8.3931	3	4	6	10	16
180	77950	6.9772	2	3	5	8	13
181	20494	4.2234	1	2	4	5	7
182	231480	5.7533	2	3	4	7	11
183	71521	3.8393	1	2	3	5	7
184	67	3.8358	1	2	3	4	5
185	3615	5.9422	1	2	4	7	12
186	5	4.0000	1	1	3	6	8
187	860	3.8558	1	1	3	5	8
188	53223	6.9469	2	3	5	8	14
189	7789	3.7621	1	1	3	5	8
190	54	4.4074	1	2	3	4	6
191	10304	18.2203	6	8	14	22	35
192	820	8.8305	2	5	8	11	16
193	10321	15.8257	6	9	13	19	28
194	904	9.1040	3	5	8	11	16
195	12380	11.7961	5	7	10	14	20
196	1026	7.3899	4	5	7	9	12
197	33963	9.9541	4	6	8	12	17
198	10346	5.2905	2	3	5	7	9
199	2660	13.3534	4	6	10	17	26
200	1683	13.2133	2	5	10	17	28
201	1677	17.0030	4	7	12	22	35
202	20872	8.7625	2	4	7	11	17
203	29280	8.8699	2	4	7	11	18
204	44310	7.5089	2	4	6	9	14
205	21520	8.4757	2	4	6	10	17
206	1779	4.6549	1	2	4	6	9
207	36615	6.5464	2	3	5	8	12
208	11419	3.6754	1	2	3	5	7
209	303651	8.7652	5	6	8	10	13
210	129230	10.9177	5	6	9	12	18
211	25020	7.9683	4	5	7	9	12
212	10	3.8000	1	3	4	5	5
213	6329	11.6949	3	5	8	14	23
214	48908	8.3508	3	4	6	10	15
215	39409	4.7896	2	3	4	6	8
216	6597	13.2759	3	6	10	17	26
217	17833	18.9865	4	7	13	23	40
218	21393	7.6410	2	4	6	9	14
219	18645	4.4635	2	2	4	5	8
220	5	6.2000	2	2	6	7	10
221	4727	9.4007	2	4	7	11	19
222	3985	4.6979	1	2	4	6	9
223	18602	3.3396	1	2	2	4	6
224	8372	2.6646	1	1	2	3	5
225	7483	5.2232	1	2	3	6	12
226	5574	7.8281	2	3	5	9	17

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
227	5634	3.2157	1	1	2	4	6
228	3492	3.6904	1	1	2	4	8
229	1775	2.5228	1	1	2	3	5
230	2838	5.8439	1	2	3	7	12
231	10537	5.6445	1	2	3	7	13
232	775	5.9277	1	1	3	6	16
233	4860	10.7298	2	4	8	13	22
234	2420	4.8157	1	2	4	6	10
235	6120	8.9845	2	3	6	10	18
236	38386	7.8166	2	3	6	9	15
237	1605	5.3234	1	2	4	6	10
238	6734	12.7251	3	6	9	15	26
239	60904	9.1849	3	4	7	11	18
240	11208	8.9697	2	4	7	11	17
241	3260	5.2215	1	3	4	6	10
242	2281	9.4638	3	4	7	11	18
243	88697	6.5167	2	3	5	8	12
244	11351	6.8297	2	3	5	8	13
245	4564	4.9634	1	2	3	6	9
246	1431	4.8595	2	2	4	6	9
247	9989	4.6786	1	2	3	6	9
248	6510	6.0246	2	3	4	7	11
249	9415	5.2349	1	2	3	6	11
250	3290	6.1280	1	2	4	7	12
251	2507	3.5548	1	1	2	4	7
252	2	6.0000	2	2	10	10	10
253	17261	7.2853	2	3	5	8	14
254	10298	4.4081	1	2	3	5	8
255	1	10.0000	10	10	10	10	10
256	9475	4.7850	1	2	3	6	9
257	26630	4.2972	2	2	3	5	7
258	21946	3.1009	1	2	3	4	5
259	4351	4.3691	1	2	2	4	9
260	5570	2.2197	1	1	2	3	4
261	2585	2.5455	1	1	2	3	4
262	868	3.9124	1	1	2	5	8
263	30392	17.7629	5	7	12	21	36
264	3875	9.7752	3	4	7	12	20
265	4819	8.6777	1	3	6	10	18
266	3324	4.0884	1	1	3	5	8
267	232	4.1595	1	1	2	5	10
268	1219	4.2231	1	1	2	5	9
269	11374	11.0770	2	4	8	14	23
270	4423	3.6878	1	1	2	4	8
271	20737	10.3003	3	5	8	12	19
272	6755	8.3843	3	4	6	10	16
273	1752	6.0736	2	3	5	7	12
274	2582	9.1971	2	3	6	11	18
275	251	4.0956	1	1	2	5	9
276	859	5.7334	1	2	4	7	10
277	74776	7.8329	3	4	6	9	14
278	26182	5.7631	2	3	5	7	10
279	10	4.3000	1	3	4	6	7
280	13247	6.0380	1	3	4	7	11
281	6270	4.0675	1	2	3	5	8
282	1	1.0000	1	1	1	1	1
283	5395	6.5520	2	3	5	8	13
284	1960	4.4112	1	2	3	5	8
285	4930	17.6406	4	8	13	21	34
286	1891	9.7324	4	5	7	11	18
287	6466	16.6157	4	7	11	19	33
288	653	8.3629	3	4	6	8	15
289	4563	4.9001	1	2	3	4	10
290	9202	3.1564	1	2	2	3	5
291	111	1.9730	1	1	1	2	4
292	5170	15.1474	3	6	11	19	31
293	395	6.8557	1	2	5	9	14
294	80666	6.7243	2	3	5	8	12
295	3224	5.4100	2	2	4	6	10
296	227107	7.5655	2	3	5	9	15

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
297	40135	4.8183	2	2	4	6	9
298	81	4.2963	1	1	2	4	10
299	905	6.3901	1	2	4	8	13
300	12698	8.5099	2	4	6	10	16
301	1891	4.9804	1	2	4	6	10
302	6980	14.9606	7	9	12	18	26
303	18216	11.8073	5	7	9	14	21
304	13382	11.8629	3	5	9	14	23
305	2692	5.6118	2	3	5	7	10
306	11838	7.5201	2	3	5	10	15
307	3299	3.7014	1	2	3	4	6
308	9917	8.2603	2	3	6	10	17
309	3783	3.4335	1	2	3	4	7
310	32915	5.1680	1	2	3	6	10
311	14111	2.5038	1	1	2	3	5
312	2543	5.3917	1	2	4	7	11
313	1154	2.6023	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	29182	10.9542	1	3	7	14	24
316	57588	8.4956	2	3	6	11	17
317	690	4.3174	1	2	3	4	8
318	6220	8.2323	2	3	6	10	17
319	544	3.2831	1	1	2	4	7
320	168207	7.5966	3	4	6	9	14
321	26158	5.3687	2	3	4	6	9
322	72	4.5833	2	2	4	5	9
323	19232	4.0182	1	2	3	5	8
324	10858	2.3119	1	1	2	3	4
325	8572	5.3898	1	2	4	6	10
326	2823	3.4307	1	2	3	4	7
327	3	3.0000	1	1	4	4	4
328	1023	5.0205	1	2	4	6	10
329	197	2.6701	1	1	2	3	5
331	33508	7.1297	2	3	5	9	14
332	4698	4.1350	1	2	3	5	8
333	299	7.0368	1	3	5	10	15
334	28600	7.6310	4	5	7	8	11
335	12704	6.0778	4	5	6	7	9
336	81940	4.9549	2	3	4	6	9
337	58596	3.3036	2	2	3	4	5
338	8839	5.8370	1	2	4	7	13
339	3107	4.7023	1	2	3	5	10
340	3	2.3333	1	1	2	4	4
341	9209	4.0488	1	2	3	4	7
342	307	4.1564	1	1	2	5	10
344	6604	3.8139	1	1	3	4	7
345	1808	4.8623	1	2	3	6	10
346	6645	7.7943	2	3	5	9	16
347	554	3.7365	1	1	3	5	8
348	3661	5.1478	1	2	4	6	10
349	1010	3.3426	1	1	2	4	6
350	7431	5.5438	2	3	5	7	10
352	756	4.6019	1	2	3	6	9
353	2445	10.1877	4	5	8	12	19
354	9943	7.2639	3	4	6	8	12
355	5537	4.3150	3	3	4	5	6
356	34772	3.7010	2	2	3	4	6
357	6736	11.1651	4	6	9	13	21
358	26416	5.5984	3	4	4	6	9
359	26404	3.7891	2	3	4	4	5
360	9475	4.5882	2	3	3	5	8
361	511	5.0431	1	2	3	5	11
362	3	1.3333	1	1	1	2	2
363	5120	3.9785	1	2	3	4	7
364	2078	3.7671	1	1	2	5	8
365	2643	9.4813	2	3	6	12	20
366	4656	9.1016	2	3	6	11	19
367	625	3.3776	1	1	2	4	7
368	1750	7.3937	2	4	6	9	15
369	2330	4.0159	1	1	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
370	857	6.1680	3	3	4	6	10
371	864	3.9699	3	3	3	4	5
372	586	3.5256	1	2	3	4	6
373	3116	2.2073	1	1	2	2	3
374	120	3.2167	1	2	2	3	5
375	4	51.5000	2	2	3	11	190
376	173	3.3410	1	2	2	3	7
377	32	5.7813	1	1	3	10	13
378	137	3.0438	1	2	3	4	5
379	338	2.8639	1	1	2	3	6
380	67	2.1045	1	1	1	3	4
381	225	2.6578	1	1	1	3	5
382	48	1.4167	1	1	1	1	2
383	1178	4.1061	1	2	3	5	8
384	126	2.7619	1	1	2	3	5
385	2	2.5000	1	1	4	4	4
389	12	7.6667	1	2	7	10	15
390	11	4.8182	1	1	3	4	8
391	1	4.0000	4	4	4	4	4
392	2421	13.2978	5	6	10	16	26
393	1	3.0000	3	3	3	3	3
394	1845	9.3176	1	2	6	11	20
395	66925	6.0837	1	3	4	7	12
396	14	2.0714	1	1	1	4	5
397	13735	6.9771	2	3	5	9	14
398	16149	7.4775	3	4	6	9	14
399	1442	4.7961	1	2	4	6	9
400	8087	11.8312	2	4	8	15	26
401	6407	13.6969	3	5	10	17	29
402	1880	4.7899	1	2	3	6	10
403	31756	10.7486	2	4	8	14	22
404	4324	5.1859	1	2	4	7	10
406	3656	13.0126	3	6	9	16	26
407	816	5.3223	1	2	4	7	10
408	3620	8.5298	1	2	5	10	20
409	6885	7.9063	2	4	5	8	17
410	115896	3.4291	1	2	3	4	6
411	89	3.7079	1	1	3	4	6
412	87	3.2299	1	1	2	4	6
413	8628	9.9350	2	4	7	12	20
414	1111	5.4851	1	2	4	7	11
415	34634	18.7088	5	8	14	23	37
416	165302	9.5625	2	5	8	12	18
417	34	7.5294	2	3	5	7	17
418	15792	7.7252	3	4	6	9	14
419	16751	6.7324	2	3	5	8	12
420	3070	4.9896	2	3	4	6	9
421	13327	5.2403	2	3	4	6	10
422	92	4.3261	1	2	3	5	8
423	8045	10.0675	3	4	7	12	20
424	2342	23.0478	3	8	15	26	46
425	17532	5.9067	1	2	4	7	12
426	5260	6.6293	2	3	5	8	13
427	1916	6.4541	1	2	4	8	13
428	1022	9.3875	1	3	6	11	20
429	32989	10.9768	2	4	7	12	21
430	55906	11.5219	2	5	8	15	23
431	185	7.6595	2	3	5	9	17
432	473	7.4038	1	3	5	9	16
433	6970	4.1164	1	1	3	5	9
434	19096	6.8571	2	3	5	8	13
435	13108	5.5738	1	3	4	6	11
436	2435	17.0119	5	10	16	24	28
437	12492	13.5556	5	8	12	18	25
439	862	9.5186	1	3	6	12	21
440	4409	11.5321	2	4	7	14	25
441	660	3.8167	1	1	2	4	7
442	12872	9.6969	1	3	6	12	20
443	4362	3.3304	1	1	2	4	7
444	3259	6.5170	2	3	5	8	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY93 Medpar Update 12/93 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
445	1547	4.1261	1	2	3	5	8
447	3349	3.1400	1	1	2	4	6
448	1	2.0000	2	2	2	2	2
449	28599	5.3042	1	2	4	6	11
450	6390	2.7858	1	1	2	3	5
451	6	2.0000	1	1	1	3	3
452	18951	5.8673	1	2	4	7	12
453	4193	3.4226	1	2	2	4	7
454	4519	6.5499	1	2	4	7	14
455	1093	3.6075	1	1	2	4	7
456	180	10.2056	1	2	5	12	25
457	126	5.6032	1	1	3	8	13
458	1603	19.8047	5	9	15	25	39
459	573	12.2792	3	5	9	15	27
460	2269	8.3486	2	3	6	10	16
461	4302	5.4547	1	1	2	4	14
462	10139	16.5278	6	8	14	21	30
463	9139	6.2674	2	3	5	7	12
464	2247	4.1081	1	2	3	5	8
465	313	3.1502	1	1	2	3	6
466	2816	5.3612	1	1	2	4	9
467	2945	5.0156	1	1	2	5	9
468	61688	17.8246	4	8	14	22	35
471	8311	11.2860	5	7	9	13	18
472	149	30.5101	2	8	21	39	63
473	8348	16.2351	2	4	9	25	39
475	80231	13.6842	2	6	11	18	27
476	8720	15.5812	5	9	13	19	27
477	35078	9.8071	1	3	7	12	20
478	111354	9.6146	2	4	7	12	20
479	16210	5.1031	1	2	4	7	10
480	269	33.8141	12	15	25	44	66
481	115	38.1304	21	26	35	43	58
482	7201	17.6463	6	8	13	20	34
483	35287	52.6801	17	27	42	64	97
484	296	20.1284	3	8	14	26	42
485	2791	14.4643	6	7	11	17	26
486	1960	16.8240	2	7	12	22	34
487	3242	10.1875	2	4	8	13	20
488	876	21.1039	6	9	15	25	39
489	9289	12.4757	3	5	8	15	25
490	3042	8.1190	2	3	5	9	16
491	8218	5.3304	2	3	4	6	9
492	1545	16.7851	3	5	8	27	37
493	49835	6.2719	1	2	5	8	13
494	31647	2.3298	1	1	1	3	5
	10544652						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1994

State	Urban	Rural
ALABAMA	0.447	0.518
ALASKA	0.515	0.801
ARIZONA	0.484	0.637
ARKANSAS	0.585	0.516
CALIFORNIA	0.458	0.566
COLORADO	0.549	0.619
CONNECTICUT	0.574	0.596
DELAWARE	0.603	0.527
DISTRICT OF COLUMBIA	0.533	
FLORIDA	0.462	0.464
GEORGIA	0.555	0.553
HAWAII	0.547	0.632

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1994—Continued

State	Urban	Rural
IDAHO	0.599	0.667
ILLINOIS	0.537	0.613
INDIANA	0.615	0.677
IOWA	0.573	0.741
KANSAS	0.549	0.702
KENTUCKY	0.541	0.573
LOUISIANA	0.506	0.561
MAINE	0.688	0.605
MARYLAND	0.764	0.807
MASSACHUSETTS	0.702	0.602
MICHIGAN	0.546	0.668

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1994—Continued

State	Urban	Rural
MINNESOTA	0.597	0.686
MISSISSIPPI	0.578	0.547
MISSOURI	0.498	0.555
MONTANA	0.553	0.659
NEBRASKA	0.559	0.711
NEVADA	0.423	0.521
NEW HAMPSHIRE	0.610	0.644
NEW JERSEY	0.691	
NEW MEXICO	0.549	0.556
NEW YORK	0.635	0.730
NORTH CAROLINA	0.579	0.536

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1994—Continued

State	Urban	Rural
NORTH DAKOTA	0.660	0.693
OHIO	0.616	0.656
OKLAHOMA	0.529	0.583
OREGON	0.601	0.663
PENNSYLVANIA	0.469	0.598
PUERTO RICO	0.554	0.876
RHODE ISLAND	0.606	
SOUTH CAROLINA	0.537	0.537
SOUTH DAKOTA	0.569	0.653
TENNESSEE	0.545	0.568
TEXAS	0.509	0.609
UTAH	0.596	0.655
VERMONT	0.619	0.616
VIRGINIA	0.553	0.575
WASHINGTON	0.663	0.759
WEST VIRGINIA	0.585	0.528
WISCONSIN	0.655	0.705
WYOMING	0.616	0.760

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1994

State	Ratio
ALABAMA	0.059
ALASKA	0.093
ARIZONA	0.063
ARKANSAS	0.050
CALIFORNIA	0.045
COLORADO	0.055
CONNECTICUT	0.046
DELAWARE	0.055
DISTRICT OF COLUMBIA	0.043
FLORIDA	0.059
GEORGIA	0.050
HAWAII	0.056
IDAHO	0.074
ILLINOIS	0.049
INDIANA	0.065
IOWA	0.060
KANSAS	0.067
KENTUCKY	0.055
LOUISIANA	0.076
MAINE	0.043
MASSACHUSETTS	0.065
MICHIGAN	0.060
MINNESOTA	0.056
MISSISSIPPI	0.057
MISSOURI	0.058
MONTANA	0.073
NEBRASKA	0.060
NEVADA	0.036
NEW HAMPSHIRE	0.064
NEW JERSEY	0.058
NEW MEXICO	0.062
NEW YORK	0.062
NORTH CAROLINA	0.050
NORTH DAKOTA	0.073
OHIO	0.063
OKLAHOMA	0.062
OREGON	0.054
PENNSYLVANIA	0.050
PUERTO RICO	0.090
RHODE ISLAND	0.027
SOUTH CAROLINA	0.068

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1994—Continued

State	Ratio
SOUTH DAKOTA	0.068
TENNESSEE	0.061
TEXAS	0.065
UTAH	0.052
VERMONT	0.052
VIRGINIA	0.064
WASHINGTON	0.072
WEST VIRGINIA	0.058
WISCONSIN	0.048
WYOMING	0.075

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
010006	07/01/92	06/30/93	1.3887	0.9953
010011	07/01/92	06/30/93	1.4491	0.9986
010012	07/01/92	06/30/93	1.3102	0.9590
010015	04/01/92	04/01/93	1.0044	0.9386
010018	07/01/92	06/30/93	0.6498	0.9956
010022	07/01/92	06/30/93	0.9653	0.9655
010023	07/01/92	06/30/93	1.3674	0.9923
010024	07/01/92	06/30/93	1.3014	0.9908
010025	07/01/92	06/30/93	1.2180	0.9727
010031	07/01/92	06/30/93	1.2311	0.9952
010034	07/01/92	06/30/93	1.0516	0.9721
010036	04/01/92	03/31/93	1.1597	0.9715
010038	07/01/92	06/30/93	1.2305	0.9861
010039	07/01/92	06/30/93	1.6295	0.9982
010050	07/01/92	06/30/93	0.9415	0.9667
010054	07/01/92	06/30/93	1.2386	0.9738
010055	06/01/92	06/30/93	1.3649	0.9986
010056	07/01/92	06/30/93	1.3739	0.9986
010058	07/01/92	06/30/93	1.0171	0.9494
010064	07/01/92	06/30/93	1.7873	0.9987
010066	07/01/92	06/30/93	0.9014	0.9384
010068	07/01/92	06/30/93	1.2743	0.9755
010072	07/01/92	06/30/93	1.1717	0.9653
010078	07/01/92	06/30/93	1.2109	0.9900
010080	04/01/92	03/31/93	1.0051	0.9715
010085	07/01/92	06/30/93	1.2290	0.9756
010086	07/01/92	06/30/93	1.0039	0.9665
010089	07/01/92	06/30/93	1.1344	0.9836
010090	07/01/92	06/30/93	1.5855	0.9987
010091	07/01/92	06/30/93	0.9824	0.9367
010098	07/01/92	06/30/93	0.9434	0.9763
010101	07/01/92	06/30/93	1.0809	0.9737
010103	07/01/92	06/30/93	1.6520	0.9994
010104	07/01/92	06/30/93	1.5769	0.9988
010113	04/01/92	03/31/93	1.6265	0.9990
010114	07/01/92	06/30/93	1.2621	0.9827
010118	07/01/92	06/30/93	1.2150	0.9772
010121	07/01/92	06/30/93	1.1506	0.9790
010128	07/01/92	06/30/93	0.9296	0.9451
010131	07/01/92	06/30/93	1.2393	0.9827
010134	04/01/92	03/31/93	0.8266	0.9450
010136	05/01/92	04/30/93	0.9613	1.0000
010138	07/01/92	06/30/93	0.9694	0.9343
010148	07/01/92	06/30/93	0.9598	0.9457
010150	04/01/92	03/31/93	1.0504	0.9834
020002	06/30/92	06/30/93	0.9910	0.9426
020004	06/30/92	06/30/93	1.0881	0.9726
020007	06/30/92	06/30/93	0.9008	0.8928
020008	06/30/92	06/30/93	1.0836	0.9619
020009	06/30/92	06/30/93	1.0013	0.9389
020010	06/30/92	06/30/93	1.0549	1.0000
020011	06/30/92	06/30/93	1.0259	0.8910
020013	06/30/92	06/30/93	1.0187	0.9821
020014	06/30/92	06/30/93	1.0401	0.9811
020024	06/30/92	06/30/93	1.0609	0.9645
030003	07/01/92	06/30/93	1.3932	0.9787
030006	07/01/92	06/30/93	1.5915	0.9982
030007	07/01/92	06/30/93	1.2449	0.9747
030009	07/01/92	06/30/93	1.2010	0.9849

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
030010	07/01/92	06/30/93	1.4099	0.9981
030011	07/01/92	06/30/93	1.4530	0.9959
030016	07/01/92	06/30/93	1.3142	0.9904
030017	07/01/92	06/30/93	1.4177	0.9994
030019	07/01/92	06/30/93	1.2348	0.9905
030022	07/01/92	06/30/93	1.5141	0.9925
030024	07/01/92	06/30/93	1.6643	0.9991
030027	07/01/92	06/30/93	1.1036	0.9684
030033	07/01/92	06/30/93	1.2370	0.9570
030034	04/01/92	03/31/93	1.1662	0.9722
030037	07/01/92	06/30/93	1.9171	0.9953
030040	07/01/92	06/30/93	0.9815	0.9335
030043	07/01/92	06/30/93	1.2198	0.9486
030049	07/01/92	06/30/93	0.9968	0.9659
030054	07/01/92	06/30/93	0.8844	0.9126
030055	07/01/92	06/30/93	1.2598	0.9767
030059	07/01/92	06/30/93	1.2755	0.9894
030064	07/01/92	06/30/93	1.5156	0.9905
040001	04/01/92	03/31/93	1.1441	0.9669
040002	07/01/92	06/30/93	1.2325	0.9818
040003	07/01/92	06/30/93	0.9818	0.9762
040008	07/01/92	06/30/93	1.0941	0.9700
040011	07/01/92	06/30/93	0.9698	0.9681
040015	07/01/92	06/30/93	1.1194	0.9441
040016	07/01/92	06/30/93	1.5806	0.9978
040017	04/01/92	04/01/93	1.3143	0.9754
040019	07/01/92	06/30/93	1.2152	0.9544
040022	07/01/92	06/30/93	1.7959	0.9925
040025	07/01/92	06/30/93	0.9581	0.9780
040026	07/01/92	06/30/93	1.5925	0.9966
040030	07/01/92	06/30/93	0.8883	0.9489
040032	07/01/92	06/30/93	0.9579	0.9684
040035	07/01/92	06/30/93	0.9364	0.9695
040039	07/01/92	06/30/93	1.2626	0.9800
040040	07/01/92	06/30/93	1.1053	0.9558
040047	07/01/92	06/30/93	1.0086	0.9851
040048	07/01/92	06/30/93	1.1903	0.9820
040051	04/01/92	03/31/93	1.0813	0.9654
040053	07/01/92	06/30/93	1.1473	0.9264
040054	07/01/92	06/30/93	1.0399	0.9742
040055	07/01/92	06/30/93	1.3618	0.9994
040058	07/01/92	06/30/93	1.1303	0.9797
040060	02/01/92	01/31/93	0.9352	0.9203
040062	07/01/92	06/30/93	1.4976	0.9981
040063	07/01/92	06/30/93	1.5569	0.9953
040069	07/01/92	06/30/93	1.0296	0.9580
040070	07/01/92	06/30/93	0.9996	0.9413
040071	07/01/92	06/30/93	1.3957	0.9964
040074	07/01/92	06/30/93	1.2156	0.9894
040076	07/01/92	06/30/93	1.1169	0.9528
040077	07/01/92	06/30/93	0.9376	0.9517
040080	07/01/92	06/30/93	1.0356	0.9475
040082	04/01/92	03/31/93	1.2767	0.9604
040084	07/01/92	06/30/93	1.0897	0.9782
040088	07/01/92	06/30/93	1.2869	0.9857
040091	07/01/92	06/30/93	1.3335	0.9582
040093	07/01/92	06/30/93	0.9728	0.9497
040095	07/01/92	06/30/93	0.8456	0.9644
040109	07/01/92	06/30/93	1.0851	0.9714
040116	03/01/92	02/28/93	1.4142	0.9969
040124	07/01/92	06/30/93	1.1749	0.9699
040126	07/01/92	06/30/93	0.9786	0.9552
050006	07/01/92	06/30/93	1.3219	0.9869
050009	07/01/92	06/30/93	1.5026	0.9919
050015	07/01/92	06/30/93	1.3137	0.9808
050017	04/01/92	03/31/93	2.0390	0.9985
050025	07/01/92	06/30/93	1.5989	0.9973
050026	07/01/92	06/30/93	1.4759	0.9923
050028	07/01/92	06/30/93	1.3235	0.9846
050029	07/01/92	06/30/93	1.2636	0.9813
050033	07/01/92	06/30/93	1.4640	0.9956
050036	07/01/92	06/30/93	1.7510	0.9907
050038	07/01/92	06/30/93	1.4405	0.9905
050039	07/01/92	06/30/93	1.6376	0.9962
050040	07/01/92	06/30/93	1.2973	0.9744
050041	06/01/92	06/01/93	1.2922	0.9596
050042	07/01/92	06/30/93	1.2613	0.9801
050045	07/01/92	06/30/93	1.2888	0.9802
050046	05/01/92	04/30/93	1.1699	0.9734
050051	07/01/92	06/30/93	1.0882	0.9748
050054	07/01/92	06/30/93	1.3047	0.9791
050055	07/01/92	06/30/93	1.2551	0.9897
050056	07/01/92	06/30/93	1.4266	0.9955
050057	07/01/92	06/30/93	1.4707	0.9929

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050063	07/01/92	06/30/93	1.3880	0.9886
050065	04/01/92	03/31/93	1.6010	0.9950
050066	04/01/92	03/31/93	1.2635	0.9967
050067	07/01/92	06/30/93	1.3440	0.9821
050068	07/01/92	06/30/93	1.0850	0.9925
050069	07/01/92	06/30/93	1.6511	0.9987
050077	07/01/92	06/30/93	1.6054	0.9973
050079	07/01/92	06/30/93	1.4330	0.9952
050082	07/01/92	06/30/93	1.4949	0.9980
050088	07/01/92	06/30/93	1.1183	0.9908
050089	07/01/92	06/30/93	1.3358	0.9899
050090	07/01/92	06/30/93	1.2798	0.9795
050092	07/01/92	06/30/93	0.8834	0.9638
050093	06/01/92	05/31/93	1.5283	0.9991
050095	07/01/92	06/30/93	1.0690	0.9058
050104	07/01/92	06/30/93	1.3920	0.9961
050110	07/01/92	06/30/93	1.2016	0.9633
050113	07/01/92	06/30/93	1.1460	0.9826
050114	05/01/92	04/30/93	1.4470	0.9810
050115	07/01/92	06/30/93	1.5445	0.9986
050116	07/01/92	06/30/93	1.4447	0.9955
050118	06/01/92	06/01/93	1.1834	0.9791
050124	07/01/92	06/30/93	1.2043	0.9865
050128	07/01/92	06/30/93	1.5394	0.9953
050129	07/01/92	06/30/93	1.4937	0.9953
050133	07/01/92	06/30/93	1.2980	0.9682
050136	07/01/92	06/30/93	1.4183	0.9898
050147	06/01/92	06/01/93	0.7090	0.9619
050148	07/01/92	06/30/93	1.0925	0.9700
050152	07/01/92	06/30/93	1.3928	0.9952
050153	07/01/92	06/30/93	1.6196	0.9977
050159	07/01/92	06/30/93	1.3053	0.9928
050167	07/01/92	06/30/93	1.3960	0.9950
050168	07/01/92	06/30/93	1.6246	0.9938
050170	07/01/92	06/30/93	1.4427	0.9937
050172	07/01/92	06/30/93	1.3713	0.9838
050174	07/01/92	06/30/93	1.6712	0.9972
050175	07/01/92	06/30/93	1.3284	0.9927
050177	04/01/92	03/31/93	1.2171	0.9960
050179	02/01/92	01/31/93	1.2380	0.9811
050181	07/01/92	06/30/93	1.2282	0.9663
050183	07/01/92	06/30/93	1.1831	0.9925
050188	06/01/92	06/01/93	1.4088	0.9894
050191	07/01/92	06/30/93	1.4382	0.9903
050192	07/01/92	06/30/93	1.2205	0.9823
050193	07/01/92	06/30/93	1.3554	0.9845
050194	07/01/92	06/30/93	1.2223	0.9848
050195	07/01/92	06/30/93	1.6004	0.9969
050196	01/01/92	01/31/93	1.3659	0.9837
050197	07/01/92	06/30/93	1.9446	0.9976
050199	07/01/92	06/30/93	1.0950	0.9936
050207	07/01/92	06/30/93	1.2976	0.9907
050213	07/01/92	06/30/93	1.3163	0.9856
050215	07/01/92	06/30/93	1.5123	0.9987
050228	07/01/92	06/30/93	1.3447	0.9777
050230	03/01/92	02/28/93	1.4256	0.9610
050232	07/01/92	06/30/93	1.8463	0.9970
050240	07/01/92	06/30/93	1.5014	0.9885
050242	07/01/92	06/30/93	1.4062	0.9971
050243	07/01/92	06/30/93	1.5181	0.9915
050245	07/01/92	06/30/93	1.4081	0.9929
050248	07/01/92	06/30/93	1.1376	0.9706
050258	07/01/92	06/30/93	1.3360	0.9873
050260	07/01/92	06/30/93	1.0049	0.9487
050261	07/01/92	06/30/93	1.1734	0.9890
050262	07/01/92	06/30/93	1.7774	0.9960
050263	05/01/92	04/30/93	1.2593	0.9862
050267	07/01/92	06/30/93	1.5506	0.9970
050274	07/01/92	06/30/93	1.1300	0.9675
050276	07/01/92	06/30/93	1.2055	0.9872
050277	07/01/92	06/30/93	1.3938	0.9941
050278	06/01/92	05/31/93	1.4379	0.9855
050279	07/01/92	06/30/93	1.2385	0.9851
050280	07/01/92	06/30/93	1.5586	0.9979
050283	07/01/92	06/30/93	1.2721	0.9794
050289	07/01/92	06/30/93	1.7713	0.9965
050290	06/01/92	05/31/93	1.6454	0.9975
050291	07/01/92	06/30/93	1.2432	0.9914
050292	07/01/92	06/30/93	1.0866	0.9921
050293	07/01/92	06/30/93	1.2437	0.8748
050295	07/01/92	06/30/93	1.4227	0.9943
050296	07/01/92	06/30/93	1.1787	0.9682
050298	01/01/92	01/13/93	1.2101	0.9724
050299	04/01/92	03/31/93	1.3082	0.9932

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050307	06/01/92	05/31/93	1.4722	0.9911
050312	06/01/92	06/01/93	1.8112	0.9973
050315	07/01/92	06/30/93	1.3059	0.9872
050320	07/01/92	06/30/93	1.4047	0.9959
050325	07/01/92	06/30/93	1.2668	0.9737
050331	03/01/92	02/28/93	1.3679	0.9798
050333	07/01/92	06/30/93	0.9448	0.9491
050334	07/01/92	06/30/93	1.5545	0.9995
050337	05/01/92	04/30/93	1.3333	0.9663
050342	07/01/92	06/30/93	1.4699	0.9891
050343	07/01/92	06/30/93	1.0441	0.9994
050348	07/01/92	06/30/93	1.5973	0.9975
050349	07/01/92	06/30/93	0.9337	0.9761
050350	07/01/92	06/30/93	1.4012	0.9946
050353	07/01/92	06/30/93	1.5474	0.9977
050355	07/01/92	06/30/93	0.9592	0.9460
050359	07/01/92	06/30/93	1.0815	0.9975
050373	07/01/92	06/30/93	1.3025	0.9778
050376	07/01/92	06/30/93	1.3313	0.9904
050377	07/01/92	06/30/93	0.8532	0.9797
050378	05/01/92	04/30/93	1.1442	0.9867
050379	07/01/92	06/30/93	1.1120	0.9594
050380	07/01/92	06/30/93	1.6360	0.9980
050382	07/01/92	06/30/93	1.4092	0.9999
050388	07/01/92	06/30/93	0.8767	0.8843
050390	07/01/92	06/30/93	1.3113	0.9918
050392	07/01/92	06/30/93	0.9971	0.9728
050393	07/01/92	06/30/93	1.4216	0.9963
050397	07/01/92	06/30/93	1.0700	0.9926
050401	05/01/92	04/30/93	1.1840	0.9969
050406	07/01/92	06/30/93	1.1086	0.9819
050414	04/01/92	03/31/93	1.3348	0.9595
050418	06/01/92	05/31/93	1.3255	0.9890
050419	07/01/92	06/30/93	1.3320	0.9736
050430	07/01/92	06/30/93	0.9840	0.9563
050432	06/01/92	06/01/93	1.5102	0.9938
050433	07/01/92	06/30/93	1.0371	0.9742
050434	04/01/92	03/31/93	1.0993	0.8438
050435	07/01/92	06/30/93	1.2445	0.9848
050436	07/01/92	06/30/93	1.0137	0.9635
050443	07/01/92	06/30/93	0.9322	0.9607
050444	07/01/92	06/30/93	1.2646	0.9896
050446	07/01/92	06/30/93	0.9086	0.9235
050448	02/01/92	01/31/93	1.2446	0.9783
050449	07/01/92	06/30/93	1.2948	0.9916
050454	07/01/92	06/30/93	1.8566	0.9960
050457	07/01/92	06/30/93	1.8974	0.9953
050459	07/01/92	06/30/93	1.2253	0.9784
050464	06/01/92	06/01/93	1.8761	0.9985
050470	07/01/92	06/30/93	1.1447	0.9580
050476	07/01/92	06/30/93	1.2985	0.9738
050477	07/01/92	06/30/93	1.3934	0.9923
050482	07/01/92	06/30/93	0.9619	0.9722
050485	07/01/92	06/30/93	1.6529	0.9994
050488	07/01/92	06/30/93	1.3094	0.9875
050491	07/01/92	06/30/93	1.3725	1.0000
050494	07/01/92	06/30/93	1.0640	0.9623
050496	07/01/92	06/30/93	1.7850	0.9970
050497	07/01/92	06/30/93	0.8830	0.9483
050502	07/01/92	06/30/93	1.6628	0.9991
050516	04/01/92	03/31/93	1.6488	0.9951
050522	06/01/92	06/01/93	1.3492	0.9917
050528	07/01/92	06/30/93	1.2203	0.9832
050534	06/01/92	06/01/93	1.4091	0.9864
050535	05/01/92	04/30/93	1.3630	0.9800
050539	07/01/92	06/30/93	1.1774	0.9663
050542	07/01/92	06/30/93	1.1053	0.9565
050545	07/01/92	06/30/93	0.8775	0.9761
050546	07/01/92	06/30/93	0.9002	1.0000
050547	07/01/92	06/30/93	0.9777	0.9858
050551	06/01/92	06/01/93	1.3227	0.9891
050559	07/01/92	06/30/93	1.3525	0.9679
050560	05/01/92	04/30/93	1.3589	0.9926
050565	07/01/92	06/30/93	1.2083	0.9864
050566	07/01/92	06/30/93	0.9220	0.9718
050568	07/01/92	06/30/93	1.3413	0.9889
050569	07/01/92	06/30/93	1.1891	0.9691
050573	07/01/92	06/30/93	1.6729	0.9978
050577	07/01/92	06/30/93	1.2490	0.9935
050578	07/01/92	06/30/93	1.3816	0.9722
050579	06/01/92	06/01/93	1.3668	0.9880
050581	06/01/92	06/01/93	1.4450	0.9703
050583	06/01/92	06/01/93	1.7185	0.9962
050584	06/01/92	06/01/93	1.2628	0.9681

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050589	06/01/92	06/01/93	1.3041	0.9778
050594	07/01/92	06/30/93	2.0107	0.9835
050599	07/01/92	06/30/93	1.6233	0.9967
050603	07/01/92	06/30/93	1.4287	0.9951
050613	07/01/92	06/30/93	1.0557	0.9687
050615	05/01/92	04/30/93	1.4088	0.9983
050618	07/01/92	06/30/93	1.2387	0.9742
050623	07/01/92	06/30/93	1.2689	1.0000
050625	04/01/92	04/01/93	1.5100	0.9980
050633	06/01/92	06/01/93	1.2686	0.9857
050636	07/01/92	06/30/93	1.3734	0.9709
050637	05/01/92	04/30/93	1.1883	0.9990
050638	07/01/92	06/30/93	0.9394	1.0000
050641	07/01/92	06/30/93	1.1739	0.9919
050661	02/01/92	01/31/93	0.9010	0.9830
050662	07/01/92	06/30/93	0.8019	0.9925
050666	07/01/92	06/30/93	1.1122	0.9796
050667	07/01/92	06/30/93	1.0778	0.8992
050668	07/01/92	06/30/93	1.1637	0.9715
050671	07/01/92	06/30/93	1.1480	1.0000
050672	07/01/92	06/30/93	0.6476	0.9937
050675	02/01/92	01/31/93	1.5323	0.9929
050676	07/01/92	06/30/93	1.0095	0.8493
050678	07/01/92	06/30/93	1.1000	0.9936
050682	07/01/92	06/30/93	0.9150	0.9781
050684	07/01/92	06/30/93	1.2051	0.9878
050685	07/01/92	06/30/93	1.1556	0.9796
050688	07/01/92	06/30/93	1.2475	0.9833
050689	06/01/92	06/01/93	1.4617	0.9742
050694	07/01/92	06/30/93	1.3062	0.9754
050700	07/01/92	06/30/93	1.3902	0.9868
060008	06/30/92	06/30/93	1.0146	0.9731
060012	06/30/92	06/30/93	1.4368	0.9969
060013	06/30/92	06/30/93	1.2758	0.9888
060015	06/30/92	06/30/93	1.5408	0.9952
060016	06/30/92	06/30/93	1.1932	0.9711
060020	06/30/92	06/30/93	1.5386	0.9952
060023	05/31/92	05/31/93	1.4694	0.9972
060024	06/30/92	06/30/93	1.6441	0.9914
060026	07/01/92	06/30/93	1.4552	0.9962
060028	05/31/92	05/31/93	1.3930	0.9980
060031	06/30/92	06/30/93	1.4921	0.9970
060032	06/30/92	06/30/93	1.4334	0.9968
060036	04/01/92	03/31/93	1.1897	0.9816
060054	05/01/92	04/30/93	1.2515	0.9872
060104	06/30/92	06/30/93	1.2690	0.9802
080001	07/01/92	06/30/93	1.6160	0.9995
080002	07/01/92	06/30/93	1.1956	0.9871
080003	07/01/92	06/30/93	1.3182	0.9906
080004	07/01/92	06/30/93	1.3426	0.9880
080006	07/01/92	06/30/93	1.1986	0.9837
080007	07/01/92	06/30/93	1.2274	0.9838
090001	07/01/92	06/30/93	1.4054	0.9992
090003	07/01/92	06/30/93	1.3516	0.9990
090004	07/01/92	06/30/93	1.5368	0.9996
090010	07/01/92	06/30/93	0.9566	0.9972
090011	07/01/92	06/30/93	1.9483	0.9987
100001	07/01/92	06/30/93	1.4829	0.9980
100010	07/01/92	06/30/93	1.4149	0.9951
100027	06/01/92	05/31/93	0.8377	0.9815
100032	07/01/92	06/30/93	1.8719	0.9979
100038	05/01/92	04/30/93	1.6635	0.9990
100039	07/01/92	06/30/93	1.6848	0.9932
100060	01/01/92	01/03/93	1.7598	0.9969
100067	07/01/92	06/30/93	1.4262	0.9964
100068	04/01/92	03/31/93	1.5047	0.9985
100070	07/01/92	06/30/93	1.4039	0.9815
100075	07/01/92	06/30/93	1.6701	0.9992
100076	04/01/92	03/31/93	1.4902	0.9953
100079	06/01/92	05/31/93	1.0775	0.9805
100084	07/01/92	06/30/93	1.4791	0.9788
100086	07/01/92	06/30/93	1.3997	0.9917
100106	05/15/92	05/31/93	1.0240	0.9656
100113	07/01/92	06/30/93	2.0728	0.9979
100114	04/01/92	03/31/93	1.4689	0.9946
100122	07/01/92	06/30/93	1.3765	0.9853
100126	06/01/92	06/01/93	1.4760	0.9935
100129	07/01/92	06/30/93	1.3626	0.9846
100160	07/01/92	06/30/93	1.2342	0.9533
100161	06/01/92	05/31/93	1.4640	0.9909
100168	07/01/92	06/30/93	1.3185	0.9856
100172	06/01/92	05/31/93	1.3486	1.0000
100179	05/01/92	04/30/93	1.6536	0.9980
100191	07/01/92	06/30/93	1.3251	0.9895

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
100200	07/01/92	06/30/93	1.3297	0.9913
100204	03/01/92	02/28/93	1.5702	0.9987
100207	04/01/92	03/31/93	1.4361	0.9911
100213	05/01/92	04/30/93	1.6340	0.9974
100225	06/01/92	06/01/93	1.3288	0.9926
100231	06/01/92	05/31/93	1.7343	0.9991
100240	06/01/92	05/31/93	0.8139	1.0000
100242	02/01/92	01/31/93	1.3248	0.9928
100244	07/01/92	06/30/93	1.3628	0.9853
100249	06/01/92	06/01/93	1.2782	0.9815
100252	02/01/92	01/31/93	1.2137	0.9827
100254	05/01/92	04/30/93	1.6057	0.9995
100256	03/01/92	02/28/93	1.9054	0.9977
100258	06/01/92	06/01/93	1.7092	0.9860
100264	03/01/92	02/28/93	1.4358	0.9742
100268	06/01/92	06/01/93	1.2440	0.9733
100270	06/01/92	05/31/93	0.8651	0.9601
100271	07/01/92	06/30/93	1.5784	0.9977
100276	07/01/92	06/30/93	1.3458	0.9898
100277	07/01/92	06/30/93	1.0666	0.9925
110003	03/01/92	02/28/93	1.3332	0.9810
110008	04/01/92	03/31/93	1.1237	0.9794
110011	07/01/92	06/30/93	1.1562	0.9885
110015	07/01/92	06/30/93	1.0947	0.9648
110017	07/01/92	06/30/93	0.9512	0.9598
110026	07/01/92	06/30/93	1.1392	0.9717
110027	07/01/92	06/30/93	1.0310	0.9809
110031	04/01/92	03/31/93	1.2713	0.9902
110034	07/01/92	06/30/93	1.4742	0.9973
110035	07/01/92	06/30/93	1.3192	0.9845
110039	07/01/92	06/30/93	1.3681	0.9905
110040	07/01/92	06/30/93	1.0531	0.9815
110041	07/01/92	06/30/93	1.1271	0.9670
110042	07/01/92	06/30/93	1.0619	0.9796
110043	07/01/92	06/30/93	1.5408	0.9991
110051	05/01/92	04/30/93	0.9895	0.9610
110052	07/01/92	06/30/93	0.9219	0.9650
110054	07/01/92	06/30/93	1.2399	0.9905
110056	07/01/92	06/30/93	0.6805	0.9393
110062	04/01/92	03/31/93	0.9656	0.9331
110064	07/01/92	06/30/93	1.2624	0.9924
110066	07/01/92	06/30/93	1.2997	0.9905
110069	03/01/92	02/28/93	1.1982	0.9854
110071	07/01/92	06/30/93	1.0206	0.9707
110093	07/01/92	06/30/93	0.9423	0.9789
110094	07/01/92	06/30/93	1.0000	0.9633
110098	07/01/92	06/30/93	1.0274	0.9618
110101	07/01/92	06/30/93	1.0655	0.9778
110103	07/01/92	06/30/93	0.9505	0.9422
110104	07/01/92	06/30/93	1.1358	0.9764
110108	07/01/92	06/30/93	0.9785	0.9296
110109	07/01/92	06/30/93	1.1235	0.9750
110113	06/01/92	05/31/93	1.0279	0.9778
110124	07/01/92	06/30/93	1.0887	0.9798
110125	05/01/92	04/30/93	1.1888	0.9829
110127	07/01/92	06/30/93	0.8709	0.9567
110128	07/01/92	06/30/93	1.1518	0.9856
110132	04/01/92	03/31/93	1.0981	0.9695
110134	07/01/92	06/30/93	0.8493	0.9689
110135	05/01/92	04/30/93	1.0841	0.9769
110136	07/01/92	06/30/93	1.1815	0.9946
110141	07/01/92	06/30/93	0.8829	0.9659
110143	06/01/92	05/31/93	1.2715	0.9895
110149	07/01/92	06/30/93	1.0546	0.9878
110152	07/01/92	06/30/93	1.1233	0.9707
110153	03/01/92	02/28/93	1.0190	0.9709
110154	07/01/92	06/30/93	0.9686	0.9729
110155	04/01/92	03/31/93	1.1090	0.9760
110156	07/01/92	06/30/93	0.9236	0.9507
110157	04/01/92	03/31/93	1.0901	0.9921
110163	05/01/92	04/30/93	1.3806	0.9933
110164	04/01/92	03/31/93	1.3352	0.9962
110168	07/01/92	06/30/93	1.6688	0.9988
110169	07/01/92	06/30/93	0.7823	0.9974
110174	07/01/92	06/30/93	1.0370	0.9567
110176	07/01/92	06/30/93	1.1320	0.9894
110178	07/01/92	06/30/93	1.5789	0.9913
110181	04/01/92	03/31/93	1.0083	0.9755
110183	02/01/92	01/31/93	1.3175	0.9914
110184	04/01/92	03/31/93	1.1037	0.9749
110185	07/01/92	06/30/93	1.0728	0.9688
110188	04/01/92	03/31/93	1.3897	0.9938
110191	07/01/92	06/30/93	1.2703	0.9880
110194	07/01/92	06/30/93	0.9879	0.9568

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
110204	07/01/92	06/30/93	0.7727	0.9675
110205	07/01/92	06/30/93	1.0314	0.9637
110208	04/01/92	03/31/93	0.9881	0.9885
120001	06/28/92	06/26/93	1.7092	0.9906
120002	07/01/92	06/30/93	1.2330	0.9734
120003	07/01/92	06/30/93	0.9867	0.9844
120004	07/01/92	06/30/93	1.3034	0.9904
120005	07/01/92	06/30/93	1.2975	0.9920
120007	07/01/92	06/30/93	1.6118	0.9988
120009	06/28/92	06/26/93	1.0000	0.9226
120010	07/01/92	06/30/93	1.6902	0.9992
120012	07/01/92	06/30/93	0.9123	0.9785
120014	07/01/92	06/30/93	1.2188	0.9796
120015	07/01/92	06/30/93	0.7376	1.0000
120016	07/01/92	06/30/93	1.0103	0.9231
120018	07/01/92	06/30/93	0.8888	0.9195
120019	07/01/92	06/30/93	1.1844	0.9709
120021	07/01/92	06/30/93	0.9131	0.9682
120024	07/01/92	06/30/93	1.0150	1.0000
120026	07/01/92	06/30/93	1.2967	0.9910
120027	07/01/92	06/30/93	1.4104	0.9886
130003	07/01/92	06/30/93	1.2129	0.9844
130007	06/01/92	05/31/93	1.5029	0.9915
130008	07/01/92	06/30/93	0.9360	0.9643
130013	07/01/92	06/30/93	1.2825	0.9841
130017	07/01/92	06/30/93	1.0174	0.9347
130022	07/01/92	06/30/93	1.1228	0.9644
130029	07/01/92	06/30/93	1.0360	0.9486
130035	07/01/92	06/30/93	0.9833	0.9476
130048	07/01/92	06/30/93	1.0838	0.9569
140001	07/01/92	06/30/93	1.2746	0.9795
140003	03/01/92	02/28/93	1.0204	0.9438
140005	04/01/92	03/31/93	0.9191	0.9736
140011	04/01/92	03/31/93	1.0792	0.9752
140014	07/01/92	06/30/93	1.1164	0.9655
140016	03/01/92	02/28/93	0.9979	0.9608
140018	07/01/92	06/30/93	1.4274	0.9954
140024	07/01/92	06/30/93	1.0095	0.9769
140025	04/01/92	03/31/93	1.1226	0.9759
140026	07/01/92	06/30/93	1.1211	0.9804
140027	05/01/92	04/30/93	1.1363	0.9826
140030	05/01/92	04/30/93	1.5206	0.9966
140032	07/01/92	06/30/93	1.3006	0.9745
140035	07/01/92	06/30/93	1.1300	0.9770
140037	07/01/92	06/30/93	1.0244	0.9534
140038	05/01/92	04/30/93	1.1015	0.9781
140040	05/01/92	04/30/93	1.2499	0.9793
140041	06/01/92	05/31/93	1.1589	0.9803
140042	04/01/92	03/31/93	1.0532	0.9692
140043	05/01/92	04/30/93	1.2634	0.9794
140045	07/01/92	06/30/93	0.9957	0.9664
140047	05/01/92	04/30/93	1.2064	0.9693
140053	07/01/92	06/30/93	1.7775	0.9988
140055	05/01/92	04/30/93	0.9066	0.9600
140059	07/01/92	06/30/93	1.0718	0.9751
140061	07/01/92	06/30/93	1.1241	0.9609
140068	04/01/92	03/31/93	1.3897	0.9904
140069	05/01/92	04/30/93	1.0697	0.9574
140070	05/01/92	04/30/93	1.3186	0.9810
140077	05/01/92	04/30/93	1.1646	0.9856
140081	07/01/92	06/30/93	1.1405	0.9515
140082	07/01/92	06/30/93	1.3525	0.9956
140083	07/01/92	06/30/93	1.2786	0.9921
140086	07/01/92	06/30/93	1.1195	0.9560
140088	07/01/92	06/30/93	1.4810	0.9974
140089	07/01/92	06/30/93	1.2304	0.9720
140091	07/01/92	06/30/93	1.6710	0.9938
140100	07/01/92	06/30/93	1.3850	0.9874
140102	07/01/92	06/30/93	1.0073	0.9572
140109	07/01/92	06/30/93	1.0849	0.9572
140110	05/01/92	04/30/93	1.2910	0.9750
140114	02/01/92	01/31/93	1.3010	0.9944
140115	07/01/92	06/30/93	1.2133	0.9952
140116	07/01/92	06/30/93	1.3128	0.9896
140117	07/01/92	06/30/93	1.2829	0.9925
140119	07/01/92	06/30/93	1.6534	0.9971
140120	05/01/92	04/30/93	1.4041	0.9869
140121	07/01/92	06/30/93	1.5159	0.9900
140127	07/01/92	06/30/93	1.2954	0.9854
140133	07/01/92	06/30/93	1.3612	0.9887
140138	07/01/92	06/30/93	1.0364	0.9522
140140	07/01/92	06/30/93	1.0876	0.9811
140144	04/01/92	03/31/93	1.0275	0.9762
140145	07/01/92	06/30/93	1.1482	0.9750

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
140146	05/01/92	04/30/93	0.9843	0.9353
140150	07/01/92	06/30/93	1.4534	0.9990
140151	07/01/92	06/30/93	1.0973	0.9988
140158	07/01/92	06/30/93	1.3970	0.9979
140164	04/01/92	03/31/93	1.2625	0.9854
140165	04/01/92	03/31/93	1.0784	0.9528
140166	07/01/92	06/30/93	1.2057	0.9793
140168	07/01/92	06/30/93	1.1798	0.9622
140170	07/01/92	06/30/93	0.9756	0.9729
140171	07/01/92	06/30/93	0.9552	0.9748
140172	07/01/92	06/30/93	1.4750	0.9902
140173	07/01/92	06/30/93	1.0277	0.9410
140174	07/01/92	06/30/93	1.4701	0.9965
140176	07/01/92	06/30/93	1.2771	0.9877
140177	04/01/92	03/31/93	1.4408	0.9905
140179	07/01/92	06/30/93	1.2653	0.9928
140184	05/01/92	04/30/93	1.1662	0.9677
140187	07/01/92	06/30/93	1.3984	0.9920
140189	07/01/92	06/30/93	1.1338	0.9825
140190	05/01/92	04/30/93	1.1182	0.9588
140193	07/01/92	06/30/93	1.0145	0.9656
140199	07/01/92	06/30/93	1.0483	0.9647
140200	07/01/92	06/30/93	1.4022	0.9982
140205	06/01/92	05/31/93	0.8890	0.9526
140210	05/01/92	04/30/93	1.0522	0.9774
140213	04/01/92	03/31/93	1.1911	0.9881
140215	07/01/92	06/30/93	1.1272	0.9843
140218	07/01/92	06/30/93	0.9415	0.9792
140223	07/01/92	06/30/93	1.5070	0.9974
140224	07/01/92	06/30/93	1.3175	0.9988
140228	06/01/92	05/31/93	1.5758	0.9981
140229	05/01/92	04/30/93	0.9146	0.9321
140230	07/01/92	06/30/93	0.9576	0.9579
140231	07/01/92	06/30/93	1.5479	0.9949
140234	07/01/92	06/30/93	1.2225	0.9828
140239	03/01/92	02/28/93	1.5959	0.9988
140242	07/01/92	06/30/93	1.5165	0.9965
140245	07/01/92	06/30/93	1.0639	0.9657
140246	07/01/92	06/30/93	1.0438	0.9689
140250	05/01/92	04/30/93	1.1929	0.9915
140251	07/01/92	06/30/93	1.3057	0.9917
140275	04/01/92	03/31/93	1.2335	0.9932
140276	07/01/92	06/30/93	2.0541	0.9990
140286	05/01/92	04/30/93	1.1350	0.9679
140297	06/01/92	05/31/93	1.2604	0.9914
140299	07/01/92	06/30/93	0.8625	0.8291
150011	07/01/92	06/30/93	1.2124	0.9855
150012	06/01/92	05/31/93	1.6088	0.9926
150019	07/01/92	06/30/93	1.0902	0.9746
150025	07/01/92	06/30/93	1.5465	0.9974
150032	07/01/92	06/30/93	1.7618	0.9968
150043	07/01/92	06/30/93	1.1048	0.9568
150056	03/01/92	02/28/93	1.7098	0.9993
150076	06/01/92	05/31/93	1.0727	0.9757
150077	07/01/92	06/30/93	1.2517	0.9790
150082	05/01/92	04/30/93	1.4578	0.9995
150084	07/01/92	06/30/93	1.8344	0.9998
150085	06/01/92	05/31/93	0.9754	0.9886
150088	06/01/92	05/31/93	1.1451	0.9803
150089	07/01/92	06/30/93	1.3676	0.9998
150099	07/01/92	06/30/93	1.2253	0.9939
150100	07/01/92	06/30/93	1.7098	0.9929
150103	07/01/92	06/30/93	1.0148	0.9555
150110	05/01/92	04/30/93	0.8928	0.9601
150115	07/01/92	06/30/93	1.3451	0.9871
150125	07/01/92	06/30/93	1.3714	0.9982
150126	07/01/92	06/30/93	1.5227	0.9954
150130	07/01/92	06/30/93	1.1604	0.9841
160005	07/01/92	06/30/93	1.0906	0.9738
160007	07/01/92	06/30/93	0.9553	0.9420
160009	07/01/92	06/30/93	1.2723	0.9542
160012	07/01/92	06/30/93	1.1126	0.9658
160013	07/01/92	06/30/93	1.2513	0.9819
160014	07/01/92	06/30/93	0.9294	0.9589
160016	07/01/92	06/30/93	1.2660	0.9784
160018	07/01/92	06/30/93	0.8704	0.9494
160020	07/01/92	06/30/93	1.1080	0.9854
160021	07/01/92	06/30/93	1.0546	0.9670
160023	07/01/92	06/30/93	1.0868	0.9655
160025	07/01/92	06/30/93	1.8610	0.9972
160026	07/01/92	06/30/93	1.1397	0.9656
160027	07/01/92	06/30/93	1.1263	0.9447
160028	07/01/92	06/30/93	1.2226	0.9802
160029	07/01/92	06/30/93	1.5142	0.9974

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
160030	07/01/92	06/30/93	1.3394	0.9878
160031	07/01/92	06/30/93	1.1329	0.9526
160032	07/01/92	06/30/93	1.1616	0.9705
160033	07/01/92	06/30/93	1.4688	0.9900
160034	07/01/92	06/30/93	0.9717	0.9415
160035	07/01/92	06/30/93	0.9060	0.9519
160036	07/01/92	06/30/93	1.0741	0.9577
160037	07/01/92	06/30/93	1.1075	0.9699
160039	07/01/92	06/30/93	1.0768	0.9524
160040	07/01/92	06/30/93	1.2978	0.9802
160041	07/01/92	06/30/93	1.1383	0.9590
160043	07/01/92	06/30/93	1.0192	0.9609
160046	07/01/92	06/30/93	1.0308	0.9576
160048	07/01/92	06/30/93	1.0747	0.9601
160049	07/01/92	06/30/93	0.9325	0.9585
160050	07/01/92	06/30/93	1.0246	0.9595
160052	07/01/92	06/30/93	1.0144	0.9540
160054	07/01/92	06/30/93	1.1122	0.9637
160055	07/01/92	06/30/93	0.9604	0.9294
160056	07/01/92	06/30/93	1.0295	0.9508
160057	07/01/92	06/30/93	1.3597	0.9849
160058	07/01/92	06/30/93	1.6921	0.9992
160059	07/01/92	06/30/93	1.2827	0.9749
160060	07/01/92	06/30/93	1.0190	0.9474
160061	07/01/92	06/30/93	0.9606	0.9721
160062	07/01/92	06/30/93	0.9648	0.9364
160063	07/01/92	06/30/93	1.1306	0.9841
160064	07/01/92	06/30/93	1.6260	0.9976
160066	07/01/92	06/30/93	1.0987	0.9533
160067	07/01/92	06/30/93	1.3107	0.9897
160068	07/01/92	06/30/93	1.0002	0.9463
160069	07/01/92	06/30/93	1.3957	0.9956
160070	07/01/92	06/30/93	1.0579	0.9657
160073	07/01/92	06/30/93	0.9694	0.9477
160074	07/01/92	06/30/93	1.0148	0.9690
160075	07/01/92	06/30/93	1.0625	0.9662
160076	07/01/92	06/30/93	1.0028	0.9716
160077	07/01/92	06/30/93	0.9863	0.9500
160079	07/01/92	06/30/93	1.3509	0.9938
160080	07/01/92	06/30/93	1.1602	0.9772
160081	07/01/92	06/30/93	1.1022	0.9617
160083	07/01/92	06/30/93	1.5011	0.9992
160085	07/01/92	06/30/93	1.0764	0.9645
160086	07/01/92	06/30/93	0.9801	0.9713
160088	07/01/92	06/30/93	1.1179	0.9284
160089	04/01/92	03/31/93	1.1702	0.9824
160090	07/01/92	06/30/93	1.0557	0.9665
160091	07/01/92	06/30/93	1.0738	0.9682
160093	07/01/92	06/30/93	1.0676	0.9631
160094	07/01/92	06/30/93	1.1235	0.9619
160095	07/01/92	06/30/93	1.0834	0.9539
160097	07/01/92	06/30/93	1.1226	0.9654
160098	07/01/92	06/30/93	1.0186	0.9432
160101	07/01/92	06/30/93	1.0908	0.9698
160102	07/01/92	06/30/93	1.4131	0.9973
160103	07/01/92	06/30/93	0.9646	0.9672
160106	07/01/92	06/30/93	1.0670	0.9647
160107	07/01/92	06/30/93	1.1944	0.9504
160108	07/01/92	06/30/93	1.1254	0.9500
160109	07/01/92	06/30/93	0.9733	0.9508
160112	07/01/92	06/30/93	1.4173	0.9742
160113	07/01/92	06/30/93	0.9989	0.9672
160114	07/01/92	06/30/93	0.9976	0.9666
160115	07/01/92	06/30/93	1.0502	0.9657
160116	07/01/92	06/30/93	1.1957	0.9772
160117	07/01/92	06/30/93	1.2994	0.9952
160118	07/01/92	06/30/93	1.0073	0.9692
160120	07/01/92	06/30/93	0.9889	0.9595
160123	07/01/92	06/30/93	1.0528	0.9733
160124	07/01/92	06/30/93	1.2288	0.9666
160126	05/01/92	04/30/93	1.0915	0.9682
160134	07/01/92	06/30/93	1.0239	0.9163
160135	07/01/92	06/30/93	0.9839	0.9674
160140	07/01/92	06/30/93	1.0374	0.9550
160142	07/01/92	06/30/93	1.0478	0.9359
160143	07/01/92	06/30/93	1.0786	0.9478
160145	07/01/92	06/30/93	1.0124	0.9488
160146	07/01/92	06/30/93	1.3758	0.9927
160151	07/01/92	06/30/93	1.1261	0.9924
160152	07/01/92	06/30/93	0.9949	0.9388
160153	07/01/92	06/30/93	1.6632	0.9980
170009	06/01/92	05/31/93	1.1910	0.9680
170010	07/01/92	06/30/93	1.1979	0.9659
170011	07/01/92	06/30/93	1.4290	0.9876

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
170013	07/01/92	06/30/93	1.2943	0.9859
170015	04/01/92	03/31/93	0.9484	0.9770
170016	06/01/92	05/31/93	1.6015	0.9977
170020	07/01/92	06/30/93	1.2509	0.9794
170025	07/01/92	06/30/93	1.2481	0.9926
170037	07/01/92	06/30/93	1.1325	0.9626
170040	07/01/92	06/30/93	1.4352	0.9950
170044	07/01/92	06/30/93	1.1346	0.9888
170045	07/01/92	06/30/93	1.0349	0.9609
170051	05/01/92	04/30/93	0.9916	0.9282
170052	05/01/92	04/30/93	1.0721	0.9745
170053	04/01/92	03/31/93	0.8402	0.9537
170056	04/01/92	03/31/93	0.9708	0.9722
170057	07/01/92	06/30/93	1.0341	0.9650
170058	07/01/92	06/30/93	1.0917	0.9763
170061	04/01/92	03/31/93	1.1704	0.9599
170067	07/01/92	06/30/93	0.8778	0.8856
170069	07/01/92	06/30/93	0.9886	0.9728
170072	04/01/92	03/31/93	0.9719	0.9656
170074	05/01/92	04/30/93	1.0960	0.9921
170084	07/01/92	06/30/93	0.8706	0.9711
170085	07/01/92	06/30/93	0.8833	0.9222
170089	07/01/92	06/30/93	1.0005	0.9599
170093	04/01/92	03/31/93	0.9303	0.9554
170095	07/01/92	06/30/93	1.1447	0.9827
170100	05/01/92	04/30/93	0.8854	0.9557
170103	07/01/92	06/30/93	1.2695	0.9752
170105	07/01/92	06/30/93	0.9734	0.9482
170115	07/01/92	06/30/93	1.0182	0.9769
170133	07/01/92	06/30/93	1.1577	0.9790
170140	07/01/92	06/30/93	1.0322	0.9821
170142	07/01/92	06/30/93	1.3252	0.9799
170171	06/01/92	05/31/93	1.1737	0.9614
180002	06/30/92	06/30/93	1.0800	0.9799
180005	06/30/92	06/30/93	1.0410	0.9766
180006	04/30/92	04/30/93	0.9102	0.9860
180007	06/30/92	06/30/93	1.4712	0.9934
180012	06/30/92	06/30/93	1.3442	0.9900
180013	03/31/92	03/31/93	1.3186	0.9935
180018	06/30/92	06/30/93	1.1516	0.9888
180020	06/30/92	06/30/93	1.0576	0.9752
180021	06/30/92	06/30/93	1.2329	0.9786
180024	06/30/92	06/30/93	1.3193	0.9633
180027	03/31/92	03/31/93	1.1578	0.9816
180028	06/30/92	06/30/93	1.0586	0.9431
180029	06/30/92	06/30/93	1.3030	0.9863
180032	06/30/92	06/30/93	1.0285	0.9621
180033	04/30/92	04/30/93	1.0399	0.9388
180034	06/30/92	06/30/93	0.9945	0.9682
180038	05/31/92	05/31/93	1.3356	0.9961
180042	06/30/92	06/30/93	1.0899	0.9710
180046	06/30/92	06/30/93	1.0670	0.9667
180047	06/30/92	06/30/93	1.0224	0.9322
180049	06/30/92	06/30/93	1.3710	0.9742
180050	06/30/92	06/30/93	1.3148	0.9635
180053	06/30/92	06/30/93	1.2756	0.9688
180054	06/30/92	06/30/93	1.0134	0.9767
180055	06/30/92	06/30/93	1.0387	0.9720
180056	06/30/92	06/30/93	1.0840	0.9832
180065	06/30/92	06/30/93	0.9510	0.9735
180067	06/30/92	06/30/93	1.8683	0.9942
180069	06/30/92	06/30/93	1.0467	0.9795
180070	06/30/92	06/30/93	1.0467	0.9826
180075	04/30/92	04/30/93	0.9790	0.9856
180087	06/30/92	06/30/93	1.0665	0.9750
180092	06/30/92	06/30/93	1.1258	0.9782
180101	02/29/92	02/28/93	1.2598	0.9737
180105	02/29/92	02/28/93	0.9336	0.9773
180108	06/30/92	06/30/93	0.9174	0.9738
180117	05/19/92	05/31/93	1.1621	0.9830
180118	06/30/92	06/30/93	0.9970	0.9772
180122	06/30/92	06/30/93	0.9805	0.9525
180125	06/30/92	06/30/93	0.9949	0.9467
180129	04/30/92	04/30/93	1.0956	0.9549
180134	06/30/92	06/30/93	0.9960	0.9472
190001	07/01/92	06/30/93	0.8982	0.9904
190007	07/01/92	06/30/93	1.0510	0.9714
190008	04/01/92	03/31/93	1.5377	0.9992
190009	07/01/92	06/30/93	1.2843	0.9975
190010	07/01/92	06/30/93	1.0161	0.9927
190015	07/01/92	06/30/93	1.1620	0.9950
190017	07/01/92	06/30/93	1.2184	0.9857
190019	07/01/92	06/30/93	1.4775	0.9984
190020	07/01/92	06/30/93	1.1977	0.9843

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
190027	07/01/92	06/30/93	1.4563	0.9974
190029	07/01/92	06/30/93	1.2305	0.9599
190033	06/01/92	05/31/93	0.9134	0.9773
190036	05/01/92	04/30/93	1.6749	0.9985
190037	07/01/92	06/30/93	1.0618	0.9510
190041	07/01/92	06/30/93	1.5466	0.9989
190045	07/01/92	06/30/93	1.2729	0.9903
190047	07/01/92	06/30/93	1.1397	0.9707
190048	07/01/92	06/30/93	1.1169	0.9615
190064	07/01/92	06/30/93	1.5051	0.9984
190071	07/01/92	06/30/93	0.8723	0.9805
190075	07/01/92	06/30/93	1.4181	0.9989
190081	07/01/92	06/30/93	0.8873	0.9291
190086	05/01/92	04/30/93	1.3069	0.9843
190098	07/01/92	06/30/93	1.4155	0.9997
190102	07/01/92	06/30/93	1.5231	0.9978
190110	07/01/92	06/30/93	0.9222	0.9718
190112	06/01/92	05/31/93	1.3659	0.9854
190114	07/01/92	06/30/93	0.9428	0.9791
190124	07/01/92	06/30/93	1.4849	1.0000
190125	07/01/92	06/30/93	1.3422	0.9976
190138	05/01/92	04/30/93	0.6983	0.9945
190140	05/01/92	04/30/93	1.0316	0.9767
190148	06/01/92	05/31/93	0.9498	0.9765
190152	06/01/92	05/31/93	1.3474	0.9918
190155	07/01/92	06/30/93	0.9280	0.9810
190156	07/01/92	06/30/93	0.8642	0.9711
190158	06/01/92	05/31/93	1.2631	0.9984
190161	07/01/92	06/30/93	0.8860	0.9956
190164	07/01/92	06/30/93	1.1555	0.9823
190165	05/01/92	05/31/93	1.0039	0.9549
190166	07/01/92	06/30/93	1.0353	0.9629
190170	04/01/92	03/31/93	1.0189	0.9752
190173	06/01/92	05/31/93	1.4031	0.9944
190176	07/01/92	06/30/93	1.5290	0.9976
190182	03/01/92	02/28/93	1.0443	1.0000
190196	05/01/92	04/30/93	0.8641	1.0000
190199	07/01/92	06/30/93	1.2198	0.9541
190204	06/01/92	05/31/93	1.5161	0.9967
200002	04/30/92	04/30/93	1.0876	0.9641
200008	06/30/92	06/30/93	1.2598	0.9958
200012	06/30/92	06/30/93	1.1625	0.9869
200013	06/30/92	06/30/93	1.0847	0.9824
200015	06/30/92	06/30/93	1.2462	0.9884
200016	06/30/92	06/30/93	0.9845	0.9502
200019	04/30/92	04/30/93	1.2423	0.9825
200020	06/30/92	06/30/93	1.1301	0.9819
200023	03/31/92	03/31/93	0.8445	0.9811
200024	06/30/92	06/30/93	1.1864	0.9851
200037	06/30/92	06/30/93	1.1980	0.9697
200038	04/30/92	04/30/93	1.0131	0.9863
200039	03/31/92	03/31/93	1.3095	0.9921
200040	05/31/92	05/31/93	1.0575	0.9719
200050	06/30/92	06/30/93	1.1318	0.9773
200051	06/30/92	06/30/93	0.9970	0.9579
200063	03/31/92	03/31/93	1.2171	0.9841
210001	07/01/92	06/30/93	1.3159	0.9883
210002	07/01/92	06/30/93	1.9614	0.9988
210003	07/01/92	06/30/93	1.5118	0.9952
210004	07/01/92	06/30/93	1.2997	0.9921
210005	07/01/92	06/30/93	1.2135	0.9845
210007	07/01/92	06/30/93	1.5117	1.0000
210008	07/01/92	06/30/93	1.3395	0.9961
210009	07/01/92	06/30/93	1.6879	0.9974
210010	07/01/92	06/30/93	1.2358	0.9830
210012	07/01/92	06/30/93	1.5520	0.9962
210013	07/01/92	06/30/93	1.2745	0.9965
210015	07/01/92	06/30/93	1.2021	0.9936
210016	07/01/92	06/30/93	1.8524	0.9978
210017	07/01/92	06/30/93	1.1037	0.9806
210018	07/01/92	06/30/93	1.2695	0.9879
210019	07/01/92	06/30/93	1.4117	0.9973
210022	07/01/92	06/30/93	1.4108	0.9910
210023	07/01/92	06/30/93	1.3535	0.9825
210024	07/01/92	06/30/93	1.3235	0.9947
210025	07/01/92	06/30/93	1.3010	0.9943
210026	07/01/92	06/30/93	1.3218	0.9915
210027	07/01/92	06/30/93	1.2215	0.9941
210028	07/01/92	06/30/93	1.0700	0.9696
210029	07/01/92	06/30/93	1.3210	0.9833
210030	07/01/92	06/30/93	1.0716	0.9881
210031	07/01/92	06/30/93	1.7487	0.9989
210032	07/01/92	06/30/93	1.2557	0.9923
210033	07/01/92	06/30/93	1.1706	0.9995

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
210034	07/01/92	06/30/93	1.2674	0.9959
210035	07/01/92	06/30/93	1.1768	0.9930
210037	07/01/92	06/30/93	1.2369	0.9911
210038	07/01/92	06/30/93	1.3975	0.9956
210039	07/01/92	06/30/93	1.1742	0.9867
210040	07/01/92	06/30/93	1.3177	0.9931
210043	07/01/92	06/30/93	1.2663	0.9946
210044	07/01/92	06/30/93	1.2581	0.9953
210045	07/01/92	06/30/93	1.0172	0.9713
210048	07/01/92	06/30/93	1.1730	0.9894
210051	07/01/92	06/30/93	1.2849	0.9934
210054	07/01/92	06/30/93	1.2401	0.9871
210055	07/01/92	06/30/93	1.2299	0.9911
210056	07/01/92	06/30/93	1.4479	0.9850
210057	07/01/92	06/30/93	1.2920	0.9950
210058	07/01/92	06/30/93	1.8195	0.9773
210059	07/01/92	06/30/93	1.3155	0.9930
220011	07/01/92	06/30/93	1.1433	0.9945
220041	07/01/92	06/30/93	1.1638	0.9928
220083	07/01/92	06/30/93	1.1315	0.9899
220133	07/01/92	06/30/93	0.8219	0.9543
220153	07/01/92	06/30/93	1.0036	0.9671
220154	07/01/92	06/30/93	0.9156	0.9654
220163	07/01/92	06/30/93	1.8781	0.9990
230001	07/01/92	06/30/93	1.1711	0.9650
230002	07/01/92	06/30/93	1.2684	0.9874
230004	07/01/92	06/30/93	1.6987	0.9968
230005	07/01/92	06/30/93	1.2847	0.9660
230006	04/01/92	03/31/93	1.0471	0.9668
230019	07/01/92	06/30/93	1.5147	0.9987
230024	07/01/92	06/30/93	1.5146	0.9987
230027	07/01/92	06/30/93	1.0650	0.9817
230029	07/01/92	06/30/93	1.5466	0.9989
230030	07/01/92	06/30/93	1.2279	0.9718
230031	07/01/92	06/30/93	1.4553	0.9882
230032	07/01/92	06/30/93	1.7423	0.9967
230034	04/01/92	03/31/93	1.1637	0.9792
230035	07/01/92	06/30/93	1.1612	0.9677
230036	07/01/92	06/30/93	1.2684	0.9794
230037	07/01/92	06/30/93	1.2282	0.9747
230038	07/01/92	06/30/93	1.5807	0.9992
230041	07/01/92	06/30/93	1.1962	0.9966
230046	07/01/92	06/30/93	1.8310	0.9994
230054	07/01/92	06/30/93	1.7246	0.9974
230058	07/01/92	06/30/93	1.0843	0.9590
230059	07/01/92	06/30/93	1.5298	0.9973
230060	07/01/92	06/30/93	1.1834	0.9924
230062	07/01/92	06/30/93	1.1577	0.9338
230066	04/01/92	03/31/93	1.3459	0.9895
230068	07/01/92	06/30/93	1.3720	0.9981
230069	07/01/92	06/30/93	1.1250	0.9714
230070	07/01/92	06/30/93	1.4443	0.9940
230072	04/01/92	03/31/93	1.2301	0.9919
230075	07/01/92	06/30/93	1.4437	0.9872
230077	07/01/92	06/30/93	2.0371	0.9972
230081	07/01/92	06/30/93	1.2221	0.9912
230082	07/01/92	06/30/93	1.1657	0.9735
230085	07/01/92	06/30/93	1.1080	0.9744
230086	07/01/92	06/30/93	1.0134	0.9655
230092	07/01/92	06/30/93	1.2768	0.9831
230093	07/01/92	06/30/93	1.2125	0.9678
230095	04/01/92	03/31/93	1.2099	0.9716
230097	07/01/92	06/30/93	1.5235	0.9989
230099	07/01/92	06/30/93	1.2303	0.9886
230100	07/01/92	06/30/93	1.2060	0.9684
230106	07/01/92	06/30/93	1.1123	0.9806
230108	07/01/92	06/30/93	1.1609	0.9695
230111	07/01/92	06/30/93	0.9743	0.9536
230113	07/01/92	06/30/93	0.9994	0.9463
230116	04/01/92	03/31/93	0.9012	0.9554
230117	07/01/92	06/30/93	1.9259	0.9987
230124	04/01/92	03/31/93	1.0817	0.9791
230132	07/01/92	06/30/93	1.4465	0.9970
230133	07/01/92	06/30/93	1.2163	0.9614
230147	07/01/92	06/30/93	1.5527	0.9965
230153	07/01/92	06/30/93	1.0579	0.9611
230154	07/01/92	06/30/93	1.0167	0.9677
230156	07/01/92	06/30/93	1.6562	0.9995
230157	07/01/92	06/30/93	1.3351	0.9927
230159	04/01/92	03/31/93	1.2687	0.9969
230162	04/01/92	03/31/93	1.0075	0.8302
230172	04/01/92	03/31/93	1.2020	0.9772
230174	07/01/92	06/30/93	1.3192	0.9866
230178	04/01/92	03/31/93	1.0435	0.9625

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
230180	07/01/92	06/30/93	1.0952	0.9875
230188	04/01/92	03/31/93	1.1123	0.9745
230189	07/01/92	06/30/93	0.9108	0.9679
230199	07/01/92	06/30/93	1.1519	0.9804
230201	07/01/92	06/30/93	1.0435	0.9794
230207	07/01/92	06/30/93	1.2446	0.9939
230212	07/01/92	06/30/93	1.0641	0.9751
230219	04/01/92	03/31/93	0.9656	0.9520
230221	04/01/92	03/31/93	1.2799	0.9974
230222	07/01/92	06/30/93	1.3153	0.9939
230232	07/01/92	06/30/93	1.0226	0.9575
230241	04/01/92	03/31/93	1.1993	0.9736
230264	07/01/92	06/30/93	1.1922	0.9743
240002	07/01/92	06/30/93	1.6643	0.9928
240005	07/01/92	06/30/93	0.9198	0.9331
240009	07/01/92	06/30/93	1.1490	0.9429
240017	05/01/92	04/30/93	1.1185	0.9694
240036	07/01/92	06/30/93	1.4719	0.9960
240037	07/01/92	06/30/93	1.0881	0.9672
240040	07/01/92	06/30/93	1.2540	0.9625
240044	05/01/92	04/30/93	1.1919	0.9711
240049	07/01/92	06/30/93	1.7207	0.9976
240075	07/01/92	06/30/93	1.2324	0.9807
240077	07/01/92	06/30/93	0.9704	0.9447
240089	04/01/92	03/31/93	1.0887	0.9768
240099	06/01/92	05/31/93	1.0278	0.9617
240101	07/01/92	06/30/93	1.2726	0.9647
240104	07/01/92	06/30/93	1.1736	0.9733
240110	07/01/92	06/30/93	1.0189	0.9510
240125	06/01/92	05/31/93	0.8969	0.9673
240129	06/01/92	05/31/93	1.0200	0.9544
240137	04/01/92	03/31/93	1.1594	0.9574
240145	03/01/92	02/28/93	0.9962	0.9326
240160	07/01/92	06/30/93	0.9996	0.9702
240171	05/01/92	04/30/93	0.9866	0.9269
250001	07/01/92	06/30/93	1.5537	0.9971
250006	07/01/92	06/30/93	0.9840	0.9802
250017	07/01/92	06/30/93	0.9604	0.9662
250031	06/01/92	05/31/93	1.2012	0.9938
250032	07/01/92	06/30/93	1.2320	0.9925
250033	04/01/92	03/31/93	0.9808	0.9335
250034	07/01/92	06/30/93	1.4846	0.9960
250044	07/01/92	06/30/93	1.0228	0.9842
250094	04/01/92	03/31/93	1.2505	0.9913
250102	07/01/92	06/30/93	1.4815	0.9993
250123	03/01/92	02/28/93	1.2418	0.9954
250126	04/01/92	03/31/93	1.0522	0.9611
250128	05/01/92	04/30/93	0.9637	0.9540
250134	07/01/92	06/30/93	0.9584	0.9964
250138	05/01/92	04/30/93	1.2494	0.9974
250141	07/01/92	06/30/93	1.2507	0.9865
260001	07/01/92	06/30/93	1.6185	0.9990
260002	06/01/92	06/01/93	1.3868	0.9861
260006	07/01/92	06/30/93	1.5103	0.9953
260007	04/01/92	03/31/93	1.3530	0.9928
260008	07/01/92	06/30/93	1.2444	0.9978
260009	06/01/92	05/31/93	1.2463	0.9802
260013	05/01/92	04/30/93	1.1793	0.9930
260020	07/01/92	06/30/93	1.6679	0.9985
260022	06/01/92	06/01/93	1.4172	0.9856
260037	02/01/92	01/31/93	1.2465	0.9899
260042	07/01/92	06/30/93	1.1939	0.9919
260048	05/01/92	04/30/93	1.3108	0.9954
260051	06/01/92	06/01/93	1.0678	0.9989
260052	07/01/92	06/30/93	1.2382	0.9813
260055	07/01/92	06/30/93	1.0799	0.9565
260059	07/01/92	06/30/93	1.0945	0.9725
260061	07/01/92	06/30/93	1.1782	0.9814
260065	07/01/92	06/30/93	1.6805	0.9989
260066	07/01/92	06/30/93	1.1133	0.9723
260067	07/01/92	06/30/93	0.9187	0.9341
260077	07/01/92	06/30/93	1.5023	0.9933
260079	07/01/92	06/30/93	1.0157	0.9570
260081	07/01/92	06/30/93	1.4241	0.9963
260082	04/01/92	03/31/93	1.1231	0.9735
260085	07/01/92	06/30/93	1.5508	0.9978
260086	04/01/92	03/31/93	1.0914	0.9716
260094	05/01/92	04/30/93	1.1018	0.9781
260095	07/01/92	06/30/93	1.3783	0.9970
260096	07/01/92	06/30/93	1.4791	0.9989
260104	07/01/92	06/30/93	1.6872	0.9983
260105	07/01/92	06/30/93	1.9174	0.9974
260108	07/01/92	06/30/93	1.7827	0.9989
260109	04/01/92	03/31/93	1.0219	0.9091

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
260112	05/01/92	04/30/93	1.4241	0.9995
260115	07/01/92	06/30/93	1.1610	0.9444
260127	07/01/92	06/30/93	0.9732	0.9691
260128	07/01/92	06/30/93	0.9836	0.9695
260129	06/01/92	05/31/93	1.0649	0.9869
260131	04/01/92	03/31/93	1.2287	0.9788
260137	06/01/92	05/31/93	1.1816	0.9956
260141	07/01/92	06/30/93	2.0078	0.9957
260142	05/01/92	04/30/93	1.1816	0.9858
260143	07/01/92	06/30/93	1.0365	0.9508
260146	07/01/92	06/30/93	1.5485	0.9929
260147	07/01/92	06/30/93	1.0168	0.9763
260164	05/01/92	04/30/93	1.1337	0.9801
260172	07/01/92	06/30/93	0.9953	0.9777
260173	07/01/92	06/30/93	1.0036	0.9424
260175	04/01/92	03/31/93	1.1435	0.9775
260177	07/01/92	06/30/93	1.2867	0.9897
260183	07/01/92	06/30/93	1.6066	0.9962
260186	05/01/92	04/30/93	1.1777	0.9713
260189	07/01/92	06/30/93	0.8986	0.9625
260197	02/01/92	01/31/93	1.2084	0.9876
270003	06/01/92	05/31/93	1.1685	0.9860
270004	07/01/92	06/30/93	1.6598	0.9991
270009	06/01/92	05/31/93	1.0707	0.9581
270011	07/01/92	06/30/93	1.0779	0.9476
270012	07/01/92	06/30/93	1.4717	0.9975
270016	07/01/92	06/30/93	0.8515	0.9738
270017	06/01/92	05/31/93	1.2325	0.9796
270023	07/01/92	06/30/93	1.3435	0.9919
270024	07/01/92	06/30/93	0.9706	0.9772
270026	07/01/92	06/30/93	0.9522	0.9490
270027	07/01/92	06/30/93	0.9947	0.9785
270028	07/01/92	06/30/93	1.0445	0.9711
270031	07/01/92	06/30/93	0.9487	0.9407
270032	07/01/92	06/30/93	1.1274	0.9582
270035	04/01/92	03/31/93	1.0040	0.9756
270036	07/01/92	06/30/93	0.9006	0.9763
270040	07/01/92	06/30/93	1.1161	0.9791
270041	07/01/92	06/30/93	0.9374	0.9476
270044	07/01/92	06/30/93	1.2216	0.9739
270046	05/01/92	04/30/93	0.9138	0.9626
270049	06/01/92	05/31/93	1.6721	0.9979
270050	07/01/92	06/30/93	1.0259	0.9506
270051	04/01/92	03/31/93	1.2706	0.9821
270052	07/01/92	06/30/93	1.0091	0.9772
270053	07/01/92	06/30/93	1.0513	0.9547
270055	07/01/92	06/30/93	0.6625	0.9910
270058	07/01/92	06/30/93	0.9352	0.9902
270060	07/01/92	06/30/93	0.9392	0.9623
270068	07/01/92	06/30/93	0.8829	0.9324
270072	07/01/92	06/30/93	0.8541	0.9525
270073	07/01/92	06/30/93	1.1727	0.9559
270079	07/01/92	06/30/93	0.9214	0.9562
270080	07/01/92	06/30/93	1.0836	0.9672
270081	07/01/92	06/30/93	0.9391	0.9678
270082	07/01/92	06/30/93	0.9112	0.9792
280003	06/01/92	05/31/93	1.9252	0.9989
280009	07/01/92	06/30/93	1.4789	0.9879
280011	07/01/92	06/30/93	0.9932	0.9785
280013	07/01/92	06/30/93	1.9595	0.9964
280014	07/01/92	06/30/93	1.0682	0.9700
280018	07/01/92	06/30/93	0.9823	0.9841
280020	07/01/92	06/30/93	1.4512	0.9893
280021	07/01/92	06/30/93	1.1094	0.9606
280022	07/01/92	06/30/93	0.9502	0.9543
280023	07/01/92	06/30/93	1.3389	0.9786
280024	07/01/92	06/30/93	0.9477	0.9797
280026	07/01/92	06/30/93	1.1405	0.9516
280028	05/01/92	04/30/93	1.0078	0.9697
280029	07/01/92	06/30/93	0.9316	0.9755
280033	07/01/92	06/30/93	1.1245	0.9738
280035	07/01/92	06/30/93	0.9331	0.9536
280037	07/01/92	06/30/93	0.9727	0.9545
280042	05/01/92	04/30/93	0.9349	0.9715
280043	07/01/92	06/30/93	1.1269	0.9685
280045	07/01/92	06/30/93	1.1421	0.9836
280049	05/01/92	04/30/93	1.0441	0.9715
280050	07/01/92	06/30/93	0.9936	0.9746
280051	07/01/92	06/30/93	0.9720	0.9915
280052	07/01/92	06/30/93	1.0553	0.9595
280055	07/01/92	06/30/93	0.9297	0.9762
280056	07/01/92	06/30/93	1.0227	0.9821
280060	07/01/92	06/30/93	1.5731	0.9994
280062	07/01/92	06/30/93	1.1412	0.9742

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
280064	05/01/92	04/30/93	1.0629	0.9643
280066	07/01/92	06/30/93	1.1077	0.9026
280068	04/01/92	03/31/93	0.9310	0.9240
280070	05/01/92	04/30/93	1.1207	0.9620
280073	07/01/92	06/30/93	1.0316	0.9634
280075	07/01/92	06/30/93	1.2022	0.9807
280077	07/01/92	06/30/93	1.2984	0.9824
280080	07/01/92	06/30/93	1.1971	0.9218
280082	03/01/92	02/28/93	1.4528	0.9867
280084	07/01/92	06/30/93	1.0239	0.9663
280090	07/01/92	06/30/93	0.9978	0.9907
280091	07/01/92	06/30/93	1.0909	0.9669
280092	07/01/92	06/30/93	0.9065	0.9200
280094	04/01/92	03/31/93	1.0786	0.9779
280097	07/01/92	06/30/93	0.9617	0.9430
280098	07/01/92	06/30/93	0.9681	0.9616
280104	07/01/92	06/30/93	1.0033	0.9172
280105	07/01/92	06/30/93	1.2791	0.9859
280110	07/01/92	06/30/93	0.9830	0.9581
280111	05/01/92	04/30/93	1.2500	0.9732
280117	07/01/92	06/30/93	1.1003	0.9749
280118	07/01/92	06/30/93	1.0522	0.9831
290001	07/01/92	06/30/93	1.6528	0.9995
290002	04/01/92	03/31/93	0.9373	0.9446
290007	07/01/92	06/30/93	1.8723	0.9931
290008	07/01/92	06/30/93	1.3094	0.9751
290011	07/01/92	06/30/93	0.8714	0.9731
290012	07/01/92	06/30/93	1.3328	0.9776
290013	07/01/92	06/30/93	0.9745	0.8662
290014	07/01/92	06/30/93	1.0135	0.9693
290015	07/01/92	06/30/93	0.9335	0.9512
290016	07/01/92	06/30/93	1.1854	0.9815
290019	07/01/92	06/30/93	1.2347	0.9884
290020	07/01/92	06/30/93	1.3102	0.9526
290027	07/01/92	06/30/93	1.0704	0.9639
300003	06/30/92	06/30/93	1.7362	0.9950
300010	06/30/92	06/30/93	1.2483	0.9631
300015	06/30/92	06/30/93	1.1486	0.9691
300019	06/30/92	06/30/93	1.2454	0.9875
300029	02/29/92	02/28/93	1.2868	0.9841
300034	06/30/92	06/30/93	1.8268	0.9972
310119	07/01/92	06/30/93	1.5219	0.9980
320001	06/30/92	06/30/93	1.4686	0.9895
320002	06/30/92	06/30/93	1.2753	0.9911
320003	06/30/92	06/30/93	1.2376	0.9760
320004	06/30/92	06/30/93	1.1610	0.9826
320005	06/30/92	06/30/93	1.2493	0.9766
320006	06/30/92	06/30/93	1.3841	0.9883
320009	06/30/92	06/30/93	1.5059	0.9967
320011	03/31/92	03/31/93	0.9680	0.9681
320012	03/31/92	03/31/93	1.0149	0.9695
320013	05/31/92	05/31/93	1.0601	0.9646
320014	06/30/92	06/30/93	0.9392	0.9606
320016	06/30/92	06/30/93	1.1359	0.9673
320017	06/30/92	06/30/93	1.2042	0.9791
320018	06/30/92	06/30/93	1.4326	0.9923
320021	03/31/92	03/31/93	1.7378	0.9946
320022	03/31/92	03/31/93	1.2852	0.9686
320030	07/01/92	06/30/93	1.0282	0.9533
320031	06/30/92	06/30/93	0.9178	0.9920
320032	04/01/92	03/31/93	0.9760	0.9440
320037	06/30/92	06/30/93	1.1064	0.9044
320046	03/31/92	03/31/93	1.0802	0.9558
320065	04/01/92	03/31/93	1.1911	0.9721
320068	06/30/92	06/30/93	0.9798	0.9432
320069	06/30/92	06/30/93	1.0300	0.9444
320074	06/30/92	06/30/93	1.1289	0.9824
320076	03/31/92	03/31/93	1.2042	0.9872
320079	03/31/92	03/31/93	1.1822	0.9856
320080	06/01/92	06/01/93	0.6077	0.9811
330080	07/01/92	06/30/93	1.2835	0.9920
330127	07/01/92	06/30/93	1.3479	0.9780
330128	07/01/92	06/30/93	1.4632	0.9892
330196	07/01/92	06/30/93	1.3875	0.9952
330199	07/01/92	06/30/93	1.2686	0.9973
330202	07/01/92	06/30/93	1.3911	0.9650
330204	07/01/92	06/30/93	1.3488	0.9972
330231	07/01/92	06/30/93	1.1203	0.9923
330240	07/01/92	06/30/93	1.3268	0.9965
330385	07/01/92	06/30/93	1.3892	0.9821
330396	07/01/92	06/30/93	1.2395	0.9956
340014	07/01/92	06/30/93	1.6448	0.9996
340020	06/01/92	05/31/93	1.1836	0.9743
340030	07/01/92	06/30/93	1.8932	0.9980

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
340032	07/01/92	06/30/93	1.2821	0.9878
340047	07/01/92	06/30/93	1.8979	0.9989
340052	07/01/92	06/30/93	1.0331	0.9733
340061	07/01/92	06/30/93	1.6531	0.9994
340073	07/01/92	06/30/93	1.4410	0.9905
340116	05/01/92	04/30/93	1.7855	0.9940
340136	07/01/92	06/30/93	0.9395	0.9847
340137	07/01/92	06/30/93	1.3521	0.9970
340138	07/01/92	06/30/93	1.2125	0.9858
340143	07/01/92	06/30/93	1.3619	0.9853
340144	03/01/92	02/28/93	1.3009	0.9842
340148	07/01/92	06/30/93	1.4328	0.9958
340153	03/01/92	02/28/93	1.8547	0.9922
340154	07/01/92	06/30/93	0.8184	0.9096
340155	07/01/92	06/30/93	1.4549	0.9973
340158	07/01/92	06/30/93	1.0785	0.9681
340160	07/01/92	06/30/93	1.0984	0.9703
340164	06/01/92	05/31/93	1.3438	0.9945
350001	07/01/92	06/30/93	1.0514	0.9757
350002	07/01/92	06/30/93	1.7127	0.9986
350003	07/01/92	06/30/93	1.1517	0.9806
350005	07/01/92	06/30/93	1.1014	0.9550
350006	07/01/92	06/30/93	1.2565	0.9843
350008	07/01/92	06/30/93	1.0572	0.9612
350009	07/01/92	06/30/93	1.1496	0.9754
350010	04/01/92	03/31/93	1.0668	0.9688
350011	07/01/92	06/30/93	1.7301	0.9998
350012	07/01/92	06/30/93	1.0846	0.9788
350013	07/01/92	06/30/93	1.1304	0.9783
350014	07/01/92	06/30/93	1.0976	0.9952
350017	07/01/92	06/30/93	1.3269	0.9884
350021	07/01/92	06/30/93	1.0627	0.9876
350025	07/01/92	06/30/93	0.9811	0.9573
350029	07/01/92	06/30/93	0.9055	0.9685
350030	07/01/92	06/30/93	1.0165	0.9791
350034	07/01/92	06/30/93	0.9431	0.9814
350035	07/01/92	06/30/93	0.9575	0.9347
350036	07/01/92	06/30/93	0.9062	0.9573
350039	07/01/92	06/30/93	1.0077	0.9616
350043	07/01/92	06/30/93	1.5640	0.9978
350044	07/01/92	06/30/93	0.8428	0.9818
350047	07/01/92	06/30/93	1.2006	0.9689
350049	07/01/92	06/30/93	1.1705	0.9849
350050	07/01/92	06/30/93	1.0334	0.9748
350053	07/01/92	06/30/93	0.9177	0.9503
350056	07/01/92	06/30/93	0.9388	0.9407
350058	04/01/92	03/31/93	1.0556	0.9548
350060	07/01/92	06/30/93	0.9732	0.9437
350061	04/01/92	03/31/93	0.9773	0.9809
350065	03/01/92	02/28/93	0.9930	0.9132
360003	06/30/92	06/30/93	1.6387	0.9984
360006	06/30/92	06/30/93	1.7618	0.9993
360008	06/30/92	06/30/93	1.2175	0.9745
360011	06/30/92	06/30/93	1.2324	0.9830
360014	06/30/92	06/30/93	1.1551	0.9670
360017	07/01/92	06/30/93	1.7054	0.9986
360028	07/01/92	06/30/93	1.3681	0.9889
360029	06/30/92	06/30/93	1.1280	0.9862
360035	05/31/92	05/31/93	1.4862	0.9984
360040	06/30/92	06/30/93	1.2404	0.9732
360048	06/30/92	06/30/93	1.8617	0.9973
360050	06/30/92	06/30/93	1.1901	0.9429
360052	07/01/92	06/30/93	1.6911	0.9984
360054	06/30/92	06/30/93	1.2883	0.9778
360058	04/01/92	03/31/93	1.1324	0.9759
360085	07/01/92	06/30/93	1.7255	0.9960
360090	06/30/92	06/30/93	1.2526	0.9920
360134	07/01/92	06/30/93	1.5733	0.9991
360161	06/30/92	06/30/93	1.2240	0.9874
360178	06/30/92	06/30/93	1.2489	0.9758
360185	06/30/92	06/30/93	1.2036	0.9878
360187	06/30/92	06/30/93	1.3570	0.9889
360238	06/30/92	06/30/93	0.8991	0.9719
360243	06/30/92	06/30/93	0.8598	0.9719
360244	05/31/92	05/31/93	0.8028	1.0000
360245	06/30/92	06/30/93	0.9667	0.9637
370004	07/01/92	06/30/93	1.3255	0.9771
370005	07/01/92	06/30/93	1.0698	0.9769
370008	07/01/92	06/30/93	1.3876	0.9984
370011	07/01/92	06/30/93	1.0771	0.9694
370012	07/01/92	06/30/93	0.8856	0.9436
370013	07/01/92	06/30/93	1.6748	0.9997
370015	07/01/92	06/30/93	1.2197	0.9690
370016	07/01/92	06/30/93	1.3893	0.9961

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
370019	07/01/92	06/30/93	1.2653	0.9823
370022	07/01/92	06/30/93	1.3011	0.9839
370023	07/01/92	06/30/93	1.3601	0.9762
370026	07/01/92	06/30/93	1.4078	0.9874
370028	07/01/92	06/30/93	1.6764	0.9985
370029	07/01/92	06/30/93	1.2087	0.9389
370030	07/01/92	06/30/93	1.2752	0.9644
370034	07/01/92	06/30/93	1.1381	0.9840
370035	07/01/92	06/30/93	1.4667	0.9983
370036	07/01/92	06/30/93	0.9581	0.9620
370038	07/01/92	06/30/93	0.9680	0.9620
370041	07/01/92	06/30/93	1.0112	0.9704
370042	07/01/92	06/30/93	0.8783	0.9609
370043	07/01/92	06/30/93	0.9371	0.9719
370045	07/01/92	06/30/93	1.0500	0.9671
370046	07/01/92	06/30/93	1.0085	0.9089
370047	07/01/92	06/30/93	1.2211	0.9918
370048	07/01/92	06/30/93	1.1440	0.9438
370056	07/01/92	06/30/93	1.4542	0.9957
370059	07/01/92	06/30/93	1.2405	0.9757
370060	07/01/92	06/30/93	1.1472	0.9690
370063	07/01/92	06/30/93	1.1109	0.9908
370064	05/01/92	04/30/93	0.9992	0.9533
370065	07/01/92	06/30/93	1.0637	0.9603
370072	07/01/92	06/30/93	0.9402	0.9647
370076	07/01/92	06/30/93	1.2432	0.9720
370079	07/01/92	06/30/93	0.8918	0.9770
370080	07/01/92	06/30/93	0.9759	0.9499
370082	07/01/92	06/30/93	1.0867	0.9608
370083	04/01/92	03/31/93	1.0187	0.9826
370084	07/01/92	06/30/93	1.0427	0.9570
370085	04/01/92	03/31/93	0.9027	0.9711
370086	07/01/92	06/30/93	1.1969	0.9786
370089	07/01/92	06/30/93	1.2758	0.9752
370091	07/01/92	06/30/93	1.6171	0.9993
370097	04/01/92	03/31/93	1.3427	0.9951
370099	07/01/92	06/30/93	1.1751	0.9792
370100	07/01/92	06/30/93	1.0380	0.9617
370103	07/01/92	06/30/93	0.9206	0.9554
370112	04/01/92	03/31/93	1.0238	0.9618
370113	07/01/92	06/30/93	1.0897	0.9806
370122	04/01/92	03/31/93	1.1641	0.9543
370123	07/01/92	06/30/93	1.2660	0.9923
370125	07/01/92	06/30/93	0.9998	0.9732
370126	07/01/92	06/30/93	1.1368	0.9738
370131	05/01/92	04/30/93	1.0006	0.9792
370133	07/01/92	06/30/93	1.1415	0.9460
370136	07/01/92	06/30/93	1.1038	0.9719
370139	07/01/92	06/30/93	1.0054	0.9845
370140	07/01/92	06/30/93	1.0293	0.9675
370153	07/01/92	06/30/93	1.1787	0.9636
370154	07/01/92	06/30/93	0.9905	0.9424
370156	07/01/92	06/30/93	1.1328	0.9468
370158	07/01/92	06/30/93	1.0416	0.9474
370163	07/01/92	06/30/93	0.8611	0.9537
370166	02/01/92	01/31/93	1.1306	0.9749
370178	07/01/92	06/30/93	1.0305	0.9454
370183	07/01/92	06/30/93	1.1166	0.9635
370186	07/01/92	06/30/93	0.9621	0.9591
380001	07/01/92	06/30/93	1.2869	0.9761
380002	07/01/92	06/30/93	1.1920	0.9778
380003	07/01/92	06/30/93	1.1764	0.9685
380005	07/01/92	06/30/93	1.1703	0.9685
380007	04/01/92	03/31/93	1.7673	0.9951
380008	04/01/92	03/31/93	1.0775	0.9755
380009	07/01/92	06/30/93	1.6977	0.9962
380011	07/01/92	06/30/93	1.2002	0.9900
380013	07/01/92	06/30/93	1.2882	0.9526
380017	04/01/92	03/31/93	1.7694	0.9968
380023	07/01/92	06/30/93	1.2982	0.9719
380025	04/01/92	03/31/93	1.2571	0.9805
380027	07/01/92	06/30/93	1.2605	0.9831
380031	07/01/92	06/30/93	1.0279	0.9841
380033	07/01/92	06/30/93	1.6523	0.9985
380035	05/01/92	04/30/93	1.2898	0.9757
380037	07/01/92	06/30/93	1.2941	0.9667
380040	07/01/92	06/30/93	1.3225	0.9671
380048	07/02/92	06/30/93	1.0469	0.9374
380062	07/01/92	06/30/93	1.0837	0.9014
380063	07/01/92	06/30/93	1.2123	0.9891
380065	07/01/92	06/30/93	1.0024	0.9367
380066	07/01/92	06/30/93	1.3532	0.9659
380069	07/01/92	06/30/93	1.2363	1.0000
380071	05/01/92	04/30/93	1.2746	0.9602

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
380072	07/01/92	06/30/93	0.9778	0.9510
380078	07/01/92	06/30/93	1.2209	0.9442
380081	07/01/92	06/30/93	1.1384	0.9568
380083	07/01/92	06/30/93	1.1293	0.9751
380084	05/01/92	04/30/93	1.2451	0.9648
380087	07/01/92	06/30/93	1.0345	0.9330
380088	07/01/92	06/30/93	0.9602	0.9762
380089	04/01/92	03/31/93	1.2756	0.9883
380090	07/01/92	06/30/93	1.3049	0.9812
390001	07/01/92	06/30/93	1.3158	0.9937
390002	07/01/92	06/30/93	1.3254	0.9972
390003	07/01/92	06/30/93	1.1874	0.9900
390004	07/01/92	06/30/93	1.3731	0.9966
390005	07/01/92	06/30/93	1.0259	0.9579
390006	07/01/92	06/30/93	1.7515	0.9995
390007	07/01/92	06/30/93	1.2186	0.9871
390008	07/01/92	06/30/93	1.1426	0.9672
390009	07/01/92	06/30/93	1.5933	0.9980
390010	07/01/92	06/30/93	1.2406	0.9878
390011	07/01/92	06/30/93	1.2049	0.9928
390012	07/01/92	06/30/93	1.1965	0.9899
390013	07/01/92	06/30/93	1.1910	0.9911
390014	07/01/92	06/30/93	1.2126	1.0000
390015	07/01/92	06/30/93	1.1682	0.9564
390016	07/01/92	06/30/93	1.1726	0.9914
390017	07/01/92	06/30/93	1.1914	0.9854
390018	07/01/92	06/30/93	1.2140	0.9893
390019	07/01/92	06/30/93	1.1170	0.9789
390022	07/01/92	06/30/93	1.3655	0.9855
390023	07/01/92	06/30/93	1.2347	0.9954
390024	07/01/92	06/30/93	0.7668	0.9962
390025	07/01/92	06/30/93	0.8310	1.0000
390026	07/01/92	06/30/93	1.2454	0.9891
390027	07/01/92	06/30/93	1.8758	0.9967
390029	07/01/92	06/30/93	1.7372	0.9974
390030	07/01/92	06/30/93	1.2064	0.9867
390031	07/01/92	06/30/93	1.1617	0.9864
390032	07/01/92	06/30/93	1.2017	0.9907
390035	07/01/92	06/30/93	1.2954	0.9899
390036	07/01/92	06/30/93	1.2432	0.9893
390037	07/01/92	06/30/93	1.2067	0.9884
390039	07/01/92	06/30/93	1.1414	0.9720
390040	07/01/92	06/30/93	0.9423	0.9892
390041	07/01/92	06/30/93	1.2454	0.9748
390042	07/01/92	06/30/93	1.2906	0.9823
390043	07/01/92	06/30/93	1.0379	0.9802
390044	07/01/92	06/30/93	1.5769	0.9994
390045	07/01/92	06/30/93	1.4113	0.9921
390046	07/01/92	06/30/93	1.4413	0.9987
390047	07/01/92	06/30/93	1.6752	0.9951
390048	07/01/92	06/30/93	1.1553	0.9889
390049	07/01/92	06/30/93	1.5229	0.9988
390050	07/01/92	06/30/93	2.0247	0.9978
390051	07/01/92	06/30/93	2.1329	0.9987
390052	07/01/92	06/30/93	1.1557	0.9740
390055	07/01/92	06/30/93	1.6897	0.9988
390056	07/01/92	06/30/93	1.0886	0.9813
390057	07/01/92	06/30/93	1.2812	0.9916
390058	07/01/92	06/30/93	1.3074	0.9800
390061	07/01/92	06/30/93	1.3415	0.9914
390062	07/01/92	06/30/93	1.1464	0.9870
390063	07/01/92	06/30/93	1.6702	0.9984
390064	07/01/92	06/30/93	1.4676	0.9986
390065	07/01/92	06/30/93	1.2253	0.9789
390066	07/01/92	06/30/93	1.2485	0.9891
390067	07/01/92	06/30/93	1.7101	0.9990
390068	07/01/92	06/30/93	1.3035	0.9911
390069	07/01/92	06/30/93	1.2848	0.9902
390070	07/01/92	06/30/93	1.2512	0.9903
390071	07/01/92	06/30/93	1.0718	0.9811
390072	07/01/92	06/30/93	1.0750	0.9768
390073	07/01/92	06/30/93	1.5510	0.9967
390074	07/01/92	06/30/93	1.1962	0.9917
390075	07/01/92	06/30/93	1.3071	0.9915
390076	07/01/92	06/30/93	1.2633	0.9928
390078	07/01/92	06/30/93	1.0587	0.9872
390079	07/01/92	06/30/93	1.6864	0.9989
390080	07/01/92	06/30/93	1.2043	0.9886
390081	07/01/92	06/30/93	1.2499	0.9942
390083	07/01/92	06/30/93	1.1671	0.9880
390084	07/01/92	06/30/93	1.1506	0.9947
390086	07/01/92	06/30/93	1.1057	0.9657
390088	07/01/92	06/30/93	1.2720	0.9951
390090	07/01/92	06/30/93	1.7434	0.9981

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
390091	07/01/92	06/30/93	1.1383	0.9889
390093	07/01/92	06/30/93	1.1884	0.9829
390095	07/01/92	06/30/93	1.2039	0.9901
390096	07/01/92	06/30/93	1.2121	0.9919
390097	07/01/92	06/30/93	1.2872	0.9873
390098	07/01/92	06/30/93	1.7055	0.9990
390100	07/01/92	06/30/93	1.6822	0.9983
390101	07/01/92	06/30/93	1.2718	0.9930
390102	07/01/92	06/30/93	1.3139	0.9901
390103	07/01/92	06/30/93	1.0711	0.9902
390104	07/01/92	06/30/93	1.0524	0.9751
390106	07/01/92	06/30/93	0.9731	0.9787
390107	07/01/92	06/30/93	1.1853	0.9878
390108	07/01/92	06/30/93	1.3330	0.9885
390109	07/01/92	06/30/93	1.1771	0.9856
390110	07/01/92	06/30/93	1.5573	0.9955
390111	07/01/92	06/30/93	1.7255	0.9984
390112	07/01/92	06/30/93	1.1518	0.9856
390113	07/01/92	06/30/93	1.2535	0.9889
390114	07/01/92	06/30/93	1.0698	0.9988
390115	07/01/92	06/30/93	1.2912	0.9831
390116	07/01/92	06/30/93	1.1817	0.9872
390117	07/01/92	06/30/93	1.1704	0.9759
390118	07/01/92	06/30/93	1.2138	0.9920
390119	07/01/92	06/30/93	1.3431	0.9975
390121	07/01/92	06/30/93	1.2155	0.9964
390122	07/01/92	06/30/93	1.0559	0.9633
390123	07/01/92	06/30/93	1.2329	0.9910
390125	07/01/92	06/30/93	1.2175	0.9920
390126	07/01/92	06/30/93	1.2517	0.9897
390127	07/01/92	06/30/93	1.1743	0.9927
390130	07/01/92	06/30/93	1.1382	0.9611
390131	07/01/92	06/30/93	1.2000	0.9933
390132	07/01/92	06/30/93	1.1819	0.9953
390133	07/01/92	06/30/93	1.7159	0.9983
390135	07/01/92	06/30/93	1.2360	0.9938
390136	07/01/92	06/30/93	1.2006	0.9934
390137	07/01/92	06/30/93	1.1607	0.9956
390138	07/01/92	06/30/93	1.1752	0.9753
390139	07/01/92	06/30/93	1.4335	0.9977
390142	07/01/92	06/30/93	1.6545	0.9997
390145	07/01/92	06/30/93	1.2364	0.9923
390146	07/01/92	06/30/93	1.2349	0.9798
390147	07/01/92	06/30/93	1.2353	0.9900
390148	07/01/92	06/30/93	1.0990	0.9932
390149	07/01/92	06/30/93	1.1934	0.9839
390150	07/01/92	06/30/93	1.1865	0.9737
390151	07/01/92	06/30/93	1.2403	0.9920
390152	07/01/92	06/30/93	1.0836	0.9936
390153	07/01/92	06/30/93	1.2394	0.9899
390154	07/01/92	06/30/93	1.1601	0.9766
390155	07/01/92	06/30/93	1.2085	0.9821
390156	07/01/92	06/30/93	1.3432	0.9920
390157	07/01/92	06/30/93	1.2125	0.9912
390158	07/01/92	06/30/93	1.2654	0.9908
390159	07/01/92	06/30/93	1.3033	0.9838
390160	07/01/92	06/30/93	1.1741	0.9834
390161	07/01/92	06/30/93	1.2248	0.9752
390162	07/01/92	06/30/93	1.2829	0.9963
390163	07/01/92	06/30/93	1.1542	0.9879
390164	07/01/92	06/30/93	2.1777	0.9916
390166	07/01/92	06/30/93	1.1112	0.9761
390167	07/01/92	06/30/93	1.2712	0.9908
390168	07/01/92	06/30/93	1.1686	0.9843
390170	07/01/92	06/30/93	1.7674	0.9989
390171	07/01/92	06/30/93	1.1298	0.9661
390172	07/01/92	06/30/93	1.2168	0.9880
390173	07/01/92	06/30/93	1.1585	0.9830
390174	07/01/92	06/30/93	1.6330	0.9986
390176	07/01/92	06/30/93	1.1420	0.9904
390178	07/01/92	06/30/93	1.2913	0.9886
390179	07/01/92	06/30/93	1.2548	0.9940
390180	07/01/92	06/30/93	1.4527	0.9955
390181	07/01/92	06/30/93	1.0497	0.9853
390183	07/01/92	06/30/93	1.1095	0.9709
390184	07/01/92	06/30/93	1.1507	0.9767
390185	07/01/92	06/30/93	1.1334	0.9772
390189	07/01/92	06/30/93	1.1572	0.9791
390191	07/01/92	06/30/93	1.0685	0.9766
390192	07/01/92	06/30/93	1.1040	0.9779
390193	07/01/92	06/30/93	1.1558	0.9955
390194	07/01/92	06/30/93	1.1247	0.9810
390195	07/01/92	06/30/93	1.7174	0.9990
390197	07/01/92	06/30/93	1.2667	0.9937

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
390198	07/01/92	06/30/93	1.2078	0.9952
390199	07/01/92	06/30/93	1.2579	0.9800
390200	07/01/92	06/30/93	1.0244	0.9554
390201	07/01/92	06/30/93	1.2861	0.9852
390203	07/01/92	06/30/93	1.2389	0.9916
390204	07/01/92	06/30/93	1.2899	0.9887
390205	07/01/92	06/30/93	1.2691	0.9811
390206	07/01/92	06/30/93	1.3436	0.9935
390209	07/01/92	06/30/93	0.9599	0.9509
390211	07/01/92	06/30/93	1.2153	0.9880
390213	07/01/92	06/30/93	1.0399	0.9892
390215	07/01/92	06/30/93	1.1271	0.9861
390217	07/01/92	06/30/93	1.2120	0.9838
390219	07/01/92	06/30/93	1.2197	0.9767
390220	07/01/92	06/30/93	1.1666	0.9877
390222	07/01/92	06/30/93	1.2312	0.9919
390223	07/01/92	06/30/93	1.7151	0.9969
390225	07/01/92	06/30/93	1.2323	0.9800
390226	07/01/92	06/30/93	1.6795	0.9987
390228	07/01/92	06/30/93	1.2042	0.9931
390229	07/01/92	06/30/93	1.4986	0.9944
390231	07/01/92	06/30/93	1.3378	0.9946
390233	07/01/92	06/30/93	1.3214	0.9917
390235	07/01/92	06/30/93	1.8300	0.9969
390236	07/01/92	06/30/93	1.2787	0.9826
390238	07/01/92	06/30/93	1.0505	0.9616
390242	07/01/92	06/30/93	1.3191	0.9910
390244	07/01/92	06/30/93	0.6874	0.9454
390245	07/01/92	06/30/93	1.3451	0.9920
390246	07/01/92	06/30/93	1.2021	0.9785
390247	07/01/92	06/30/93	1.0646	0.9865
390249	04/01/92	04/01/93	1.0139	0.9810
390252	07/01/92	06/30/93	0.4732	1.0000
390256	07/01/92	06/30/93	1.7536	0.9983
390258	07/01/92	06/30/93	1.2830	0.9938
390260	07/01/92	06/30/93	1.2642	0.9889
390261	07/01/92	06/30/93	2.9828	0.7079
390262	07/01/92	06/30/93	1.8488	0.9966
390263	07/01/92	06/30/93	1.5023	0.9920
390265	07/01/92	06/30/93	1.2943	0.9905
390266	07/01/92	06/30/93	1.1197	0.9815
390267	07/01/92	06/30/93	1.1940	0.9908
390268	07/01/92	06/30/93	1.2930	0.9887
390270	07/01/92	06/30/93	1.3133	0.9892
390275	07/01/92	06/30/93	0.4866	1.0000
390277	07/01/92	06/30/93	0.5078	0.9911
390278	07/01/92	06/30/93	0.8636	0.9790
400001	07/01/92	06/30/93	1.1794	0.9988
400003	07/01/92	06/30/93	1.1670	0.9984
400004	07/01/92	06/30/93	1.1947	0.9989
400006	07/01/92	06/30/93	1.2191	0.9980
400009	07/01/92	06/30/93	0.9768	0.9993
400012	07/01/92	06/30/93	1.0846	0.9989
400013	04/01/92	03/31/93	1.0349	0.9979
400015	07/01/92	06/30/93	1.2595	0.9993
400018	04/01/92	03/31/93	1.2494	0.9971
400021	06/01/92	05/31/93	1.3496	0.9992
400026	07/01/92	06/30/93	0.9066	0.9865
400027	04/01/92	03/31/93	1.1394	0.9991
400028	07/01/92	06/30/93	1.0538	1.0000
400031	07/01/92	06/30/93	1.0346	0.9803
400044	07/01/92	06/30/93	1.1728	0.9982
400048	07/01/92	06/30/93	1.0302	0.9968
400061	07/01/92	06/30/93	1.6316	0.9982
400079	07/01/92	06/30/93	1.2840	0.9969
400088	05/01/92	04/30/93	0.5187	1.0000
400102	07/01/92	06/30/93	1.1382	0.9970
400103	07/01/92	06/30/93	1.4768	0.9986
400104	07/01/92	06/30/93	1.2669	0.9986
400105	07/01/92	06/30/93	1.1923	0.9983
400110	07/01/92	06/30/93	1.1652	0.9963
400114	07/01/92	06/30/93	1.0306	0.9981
400121	07/01/92	06/30/93	0.5303	1.0000
400123	06/01/92	06/30/93	1.1224	0.9951
420002	05/01/92	04/30/93	1.3307	0.9861
420004	07/01/92	06/30/93	1.9096	0.9975
420006	07/01/92	06/30/93	1.2234	0.9846
420035	07/01/92	06/30/93	0.7510	0.9824
420053	07/01/92	06/30/93	1.0757	0.9710
420062	03/01/92	02/28/93	1.4748	0.9643
420079	04/01/92	03/31/93	1.5133	0.9991
420080	07/01/92	06/30/93	1.2817	0.9644
420082	03/01/92	02/28/93	1.3818	0.9928
420083	07/01/92	06/30/93	1.2119	0.9930

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
420084	07/01/92	06/30/93	1.2160	1.0000
420085	05/01/92	04/30/93	1.2855	0.9678
430004	03/01/92	02/28/93	1.1441	0.9718
430005	06/01/92	05/31/93	1.2176	0.9706
430007	07/01/92	06/30/93	1.1774	0.9523
430010	07/01/92	06/30/93	1.1655	0.9843
430011	07/01/92	06/30/93	1.3364	0.9701
430012	07/01/92	06/30/93	1.3191	0.9832
430018	07/01/92	06/30/93	0.9192	0.9502
430022	03/01/92	02/28/93	0.9614	0.9330
430025	03/01/92	02/28/93	0.9854	0.9421
430027	05/01/92	04/30/93	1.7075	0.9982
430029	05/01/92	04/30/93	1.0371	0.9550
430033	07/01/92	06/30/93	1.0833	0.9717
430037	07/01/92	06/30/93	0.9511	0.9742
430039	06/01/92	05/31/93	1.0682	0.9918
430042	02/01/92	01/31/93	1.0647	0.9741
430054	05/01/92	04/30/93	0.9771	0.9601
430062	06/01/92	05/31/93	0.8533	0.9719
430066	07/01/92	06/30/93	0.9785	0.9694
430077	07/01/92	06/30/93	1.5036	0.9971
440001	07/01/92	06/30/93	1.0915	0.9766
440002	07/01/92	06/30/93	1.6048	0.9983
440003	06/01/92	05/31/93	1.0884	0.9871
440006	07/01/92	06/30/93	1.3765	0.9978
440007	07/01/92	06/30/93	1.0196	0.9665
440009	07/01/92	06/30/93	1.0404	0.9718
440010	07/01/92	06/30/93	0.9436	0.9474
440011	07/01/92	06/30/93	1.2341	0.9873
440012	07/01/92	06/30/93	1.3046	0.9983
440014	07/01/92	06/30/93	1.0571	0.9538
440015	07/02/92	06/30/93	1.5169	0.9992
440016	07/01/92	06/30/93	0.9759	0.9825
440017	07/01/92	06/30/93	1.5511	0.9991
440019	07/01/92	06/30/93	1.5567	0.9996
440022	07/01/92	06/30/93	1.1395	0.9677
440023	07/01/92	06/30/93	0.9822	0.9635
440024	07/01/92	06/30/93	1.3110	0.9815
440025	07/01/92	06/30/93	1.1388	0.9832
440029	07/01/92	06/30/93	1.2412	0.9900
440030	07/01/92	06/30/93	1.1445	0.9627
440031	07/01/92	06/30/93	1.0411	0.9732
440032	07/01/92	06/30/93	0.9645	0.9682
440033	07/01/92	06/30/93	1.0660	0.9687
440035	07/01/92	06/30/93	1.2612	0.9866
440038	07/01/92	06/30/93	1.0009	0.9369
440039	07/01/92	06/30/93	1.5805	0.9968
440040	07/01/92	06/30/93	0.9473	0.9616
440051	07/01/92	06/30/93	0.9295	0.9836
440052	07/01/92	06/30/93	1.1913	0.9783
440053	07/01/92	06/30/93	1.2054	0.9794
440054	07/01/92	06/30/93	1.0314	0.9846
440056	07/01/92	06/30/93	1.0915	0.9703
440057	07/01/92	06/30/93	1.0077	0.9791
440059	07/01/92	06/30/93	1.1741	0.9641
440060	07/01/92	06/30/93	1.2047	0.9788
440063	07/01/92	06/30/93	1.5053	0.9974
440065	07/01/92	06/30/93	1.1591	0.9703
440069	07/01/92	06/30/93	1.1398	0.9964
440070	07/01/92	06/30/93	0.9806	0.9282
440073	07/01/92	06/30/93	1.3145	0.9863
440082	07/01/92	06/30/93	1.8562	0.9994
440084	07/01/92	06/30/93	1.1718	0.9778
440090	07/01/92	06/30/93	1.0750	0.9611
440102	07/01/92	06/30/93	1.0764	0.9717
440104	07/01/92	06/30/93	1.5395	0.9989
440109	07/01/92	06/30/93	1.1185	0.9452
440111	07/01/92	06/30/93	1.2333	0.9685
440114	07/01/92	06/30/93	1.0445	0.9732
440115	07/01/92	06/30/93	1.0482	0.9743
440121	07/01/92	06/30/93	1.0026	0.9839
440130	07/01/92	06/30/93	1.1325	0.9840
440131	07/01/92	06/30/93	1.0631	0.9661
440132	07/01/92	06/30/93	1.1203	0.9618
440133	07/01/92	06/30/93	1.4404	0.9987
440135	07/01/92	06/30/93	1.4303	0.9877
440137	07/01/92	06/30/93	1.0117	0.9667
440141	07/01/92	06/30/93	1.1723	0.9761
440142	07/01/92	06/30/93	1.0742	0.9772
440143	06/01/92	06/01/93	1.0227	0.9668
440144	06/01/92	06/01/93	1.2084	0.9678
440147	07/01/92	06/30/93	1.0362	1.0000
440151	05/01/92	04/30/93	1.2788	0.9627
440152	07/01/92	06/30/93	1.5562	0.9942
440153	07/01/92	06/30/93	1.2164	0.9693
440156	04/01/92	03/31/93	1.5440	0.9970
440160	07/01/92	06/30/93	0.8799	0.9609
440166	07/01/92	06/30/93	1.4280	0.9985
440170	06/01/92	06/01/93	1.3149	0.9890
440175	03/01/92	02/28/93	1.1675	0.9506
440176	03/01/92	02/28/93	1.2951	0.9934
440180	07/01/92	06/30/93	1.0799	0.9629
440183	03/01/92	02/28/93	1.5257	0.9993
440187	06/01/92	06/01/93	1.1850	0.9666
440192	05/01/92	04/30/93	1.1088	0.9263
440193	06/01/92	05/31/93	1.2509	0.9815
440197	06/01/92	05/31/93	1.3517	0.9878
440206	07/01/92	06/30/93	0.9041	0.9558
450004	07/01/92	06/30/93	1.1536	0.9905
450007	07/01/92	06/30/93	1.2710	0.9788
450008	04/01/92	03/31/93	1.3600	0.9893
450021	07/01/92	06/30/93	1.8807	0.9992
450023	07/01/92	06/30/93	1.3891	0.9977
450029	07/01/92	06/30/93	1.4218	0.9957
450031	04/01/92	03/31/93	1.7666	0.9949
450034	07/01/92	06/30/93	1.5010	0.9989
450035	07/01/92	06/30/93	1.4778	0.9992
450040	07/01/92	06/30/93	1.5594	0.9989
450042	07/01/92	06/30/93	1.6063	0.9962
450043	07/01/92	06/30/93	1.4497	0.9985
450044	07/01/92	06/30/93	1.5926	0.9985
450051	07/01/92	06/30/93	1.5383	0.9988
450052	07/01/92	06/30/93	1.1133	0.9811
450056	07/01/92	06/30/93	1.6473	0.9992
450060	07/01/92	06/30/93	1.3819	0.9890
450064	06/01/92	05/31/93	1.5531	0.9990
450078	04/01/92	03/31/93	0.9998	0.9649
450079	07/01/92	06/30/93	1.4714	0.9974
450090	07/01/92	06/30/93	1.1003	0.9837
450092	07/01/92	06/30/93	1.1585	0.9781
450096	07/01/92	06/30/93	1.4190	0.9975
450099	05/01/92	04/30/93	1.2020	0.9831
450102	07/01/92	06/30/93	1.6760	0.9971
450109	07/01/92	06/30/93	1.1462	0.9888
450113	06/01/92	05/31/93	1.2476	0.9897
450115	04/01/92	03/31/93	1.0520	0.9824
450126	03/01/92	02/28/93	1.3964	0.9704
450128	07/01/92	06/30/93	1.2333	0.9797
450143	07/01/92	06/30/93	1.0248	0.9524
450147	07/01/92	06/30/93	1.3569	0.9958
450157	03/01/92	02/28/93	1.0234	0.9783
450170	07/01/92	06/30/93	1.1074	0.9740
450177	07/01/92	06/30/93	1.1283	0.9712
450184	07/01/92	06/30/93	1.4709	0.9958
450188	04/01/92	03/31/93	1.0314	0.9639
450190	07/01/92	06/30/93	1.1661	0.9903
450192	06/01/92	05/31/93	1.0854	0.9690
450217	07/01/92	06/30/93	1.1092	0.9542
450219	06/01/92	05/31/93	1.0746	0.9641
450221	07/01/92	06/30/93	1.0233	0.9837
450222	04/01/92	03/31/93	1.7222	0.9959
450235	07/01/92	06/30/93	0.9603	0.9701
450241	06/01/92	05/31/93	0.8591	0.9336
450258	06/01/92	05/31/93	1.1491	0.9532
450269	05/01/92	04/30/93	1.0450	0.9543
450270	04/01/92	03/31/93	1.0889	0.9201
450278	07/01/92	06/30/93	1.0790	0.9728
450288	04/01/92	03/31/93	1.1797	0.9807
450289	04/01/92	03/31/93	1.3291	0.9958
450307	05/01/92	04/30/93	1.0674	0.9313
450309	06/01/92	05/31/93	1.0568	0.9369
450324	07/01/92	06/30/93	1.5651	0.9968
450325	07/01/92	06/30/93	1.2791	0.9739
450341	04/01/92	03/31/93	0.9691	0.9596
450349	07/01/92	06/30/93	1.1059	0.9719
450362	07/01/92	06/30/93	1.0115	0.9528
450365	07/01/92	06/30/93	0.8899	0.9805
450372	07/01/92	06/30/93	1.3187	0.9695
450376	07/01/92	06/30/93	1.4758	0.9966
450379	06/01/92	05/31/93	1.5684	0.9953
450381	04/01/92	03/31/93	0.9276	0.9707
450393	03/01/92	02/28/93	1.2805	0.9932
450395	07/01/92	06/30/93	1.0546	0.9566
450400	02/01/92	01/31/93	1.0925	0.9695
450411	07/01/92	06/30/93	0.9917	0.9469
450447	05/01/92	04/30/93	1.3034	0.9735
450451	07/01/92	06/30/93	1.0099	0.9515
450457	06/01/92	05/31/93	1.6648	0.9996
450460	07/01/92	06/30/93	1.0118	0.9677
450467	07/01/92	06/30/93	1.0175	0.9819
450469	07/01/92	06/30/93	1.2687	0.9951
450489	04/01/92	03/31/93	0.9594	0.9315
450497	07/01/92	06/30/93	1.1800	0.9834
450498	07/01/92	06/30/93	1.0240	0.9627
450508	07/01/92	06/30/93	1.5649	0.9956
450517	07/01/92	06/30/93	0.9498	0.9863
450537	06/01/92	05/31/93	1.3479	0.9827
450539	05/16/92	05/31/93	1.1952	0.9579
450545	07/01/92	06/30/93	1.2387	0.9911
450551	04/01/92	03/31/93	1.0443	0.9747
450563	07/01/92	06/30/93	1.2322	0.9864
450573	07/01/92	06/30/93	0.9766	0.9506
450586	07/01/92	06/30/93	1.0357	0.9867
450603	04/01/92	03/31/93	0.7893	0.9303
450610	04/01/92	03/31/93	1.4347	0.9970
450630	05/01/92	04/30/93	1.5186	0.9976
450638	06/01/92	05/31/93	1.5470	0.9973
450641	07/01/92	06/30/93	0.9676	0.9796
450643	07/01/92	06/30/93	1.1223	0.9933
450649	07/01/92	06/30/93	1.0213	0.9434
450651	04/01/92	03/31/93	1.8800	0.9972
450653	05/01/92	04/30/93	1.2438	0.9642
450658	07/01/92	06/30/93	1.0017	0.9797
450660	03/01/92	02/28/93	1.6422	0.9964
450665	07/01/92	06/30/93	0.9885	0.9778
450668	06/01/92	06/01/93	1.5576	0.9960
450669	07/01/92	06/30/93	1.2616	0.9860
450670	07/01/92	06/30/93	1.2937	0.9943
450674	03/01/92	02/28/93	0.8404	0.9908
450675	04/01/92	03/31/93	1.3580	0.9976
450678	06/01/92	06/01/93	1.5359	0.9974
450681	07/01/92	06/30/93	1.5801	0.9984
450683	05/01/92	04/30/93	1.3217	0.9745
450684	07/01/92	06/30/93	1.2727	0.9866
450688	06/01/92	05/31/93	1.3908	0.9845
450691	07/01/92	06/30/93	1.5692	0.9841
450704	07/01/92	06/30/93	1.3992	0.9858
450709	07/01/92	06/30/93	1.1264	0.9956
450723	07/01/92	06/30/93	1.2706	0.9913
450730	06/01/92	06/01/93	1.4356	0.9930
450732	07/01/92	06/30/93	1.1813	0.9651
450743	07/01/92	06/30/93	1.3875	0.9890
450749	07/01/92	06/30/93	1.0661	0.9742
450750	07/01/92	06/30/93	0.9770	0.9799
450755	06/01/92	05/31/93	1.1608	0.9720
450758	06/01/92	06/01/93	1.9720	0.9459
450765	01/01/92	01/07/93	0.9849	0.9858
450768	02/01/92	01/30/93	0.9866	0.9561
450770	07/01/92	06/30/93	1.0799	0.9963
450777	05/01/92	04/30/93	0.9897	0.9629
460003	06/01/92	05/31/93	1.5671	0.9974
460005	06/01/92	05/31/93	1.3665	0.9832
460008	03/01/92	02/28/93	1.3637	0.9765
460009	07/01/92	06/30/93	1.6864	0.9970
460030	02/01/92	01/31/93	1.1552	0.9708
460032	07/01/92	06/30/93	0.9708	0.9444
460035	07/01/92	06/30/93	0.9262	0.9665
460037	07/01/92	06/30/93	0.9978	0.9747
490007	05/01/92	04/30/93	2.0064	0.9987
490009	07/01/92	06/30/93	1.6661	0.9974
490010	06/30/92	06/30/93	1.0830	0.9734
490022	07/01/92	06/30/93	1.2419	0.9896
490028	04/01/92	03/31/93	1.3215	0.9912
490032	07/01/92	06/30/93	1.6777	0.9980
490035	07/01/92	06/30/93	1.1231	0.9911
490043	07/01/92	06/30/93	1.2379	0.9886
490046	05/01/92	04/30/93	1.4315	0.9886
490053	07/01/92	06/30/93	1.2728	0.9687
490090	07/01/92	06/30/93	1.2207	0.9874
490093	05/01/92	04/30/93	1.2643	0.9964
490094	05/01/92	04/30/93	1.2157	0.9983
490098	07/01/92	06/30/93	1.3142	0.9800
490104	07/01/92	06/30/93	0.9386	0.9832
490105	07/01/92	06/30/93	0.6961	1.0000
490106	07/01/92	06/30/93	0.8337	0.9874
490108	07/01/92	06/30/93	0.8341	0.9798
490109	07/01/92	06/30/93	0.8459	0.9903
490111	07/01/92	06/30/93	1.1800	0.9752
490114	07/01/92	06/30/93	1.0656	0.9806
490118	04/01/92	03/31/93	1.6885	0.9993
490119	05/01/92	04/30/93	1.3510	0.9881
490120	07/01/92	06/30/93	1.3402	0.9882

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
490123	04/01/92	03/31/93	1.1586	0.9662
490124	07/01/92	06/30/93	1.1936	0.9958
490127	07/01/92	06/30/93	1.0392	0.9828
490131	07/01/92	06/30/93	0.9756	0.9578
500008	07/01/92	06/30/93	1.9026	0.9968
500021	06/30/92	06/30/93	1.4523	0.9743
500023	06/30/92	06/30/93	1.2184	0.9738
500030	07/01/92	06/30/93	1.3254	0.9898
500039	04/30/92	04/30/93	1.2836	0.9930
500041	07/01/92	06/30/93	1.2695	0.9824
500064	06/30/92	06/30/93	1.5758	0.9852
500086	07/01/92	06/30/93	1.3654	0.9875
500104	04/01/92	03/31/93	1.2517	0.9747
500108	06/30/92	06/30/93	1.6495	0.9976
500127	07/01/92	06/30/93	0.6565	0.9917
500137	05/31/92	05/31/93	0.7430	0.9842
500139	02/01/92	01/31/93	1.3796	0.9802
500141	06/30/92	06/30/93	1.3345	0.9851
510015	07/01/92	06/30/93	0.9473	0.9613
510020	07/01/92	06/30/93	1.0912	0.9765
510023	07/01/92	06/30/93	1.0458	0.9686
510024	07/01/92	06/30/93	1.3772	0.9970
510025	07/01/92	06/30/93	0.9382	0.9591
510026	07/01/92	06/30/93	0.9843	0.9722
510027	07/01/92	06/30/93	1.0453	0.9606
510035	06/30/92	06/30/93	0.9781	0.9602
510036	07/01/92	06/30/93	0.9717	0.9456
510043	07/01/92	06/30/93	1.0250	0.9721
510046	07/01/92	06/30/93	1.2387	0.9936
510058	07/01/92	06/30/93	1.2040	0.9941
510061	07/01/92	06/30/93	1.0451	0.9662
510062	06/30/92	06/30/93	1.2588	0.9789
510070	06/01/92	05/31/93	1.1771	0.9895
510071	07/01/92	06/30/93	1.2677	0.9883
510072	07/01/92	06/30/93	1.0404	0.9784
510080	07/01/92	06/30/93	1.0998	0.9741
510086	07/01/92	06/30/93	1.0268	0.9817
520004	07/01/92	06/30/93	1.2064	0.9952
520006	02/29/92	02/28/93	1.0614	0.9635
520007	07/01/92	06/30/93	1.0769	0.9773
520009	07/01/92	06/30/93	1.6359	0.9975
520011	03/31/92	03/31/93	1.1708	0.9771
520013	07/01/92	06/30/93	1.3203	0.9896
520015	07/01/92	06/30/93	1.1714	0.9576
520016	07/01/92	06/30/93	1.0954	0.9568
520017	07/01/92	06/30/93	1.2136	0.9805
520025	07/01/92	06/30/93	1.1169	0.9771
520027	07/01/92	06/30/93	1.1780	0.9706
520028	07/01/92	06/30/93	1.3518	0.9867
520030	07/01/92	06/30/93	1.6482	0.9950
520040	07/01/92	06/30/93	1.3951	0.9949
520041	07/01/92	06/30/93	1.2040	0.9606
520044	07/01/92	06/30/93	1.3641	0.9842
520047	03/31/92	03/31/93	0.9911	0.9423
520051	07/01/92	06/30/93	1.9318	0.9991
520063	07/01/92	06/30/93	1.1796	0.9754
520066	07/01/92	06/30/93	1.2811	0.9883
520068	07/01/92	06/30/93	0.9665	0.9626
520074	07/01/92	06/30/93	1.1130	0.9379
520075	07/01/92	06/30/93	1.4633	0.9965
520076	07/01/92	06/30/93	1.1256	0.9816
520087	04/12/92	04/11/93	1.5710	0.9988
520088	07/01/92	06/30/93	1.2548	0.9640
520091	03/31/92	03/31/93	1.2669	0.9686
520092	04/30/92	04/30/93	1.1171	0.9635
520094	07/01/92	06/30/93	1.1033	0.9756
520096	07/01/92	06/30/93	1.5581	0.9973
520097	07/01/92	06/30/93	1.3035	0.9884
520098	07/01/92	06/30/93	1.7623	0.9963
520111	07/01/92	06/30/93	1.1029	0.9636
520112	07/01/92	06/30/93	1.1911	0.9584
520114	07/01/92	06/30/93	1.1236	0.9674
520120	07/01/92	06/30/93	1.0263	0.9769
520121	07/01/92	06/30/93	0.9624	0.9611
520122	07/01/92	06/30/93	1.0255	0.9772
520124	03/31/92	03/31/93	1.1282	0.9533
520134	07/01/92	06/30/93	1.0756	0.9643
520136	07/01/92	06/30/93	1.5163	0.9979
520141	07/01/92	06/30/93	1.1473	0.9573
520142	07/01/92	06/30/93	0.9741	0.9726
520151	02/29/92	02/28/93	1.1121	0.9570
520159	03/31/92	03/31/93	0.8914	0.9376
520161	03/31/92	03/31/93	1.0449	0.9532
520170	07/01/92	06/30/93	1.2388	0.9838

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
520176	07/01/92	06/30/93	0.7693	0.9956
520178	07/01/92	06/30/93	1.1122	0.9777
530001	06/01/92	06/01/93	1.4372	0.9965
530002	07/01/92	06/30/93	1.1496	0.9787
530003	07/01/92	06/30/93	0.8946	0.9557
530004	07/01/92	06/30/93	0.9446	0.9597
530005	07/01/92	06/30/93	1.0813	0.9601
530006	07/01/92	06/30/93	1.1766	0.9805
530009	07/01/92	06/30/93	1.0409	0.9861
530011	07/01/92	06/30/93	1.1362	0.9732
530012	07/01/92	06/30/93	1.6426	0.9980
530014	07/01/92	06/30/93	1.2638	0.9942
530015	07/01/92	06/30/93	1.1491	0.9822
530016	07/01/92	06/30/93	1.1933	0.9675
530017	07/01/92	06/30/93	0.9340	0.9600
530018	07/01/92	06/30/93	0.9974	0.9544
530019	07/01/92	06/30/93	1.0261	0.9833
530022	07/01/92	06/30/93	1.1367	0.9395
530025	07/01/92	06/30/93	1.2699	0.9846
530026	07/01/92	06/30/93	1.0857	0.9567
530027	07/01/92	06/30/93	0.9347	0.9304
530029	07/01/92	06/30/93	0.9317	0.8996
530031	07/01/92	06/30/93	0.8887	0.9511

Appendix A—Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA)(5 U.S.C. 601 through 612), unless the Secretary certifies that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area or New England County Metropolitan Area.

Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent New England County Metropolitan Area. Thus, for purposes of the prospective payment system, we classified these hospitals as urban hospitals.

It is clear that the changes being proposed in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

II. Objectives

The primary objective of the prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs and at the same time ensure that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of deficit reduction and restraints on government spending in general.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality care for beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are, in general, reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 1995, on various hospital groups. We estimate the effects of each policy change by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix.

As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on the prospective payment system, and our methodology for estimating them.

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. We have included in our analysis only hospitals paid under these systems. There were 47 Indian Health Service Hospitals in our database, which we excluded from the analysis

due to the special characteristics of the payment method for these hospitals. Only 55 short-term, acute care hospitals remain excluded from the prospective payment system under section 1814(b)(3) of the Act (in Maryland) or a demonstration project (in the Finger Lakes region of New York State). Thus, as of April 1994, just over 5,200 hospitals were receiving prospectively based payments for furnishing inpatient services. This represents about 81 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 19 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs, subject to a rate-of-increase ceiling on their inpatient operating costs per discharge. These hospitals include psychiatric, rehabilitation, long-term care, children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals is discussed below.

V. Impact on Excluded Hospitals and Units

As of April 1994, just under 2,000 specialty hospitals are excluded from the prospective payment system and are instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. In addition, 1,932 psychiatric and rehabilitation units in hospitals that are subject to the prospective payment system and 9 hospitals extensively involved either in the treatment of cancer or in cancer research are also excluded from the prospective payment system and paid in accordance with § 413.40.

In accordance with section 13502 of Public Law 103–66, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 1995 would be the hospital market basket minus 1.0 percentage point, adjusted to account for the relationship between the hospital's allowable operating cost per case and its target amounts. We are projecting an increase in the excluded hospital market basket of 3.7 percent.

The impact on excluded hospitals and units of the proposed update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital and excluded unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limit, the major effect will be the amount of excess costs that the hospitals would have to absorb.

In this context, we note that § 413.40(d)(3) allows an excluded hospital or unit whose costs exceed the rate-of-increase limit to receive the lower of its rate-of-increase ceiling plus 50 percent of reasonable costs in excess of the ceiling, or 110 percent of its ceiling. In addition, under the various provisions set forth in § 413.40, excluded hospitals and units can obtain substantial relief from the rate-of-increase limit for significant, yet justifiable, increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases to the growth rate in the hospital market basket, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

In this proposed rule, we would establish new exclusion criteria for long-term care hospitals that define a minimum level of independence a new hospital must have to qualify for exclusion from the prospective payment system (see section VI.A. of the preamble). We anticipate that this change would slow the proliferation of such hospitals in the future. The likely result of this change is that some patients who might otherwise have been treated in long-term care hospitals that are excluded from the prospective payment system will instead be treated in prospective payment hospitals. Thus, their care will be paid for under the prospective payment system rather than under the TEFRA provisions of section 1886(b) of the Act. Although we cannot quantify the impact of this change on Medicare payments to hospitals, we anticipate that it would result in a small decrease in aggregate payment levels.

We are proposing to remove from the regulations the "1986 malpractice rule" as explained in section VI.B of the preamble. This proposal is a technical change that is necessary to conform the codified Medicare regulations to the various authorities that have previously established that the malpractice rule is invalid. This proposed conforming change would not, standing alone, have significant economic effects.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate analyses of the proposed changes to each system, beginning with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1993 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate any actual cost data, the most recently available hospital cost report data were used to create some of the variables by which hospitals are categorized. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these proposed policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

The simulations estimate total payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service Hospitals, hospitals in the New York Finger Lakes demonstration project, and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not estimated here. Estimated payment impacts of proposed FY 1995 changes to the capital prospective payment system are discussed later in this impact analysis.

The proposed changes discussed separately below are the following:

- The effects of eliminating the separate rural standardized amount by

setting it equal to the other urban amount, as required by section 1886(b)(3)(B)(i)(X) of the Act.

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the FY 1991 wage data.
- The effects of changing the transfer payment policy to a graduated per diem and revising the definition of transfers to include cases going from hospitals or units paid under the prospective payment system to hospitals or units that are excluded from the prospective payment system.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board that are effective in FY 1995.
- The effects of phasing out payments for extraordinarily lengthy cases (day outlier cases) by 25 percent (with a corresponding increase in payments for extraordinarily costly cases (cost outliers)) and establishing a fixed-loss threshold for cost outliers, in accordance with section 13501(c) of Public Law 103–66, as well as the effects of increasing the marginal cost factor applicable to cost outlier payments from 75 to 80 percent.
- The total change in payments based on estimated FY 1995 total payments relative to estimated FY 1994 total payments.

To illustrate the impacts of the FY 1995 proposed changes, our FY 1995 baseline simulation model uses: the FY 1994 GROUPER (version 11.0); wage indexes based on FY 1990 wage data; the current transfer payment policy; no effects of FY 1995 reclassifications; and current outlier policy. To illustrate the effects of eliminating the rural standardized amount, the rural amount in the FY 1995 baseline is updated by the same update applied to the urban amounts (1.1 percent), to maintain the current differential. The FY 1995 baseline also includes the higher disproportionate share hospital (DSH) payments as described above and the elimination of the special protection for Medicare-dependent, small rural hospitals (MDHs). Outliers are estimated to be 5.1 percent of total DRG payments.

Each policy change is then added incrementally to this baseline, finally arriving at an FY 1995 model incorporating all of the proposed changes. This analysis then compares the percent changes in payments per case due to each change. This allows us to isolate the effects of each change from the overall change in payments from FY 1994 to FY 1995.

Several policy changes that would occur during FY 1995 are not modeled separately but are shown as combined changes from FY 1994 to FY 1995. These changes are:

- The proposed update factor applied to the standardized amounts (other than the differential update to the rural amount that is modeled in Column 1).
- Effective for discharges occurring on or after October 1, 1994, section 1886(d)(5)(F)(vii)(I)(d) of the Act requires an increase in the DSH payment adjustment to urban hospitals with 100 or more beds and for rural hospitals with 500 or more beds, that have a DSH patient percentage greater than 20.2.
- The special payment protection for MDHs is not applicable after FY 1994. (Section 1886(d)(5)(G)(i) of the Act as amended by section 13501(e) of Pub. L. 103–66).

Finally, when comparing our estimated FY 1994 payments to FY 1995 payments, another significant consideration is that we currently estimate that outlier payments during FY 1994 will be 4.0 percent of total DRG payments. When the FY 1994 final rules were published September 1, 1993 (58 FR 46270), we estimated FY 1994 outlier payments would be 5.1 percent of total DRG payments. The effects of the lower than expected outlier payments during FY 1994 are reflected in the analyses below comparing our current estimates of FY 1994 total payments to estimated FY 1995 payments.

Finally, we also compare the changes in payments from FY 1994 to FY 1995. In this comparison, our FY 1994 baseline reflects payment policies during the current year. The FY 1995 simulation similarly reflects the combination of the statutory and proposed changes to go into effect during FY 1995.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 5,248 hospitals included in the analysis. This is 54 fewer hospitals than were included in the impact analysis in the FY 1994 final rule (58 FR 46270). (Data for 80 hospitals that were included in last year's analysis were not available for analysis this year; however, data were available this year for 26 hospitals for which data were not available last year.) The next four rows of Table I contain hospitals categorized according to their geographic location (all urbans as well as large urban and other urban or rural). There are 2,947 hospitals located in urban areas (MSAs) included in our analysis. Among these, there are 1,616 hospitals located in large urban areas (populations over 1 million), and 1,331 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,301 hospitals in rural areas. The next two groupings are by bed size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows changes in payments based on hospitals' FY 1995 payment classifications, including any reclassifications under sections 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural, show the numbers of hospitals being paid based on these categorizations, after consideration of geographic reclassifications, are 3,252, 1,830, 1,422, and 1,996, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive DSH payments, or some combination of these two adjustments. There are 4,197 nonteaching hospitals in our analysis, 829 with fewer than 100 residents, and 222 with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status based on how they will be paid during FY 1995. That is, hospitals located in rural counties that have been reclassified as urban by the MGCRB for purposes of assigning the standardized amount are categorized here as urban, since they are considered urban in determining the amount of their DSH adjustment. The rural DSH hospitals, therefore, including those in the rural referral center and sole community hospital categories, represent hospitals that were not reclassified for purposes of the standardized amount. The next category groups hospitals paid on the basis of the urban standardized amount in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next six rows examine the impacts of the proposed changes on rural hospitals by special payment groups (sole community hospitals, rural referral centers, and MDHs). Rural hospitals reclassified for FY 1995 for

purposes of the standardized amount are not included here with the exception of the MDH row. This row includes all hospitals that were paid under the MDH provision during FY 1994 in order to isolate the impact of ending this provision. Of the 415 hospitals shown in this row, 3 are located in a county now designated as urban under the 1993 MSA definitions, and 39 others have been reclassified for either the standardized amount, the wage index, or both.

The rural referral centers (138), sole community hospitals (578), and rural referral center/sole community hospitals (54) shown here were not reclassified for purposes of the standardized amount. There are 19 rural referral centers and 27 sole community hospitals that would be reclassified for the standardized amount in FY 1995 and are therefore not included in these columns. In addition, one hospital that is both a rural referral center and a sole community hospital will be reclassified for the standardized amount.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken from the Medicare cost report files, the latest available being FY 1992. Data needed to calculate Medicare utilization percentages were unavailable for 66 hospitals. For the most part, these are either new hospitals or hospitals filing manual cost reports that are not yet entered into the data base.

The next series of groupings concern the geographic reclassification status of hospitals. The first three rows display hospitals that were reclassified by the MGCRB for either FY 1994 or FY 1995, or for both years. One effect of eliminating the separate rural standardized amount in FY 1995 is to reduce the number of standardized amount reclassifications. The next rows illustrate the overall number of reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments per case]

	No. of hosps.[1]	Eliminate rural standard amount[2] (1)	DRG recalibration[3] (2)	New wage data[4] (3)	Transfer policy changes[5] (4)	MGCRB reclassification[6] (5)	OBRA 93 outlier changes[7] (6)	All FY95 changes[8] (7)
By Geographic Location								
All hospitals	5,248	0.7	0.0	0.0	0.0	0.0	0.0	3.0
Urban hospitals	2,947	0.4	0.1	−0.1	−0.1	−0.4	0.0	2.9
Large urban	1,616	0.4	0.0	0.0	−0.2	−0.6	−0.1	2.9
Other urban	1,331	0.3	0.1	−0.1	−0.1	−0.1	0.1	3.0
Rural areas	2,301	2.9	−0.1	0.0	0.5	2.3	−0.1	3.8
Bed Size (urban)								
0–99 beds	733	0.4	−0.1	−0.4	0.3	−0.4	−0.1	2.4
100–199 beds	922	0.4	0.0	−0.3	0.0	−0.4	−0.1	2.6
200–299 beds	610	0.4	0.0	−0.2	−0.1	−0.3	0.0	2.7
300–499 beds	493	0.4	0.1	0.0	−0.2	−0.5	0.1	3.0
500 or more beds	189	0.4	0.1	0.2	−0.2	−0.3	0.0	3.4
Bed Size (rural)								
0–49 beds	1,187	4.6	−0.2	−0.1	0.9	−0.1	0.0	4.5
50–99 beds	687	4.1	−0.1	−0.1	0.6	0.7	−0.1	4.1
100–149 beds	227	3.0	−0.1	−0.1	0.4	3.2	−0.1	3.5
150–199 beds	106	1.8	0.0	0.0	0.2	3.6	−0.1	3.6
200 or more beds	94	1.0	0.1	0.1	0.1	4.7	−0.1	3.3
Urban by Region								
New England	170	0.4	0.1	1.0	−0.2	−0.3	−0.2	3.3
Middle Atlantic	440	0.4	0.1	0.3	−0.2	−0.5	−0.5	2.8
South Atlantic	436	0.3	0.1	0.1	0.0	−0.4	0.0	3.3
East North Central	491	0.3	0.0	0.2	−0.1	−0.2	0.1	3.2
East South Central	167	0.3	0.1	−0.1	0.0	−0.5	0.3	3.2
West North Central	198	0.3	0.1	−0.2	−0.2	−0.5	0.1	2.6
West South Central	383	0.3	0.0	−1.1	−0.3	−0.5	0.4	2.3
Mountain	120	0.3	0.1	−1.1	−0.3	−0.4	0.2	1.5
Pacific	493	0.4	0.0	−0.3	0.0	−0.2	0.1	3.0
Puerto Rico	49	0.8	0.1	−7.7	0.1	−0.5	0.3	−4.7
Rural by Region								
New England	53	1.8	0.1	0.0	0.4	1.6	−0.2	2.9
Middle Atlantic	85	1.6	0.1	0.2	0.2	0.8	−0.3	1.9
South Atlantic	298	3.2	−0.1	0.1	0.5	3.2	−0.1	5.4
East North Central	310	3.1	0.0	0.3	0.5	1.8	−0.1	3.1
East South Central	286	3.5	−0.1	−0.4	0.5	3.4	−0.1	5.3
West North Central	536	3.2	−0.1	0.0	0.6	2.5	0.0	3.6
West South Central	359	3.5	−0.1	−0.3	0.5	2.4	0.0	2.4
Mountain	224	1.7	−0.1	−0.2	0.4	0.6	0.0	3.3
Pacific	145	2.1	−0.1	0.1	0.4	1.8	0.0	3.6
Puerto Rico	5	18.0	−0.2	−10.7	0.1	−0.6	0.1	−0.8

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments per case]

	No. of hosps.[1]	Eliminate rural standard amount[2] (1)	DRG recalibration[3] (2)	New wage data[4] (3)	Transfer policy changes[5] (4)	MGCRB reclassification[6] (5)	OBRA 93 outlier changes[7] (6)	All FY95 changes[8] (7)
By Payment Categories								
Urban hospitals	3,252	0.4	0.1	0.0	−0.1	−0.2	0.0	2.9
Large urban	1,830	0.5	0.0	0.0	−0.1	−0.2	−0.1	3.0
Other urban	1,422	0.4	0.1	−0.2	−0.1	−0.2	0.1	2.8
Rural hospitals	1,996	2.8	−0.1	−0.1	0.5	1.6	−0.1	3.7
Teaching Status								
Non-teaching	4,197	1.0	0.0	−0.2	0.1	0.3	0.0	3.1
Less than 100 res.	829	0.4	0.1	0.0	−0.2	−0.3	0.0	2.8
100+ residents	222	0.4	0.1	0.3	−0.2	−0.3	−0.1	3.3
Disproportionate Share Hospitals (DSH)								
Non-DSH	3,341	0.8	0.0	−0.1	0.0	0.0	0.1	3.0
Urban DSH:								
100 beds or more	1,355	0.4	0.0	0.0	−0.1	−0.1	−0.1	3.0
Fewer than 100 beds	143	1.6	−0.3	−0.4	0.4	0.3	0.0	3.1
Rural DSH:								
Sole Community (SCH)	133	3.3	−0.2	−0.4	0.8	−0.2	−0.1	3.8
Referral Centers (RRC)	47	0.1	0.0	0.0	0.2	3.4	−0.1	3.0
Other Rural DSH Hosp:								
100 beds or more	66	5.9	−0.1	−0.3	0.6	0.6	−0.1	4.4
Fewer than 100 beds	163	6.0	−0.2	−0.3	0.8	0.2	0.0	6.4
Urban teaching and DSH:								
Both teaching and DSH	645	0.4	0.1	0.1	−0.2	−0.4	−0.1	3.0
Teaching and no DSH	361	0.4	0.1	0.1	−0.2	−0.4	0.2	3.1
No teaching and DSH	853	0.5	0.0	−0.3	0.0	0.3	0.0	3.0
No teaching and no DSH	1,393	0.5	0.0	−0.3	0.0	−0.2	0.0	2.7
Rural Hospital Types:								
Nonspecial status hospitals	845	5.7	−0.1	−0.2	0.6	0.7	−0.1	5.3
RRC	138	0.2	0.1	0.1	0.1	4.3	−0.1	2.7
SCH	578	1.8	−0.2	−0.3	0.7	0.1	0.0	3.9
Medicare-dependent hospital	415	5.7	−0.1	−0.1	0.8	0.1	−0.1	0.9
SCH and RRC	54	0.0	−0.1	0.0	0.2	1.9	−0.1	2.9
Type of Ownership:								
Voluntary	3,282	0.6	0.1	0.0	−0.1	−0.1	0.0	3.0
Proprietary	753	0.7	−0.1	−0.6	0.0	0.2	0.1	3.0
Government	1,213	1.2	0.0	0.0	0.1	0.1	−0.1	3.3
Medicare Utilization as a Percent of Inpatient Days								
0–25	305	0.5	0.0	−0.3	0.0	−0.3	0.0	2.9
25–50	1,471	0.5	0.1	0.0	−0.1	−0.2	0.0	3.1
50–65	2,244	0.8	0.0	−0.1	0.0	0.2	0.0	3.1
Over 65	1,162	1.1	0.0	−0.1	0.1	−0.2	−0.1	2.7
Unknown	66	0.6	−0.1	0.3	−0.6	−0.2	−1.4	2.2
Hospitals Reclassified by the Medicare Geographic Review Board								
Reclassification Status During FY 94 and FY 95:								
Reclassified during both FY 94 and FY 95	484	1.2	0.0	−0.1	0.1	4.3	0.1	2.9
Urban	189	0.4	0.0	−0.3	0.0	2.3	0.1	3.0
Rural	295	3.0	0.0	0.1	0.3	8.5	−0.1	2.7
Reclassified during FY 95 only	215	1.2	0.1	0.1	0.2	4.1	0.1	9.3
Urban	47	0.4	0.1	0.1	0.1	2.5	0.3	8.4
Rural	168	2.1	0.0	0.0	0.3	6.0	−0.1	10.3
Reclassified during FY 94 only	209	1.4	0.0	0.0	0.1	−0.8	−0.3	−2.1
Urban	60	0.4	0.1	0.1	0.0	−1.1	−0.4	−0.9
Rural	149	2.6	−0.1	−0.2	0.4	−0.5	−0.1	−3.6
FY 95 Reclassifications:								
All reclassified hosp.	699	1.2	0.0	−0.1	0.1	4.2	0.1	4.5
Urban	236	0.4	0.1	−0.2	0.0	2.3	0.2	4.2

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments per case]

	No. of hosps.[1]	Eliminate rural standard amount[2] (1)	DRG recalibration[3] (2)	New wage data[4] (3)	Transfer policy changes[5] (4)	MGCRB reclassification[6] (5)	OBRA 93 outlier changes[7] (6)	All FY95 changes[8] (7)
Rural	463	2.7	0.0	0.1	0.3	7.7	−0.1	5.0
All nonreclassified hospitals	4,522	0.6	0.0	0.0	−0.1	−0.6	0.0	2.8
Urban	2,711	0.4	0.1	0.0	−0.1	−0.6	0.0	2.8
Rural	1,811	3.1	−0.1	−0.1	0.5	−0.5	−0.1	3.2
Other reclassified hospitals (Section 1886(d)(8)(B))	27	0.5	0.0	−0.6	0.3	0.4	−0.2	2.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Hospital-specific data and discharges data are from FY 1993, and hospital cost report data are from reporting periods beginning in FY 1992.

[2] This column illustrates the changes in FY 1995 payments due to the elimination of the separate rural standardized amount by adjusting the rural amount to equal the other urban amount, in accordance with section 1886(d)(3)(A) of the Act.

[3] This column displays the payment impacts of the recalibration of the DRG weights and classification changes, based on FY 1993 MedPAR data, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1991 cost reports.

[5] This column displays the effects of the changes to transfer policy. It compares payments under our current policy with those resulting by changing the per diem methodology and revising the definition of transfers to include cases going to excluded hospitals or units.

[6] Shown here are the combined effects of geographic reclassification by the Medicare Geographic Classification Review Board (MGCRB). The effects shown here are exclusive of payment changes from FY 1994 to FY 1995, and therefore do not factor into the percent changes shown in Column 7.

[7] This column displays the impacts of the outlier change in accordance with section 13501(c) of Pub. L. 103–66.

[8] This column shows changes in payments from FY 1994 to FY 1995. It incorporates all of the changes displayed in columns 1 through 6. It also displays the updates to the FY 1995 standardized amounts, change in hospitals' reclassification status in FY 1995 compared to FY 1994, the effects of the higher DSH payments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, the elimination of the Medicare-dependent, small rural hospital provision, and the difference in projected outlier payments from FY 1994 to FY 1995. The sum of the first six columns plus these effects may be slightly different from the percentage changes shown here, due to rounding errors and interactive effects.

B. The Elimination of the Separate Rural Standardized Amount (Column 1)

Section 1886(d)(3)(A) of the Act provides that, beginning in FY 1995, the rural standardized amount is equal to the other urban standardized amount. Section 1886(b)(3)(B)(i)(X) of the Act, as amended by section 13501(a)(1) of Public Law 103–66, provides that the update to the urban standardized amounts for FY 1995 will equal the market basket rate of increase minus 2.5 percentage points, and the update to the rural standardized amount is the amount necessary to set the rural amount equal to the other urban amount. We project the market basket increase to be 3.6 percent, so the proposed update to the large and other urban standardized amounts is 1.1 percent and the proposed update to the rural standardized amount is 8.4 percent (the market basket rate of increase of 3.6 percent plus 4.8 percent).

The process undertaken to set the rural amount equal to the other urban amount, as well as the overall methodology used to determine the FY 1995 proposed standardized payment amounts, is described in the Addendum to this proposed rule. As described there, the net increase in rural hospitals' FY 1995 standardized payment amount compared to FY 1994 is less than 8.4 percent. The difference between the proposed FY 1995 payment rate for rural hospitals and their FY 1994 amount is 4.6 percent. This smaller net increase can be attributed to changing from separate urban and rural outlier offsets (applicable to the previously separate rates) to a single offset after the rural rate is eliminated.

To illustrate, for FY 1994, the difference between the other urban and rural final standardized amounts was 3.0 percent. These amounts reflected the differential outlier adjustment factors applied to the urban and rural standardized amounts of 0.945960 and 0.977157, respectively (See the September 1, 1993 final rule (58 FR 46349.) Similarly, section 1886(d)(8)(D) of the Act necessitated different urban and rural budget neutrality factors for geographic reclassification. Removing these differential adjustments from the FY 1994 standardized amounts, and updating the urban amounts by 1.1 percent, increases the difference between the other urban and rural amounts from 3.0 percent to 8.4 percent.

Section 1886(d)(3)(B) requires the Secretary to adjust both the large urban and other national standardized amounts by the same outlier adjustment factor beginning in FY 1995. Estimated outlier payments equal 5.1 percent of estimated total DRG payments, so a 5.1 percent offset is applied to the standardized amounts. For FY 1994, the rural outlier offset was 2.3 percent, 2.8 percent smaller than the 5.1 percent offset for FY 1995. For FY 1995, the increase in the size of the outlier offset for rural hospitals reduces the effect of the higher standardized amount.

The FY 1995 baseline employs differential outlier offsets to the separate urban and rural amounts. The net difference between the rural and other urban amounts after applying these differential offsets to the FY 1995 baseline rates (without any of the other budget neutrality factors) is 4.3 percent. Because the urban amount increases by 0.3 percent when the 5.1 national outlier offset is applied rather than the larger urban outlier offset, the net increase in the rural standardized amount to bring it up to the other urban amount is 4.6 percent.

Finally, in addition to equating the other urban and rural amounts through a higher rural update and a single outlier offset, a national labor share (the portion of the standardized amounts adjusted by the wage index) is necessary to maintain the elimination of the separate amounts. For FY 1994, the rural labor share represents 75.6 percent of the rural standardized amount, while

the urban labor share comprises about 70.8 percent of the large and other urban amounts. For FY 1995, we are proposing to determine the labor portion of the standardized amounts based on a national average labor share of 71.4 percent.

Column 1 displays the payment changes resulting from eliminating the rural amount, modeled by comparing payments simulated using our FY 1995 baseline model described earlier to simulated payments after eliminating the separate rural amount. The impacts of the higher update to the standardized amount for rural hospitals are evident. Overall, hospitals located in rural counties experience a 2.9 percent increase in payments from this change, compared to a 0.4 percent rise in payments to urban hospitals. Nationally, payments per case are estimated to rise 0.7 percent as a result of this change.

The 2.9 percent increase for hospitals in rural areas is below the 4.6 percent increase in the standardized amount for several reasons. First, this row includes all hospitals that are located in rural areas, but some rural hospitals receive a higher urban payment rate. This is reflected in the "Rural Hospital Types" rows. Rural referral centers (RRCs) have only a 0.2 percent payment effect resulting from this change. These hospitals currently receive the other urban amount and, therefore, do not gain directly from the elimination of the rural amount. They do apparently benefit slightly from the smaller outlier offset applied to the urban standardized amounts. Another rural hospital group experiencing only a relatively small impact from this change is sole community hospitals (SCHs). Their payments rise 1.8 percent, well below that for most other rural hospital groups. Because these hospitals are paid based on the greater of their applicable Federal rate or their hospital-specific rate, increasing the Federal rate has an impact upon only those SCHs that would be paid based on that rate. Of the 578 SCHs in this row, 435 are paid on the basis of their hospital-specific rate in our FY 1995 baseline model. When the rural amount is eliminated by making it equal to the other urban amount, only 66 SCHs switch from their hospital-specific rate to the Federal rate. This explains the below average payment change compared to other rural hospitals.

Conversely, nonspecial status rural hospitals, and rural hospitals receiving DSH all experience above average payment gains (between 5.7 percent and 6.0 percent). This effect appears to be primarily attributable to the decrease in the labor share of the standardized amount. In fact, substituting the current higher rural labor share on both models in this comparison reduces the payment gains for these hospital groups to 4.6 percent (except for MDHs, which fall to 4.4 percent).

The row demonstrating the largest benefit from this change is rural Puerto Rico, with an 18.0 percent increase. This stems from the calculation of separate payment rates for Puerto Rico's hospitals, which are equal to 75 percent of the Puerto Rico rate plus 25 percent of the discharge-weighted average of the urban and rural national prospective payment system rates. For FY 1994, for example, the Puerto Rico rate for other urban areas was 26.6 percent greater than the Puerto Rico rural rate. The increase in the national Puerto Rico amount is much smaller, however, so that the payment effect is less than the full increase in the rural Puerto Rico rate. Urban hospitals in Puerto Rico also receive an added increase in payments above those of other urban hospitals, due to the higher national portion. It is far below the rural Puerto Rico increase, however.

For urban hospitals nationally, the change in payments is slightly above the percentage change in the outlier offsets when moving to a single 5.1 percent offset. The FY 1994 urban outlier adjustment factor was 0.945960, which results in a 5.404 percent offset. To lower the offset to 5.1 percent, an adjustment factor of 0.949 is applied to the standardized amounts. The difference between these two factors is 0.3 percent. The increase in the labor share also has a generally favorable impact on urban hospitals due to their above average wage index values.

Eliminating the separate rural amount also has the effect of redistributing outlier payments, primarily due to the higher standardized amount paid to rural hospitals. The average rural outlier payment per case falls by 3.0 percent after eliminating the separate rural amount, and the average urban outlier payment per case rises by 0.4 percent. This occurs because fewer rural cases qualify for outlier payments due to the higher DRG payments per case; thus, the outlier thresholds must be revised to maintain the outlier pool at 5.1 percent of total DRG and outlier payments. This leads to additional outlier payments going to outlier cases in urban hospitals.

The fact that many of these cases are also in teaching hospitals and DSH hospitals leads to what we consider an anomalous impact on total payments. Pursuant to section 1886(d)(5)(A)(iv) of the Act, we set outlier payment policies so that estimated outlier payments are 5.1 percent of estimated total DRG payments. Under the statute, estimated outlier payments do not encompass IME and DSH payments made for outlier cases. The amounts of IME and DSH payments are affected by the level of outlier payments so a redistribution of outlier payments to teaching and DSH hospitals has the effect of generating a net increase in total payments.

C. The Impact of the Proposed Changes to the DRG Weights (Column 2)

In column 2 of Table I, we present the combined effects of the revised DRG classification system, and the subsequent recalibration of the DRG weights incorporating these revised DRGs, as discussed in section II of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us each year to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The impact of reclassification and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral.

The first row of Table I shows that the overall effect of these proposed changes is budget neutral. That is, the percentage change when adding the proposed FY 1995 GROUPER (version 12.0) to the FY 1995 baseline is 0.0. Since the changes illustrated in the columns of Table I are cumulative, this column reflects the elimination of the separate rural amount in both simulations. Only the version of the GROUPER is different.

Consistent with the minor changes we are proposing for the FY 1995 GROUPER, the redistributional impacts across hospital groups are very small (an increase of 0.1 for urban hospitals and a decrease of 0.1 for rural hospitals). Among other hospital categories, the net effects are slightly negative changes for small hospitals and slightly positive changes for larger hospitals. The largest single effect on any of the hospital categories examined is a 0.3 percent decrease in payments for rural DSH hospitals with fewer than 100 beds.

D. The Impact of Updating the Wage Data (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 1995 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1990 and before October 1, 1991.

As with the previous two columns, the impact of the new data on hospital

payments is isolated by holding the other payment parameters constant in the two simulations. That is, the table shows the percentage changes in payments when going from our FY 1995 baseline—using the FY 1994 wage index before geographic reclassifications based on 1990 wage survey data, eliminating the separate rural rate and incorporating the FY 1995 GROUPER—to a model substituting the FY 1995 pre-reclassification wage index based on 1991 data as described above.

Section 1886(d)(3)(E) of the Act also requires that any updates or adjustments to the wage index 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 requirements that the DRG and wage index changes must be implemented in a budget neutral manner, we compute a budget neutrality adjustment factor to apply to the standardized amounts. For the FY 1995 proposed amounts, this adjustment factor is 0.997647. This factor is applied to the standardized amounts in this column to ensure that the overall effect of the wage index changes are budget neutral.

The results indicate that the new wage data do not have a significant overall impact on urban and rural hospitals. As discussed in section III of the preamble to this proposed rule, 86.4 percent of all prospective payment system hospitals would experience a change in their wage index of less than 5 percent. This column demonstrates that hospitals with significant changes in their wage indexes are not concentrated within any particular hospital group. In contrast, the impact analysis of the final FY 1994 operating prospective payment system changes displayed numerous hospital groups with payment changes in excess of 2.0 percent due to the new wage survey data (58 FR 46459). For FY 1995, some of the largest changes are evident among urban hospitals grouped by census division. New England urban hospitals' payments rise 1.0 percent, while payments per case for urban hospitals in the West North Central and Mountain census divisions fall by 1.1 percent. The most dramatic shifts occur in Puerto Rico, where payments decline by 10.7 percent in rural hospitals and 7.7 percent in urban hospitals. These effects are attributable to data corrections. We note that the FY 1994 payment effect of the new wage data was an 11.6 percent increase for rural Puerto Rico hospitals.

This decline in the wage index values for Puerto Rico hospitals also appears to be the main cause for the 0.6 percent drop in payments among proprietary hospitals. The 20 hospitals with the greatest drop in their wage index within this category are all located in Puerto Rico. Also experiencing a 0.6 percent decline in payments per case are hospitals in rural counties deemed to be urban under section 1886(d)(8)(B) of the Act. This impact appears to be primarily related to 2 hospitals experiencing nearly 20 percent declines in their wage index values.

E. Transfer Changes (Column 4)

In column 4 of Table I, the impacts of the changes we are proposing in transfer payment policy are shown. These changes would revise our methodology for payment for transfer cases under the prospective payment system to more appropriately compensate transferring hospitals for the higher costs they incur, on average, on the first day of a hospital stay prior to transfer. Our current transfer policy pays a flat per diem amount for each day prior to transfer up to the full DRG amount. The per diem is calculated by dividing the amount that would be paid for a patient assigned to the same DRG who is discharged from the hospital, and dividing that amount by the geometric mean length of stay for that DRG. Our proposal is to replace this flat per diem methodology with a graduated methodology that would pay twice the per diem amount for the first day, and the per diem amount for each day beyond the first.

In addition, we are proposing to expand our definition of transfer cases to include patients transferred from a hospital or unit paid under the prospective payment system to a hospital or unit excluded from the prospective payment system. Currently, these case are considered to be discharges. Under this proposed change, these cases would be paid in accordance with our transfer policy, including the proposed change to the graduated payment methodology described above.

The payment impacts shown in column 4 illustrate the combined effects of these two changes, relative to the baseline simulation based on current policy (a flat per diem transfer payment methodology and cases transferred to excluded hospitals and units are paid as discharges). In order to simulate the effects of the proposed changes, it was necessary to identify current transfer cases, as well as current discharges going to an excluded hospital or unit. Current transfers are identifiable by the discharge destination code on the patient bill (see "Transfers of Medicare Hospital Patients Under the Prospective Payment System", RAND, PM–191–HCFA, January 1994, for a thorough discussion of identifying transfer cases on the MedPAR file).

Next, to determine whether payment would be made under the per diem methodology, we compared the actual length of stay prior to transfer to the geometric mean length of stay for the DRG to which the case is assigned. A full discharge or a transfer case that received the full discharge payment would be counted as 1.0, while, under our current transfer policy, a transfer case that stayed 2 days in a DRG with a geometric mean length of stay of 5 days would count as 0.4 of a discharge. To determine the transfer adjustment factor, we then added together these adjusted discharges and divided by total discharges, including transfers. In this manner, transfer cases are counted only to the extent that the transferring hospital received payment for them. To simulate our proposed change to the per diem payment methodology, we added 1 day to the actual length of stay for transfer cases, thereby replicating paying double the per diem for the first stay and the flat per diem, up to the full DRG amount, for subsequent days.

Finally, we calculated transfer-adjusted case-mix indexes for each hospital. The adjusted case-mix indexes are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted number of cases. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the fraction of the length of stay for the case divided by the geometric mean length of stay for the DRG. By adjusting the DRG weights, nontransfer cases and transfer cases that have a length of stay at least as long as the geometric mean length of stay will be represented by the full DRG weight, while transfer cases with lengths of stay below the geometric mean length of stay for the DRG will be represented by a lower number, reflective of their payment.

The FY 1995 baseline model reflected in columns 1 through 3 incorporates transfer-adjusted discharges and case-mix indexes based on current law. That is, cases transferred prior to reaching the geometric mean length of stay received payments based on the flat per diem and cases discharged to excluded hospitals and units received the full DRG amount. In column 4, our model substitutes transfer-adjusted discharges and case-mix indexes that reflect our proposed policy changes.

The first row in column 4 shows that the net effect of our proposed changes is budget neutral compared to total payments under current transfer policy. RAND estimated the number of transfers under the prospective payment system

during FY 1991 to be about 230,000. Our analysis indicates that, applying current policy, the number of cases during FY 1993 counted as discharges to excluded hospitals or units is approximately 190,000. Our preliminary analysis indicates that these latter cases are more likely to be surgical cases, and thus are more expensive on average than cases that are currently defined as transfers. Thus, redefining discharges to excluded hospitals as transfers and paying them accordingly generates savings sufficient to offset the higher per diem payments for the first day of all transfer cases.

The distributional effects of theses changes are to increase payments to rural hospitals by 0.5 percent and decrease urban hospitals' payments by 0.1 percent (that is, −0.2 percent for large urban and −0.1 percent for other urban). Rural hospitals clearly benefit from changing the per diem payment methodology. RAND found that rural hospitals as a whole transfer 4.5 percent of their patients, compared to 1.7 percent in large urban hospitals and 1.6 percent in other urban hospitals. Therefore, one would expect rural hospitals to benefit disproportionately from the change to the per diem payment methodology.

The impact on small hospitals is also positive, consistent with RAND's finding that hospitals with fewer than 50 beds transfer 6.1 percent of their cases, and hospitals with 50 to 99 beds transfer 4.9 percent of cases. These groups also benefit relative to larger hospitals. Rural hospitals with fewer than 50 beds receive a 0.9 percent increase in per case payments, and rural hospitals with 50 to 99 beds receive a 0.6 percent increase. Urban hospitals with fewer than 100 beds experience a 0.3 percent rise in payments. Among rural hospital groups, SCHs and current MDHs realize increases of 0.7 and 0.8 percent, respectively.

Due to the much larger proportion of overall payments that go to urban hospitals, a smaller percentage change in their payments is enough to offset the higher payments going to hospitals that send out a relatively higher percentage of transfers. The reduction in payments for urban hospitals comes from the proposed change in the definition of transfers to include cases going to excluded hospitals and units, as well as other hospital settings such as Veterans Administration hospitals and nonparticipating hospitals. The hospital group with the largest single negative impact is the "Unknown" Medicare utilization category, a 0.6 percent decline. This is primarily due to two or three hospitals with 5.0 to 8.0 percent decreases in their per case payment level. The next largest negative impacts are among urban hospitals in the West North Central and West South Central census divisions, each with a −0.3 percent change.

F. Impacts of MGCRB Reclassifications (Column 5)

By March 30 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may reclassify a hospital to an adjacent urban area or to a 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. (An RRC or an SCH may be redesignated to an area that is not an adjacent county.)

To this point, all of the simulation models have assumed hospitals are paid on the basis of their geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as RRCs and hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1995. As noted above, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, hospitals reclassified for the standardized amount also qualify to be treated as urban for purposes of the DSH adjustment.

The proposed FY 1995 standardized payment amounts and wage index values incorporate all of the MGCRB's reclassification decisions that will be effective for FY 1995. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of March 30, 1994. Additional changes that result from the Administrator's review of MGCRB decisions will be incorporated into the wage index values and standardized payment amounts published in the final rule implementing changes to the prospective payment system for FY 1995.

The overall effect of geographic reclassification is required to be budget neutral by section 1886(d)(8)(D) of the Act. Prior to FY 1995, the Secretary was required to adjust the urban standardized amounts so as to ensure that total aggregate payments under the prospective payment system after geographic reclassification were equal to the aggregate payments that would have been made absent these provisions. The rural standardized amounts were also adjusted to ensure that aggregate payments to rural hospitals were not affected by reclassifications. Due to the elimination of the separate rural amount beginning October 1, 1994, the Secretary is required to provide a single budget neutrality adjustment to the standardized amounts for the effects of reclassification. We applied an adjustment of 0.993814 to ensure that the effects of reclassification are budget neutral.

Rural hospitals benefit disproportionately from geographic reclassification. Their payments rise 2.3 percent, while payments to urban hospitals decline 0.4 percent. Rural referral centers experience a 4.3 percent increase overall as a result of reclassification. Of the 138 hospitals in this category, 52 are reclassified for the wage index. This positive impact on RRCs also appears in the category of rural hospitals with 200 or more beds, which have a 4.7 increase in payments.

Large urban hospitals lose 0.6 percent because, as a group, they have the smallest percentage of hospitals that are reclassified, fewer than 6 percent. There are enough hospitals in other urban areas that are reclassified to limit the decline in payments to this groups to 0.1 percent. Consequently, their payments are reduced by the budget neutrality factor. Among urban hospital groups generally, payments fall between 0.3 and 0.5 percent.

Among hospitals grouped by reclassification status during FY 1994 and FY 1995, the changes are predictable. Hospitals reclassified for FY 1994 but not for FY 1995 experience lower payments when reclassification is taken into account compared to the previous column. Because the rural payment rate now equals the other urban amount, the loss of reclassification is not as detrimental in rural areas. Payments to formerly reclassified rural hospitals fall by 0.5 percent, compared to a decline of 1.1 percent for urban hospitals reclassified in FY 1994 but not in FY 1995. Significant positive impacts are evident for hospitals reclassified for FY 1995. Rural hospitals reclassified for FY 1995 that were not reclassified for FY 1994 experience a 6.0 percent payment increase, and rural hospitals reclassified during both years experience an 8.5 percent increase.

Table II compares reclassified hospital payments for FY 1995 with payment levels that assume reclassified hospitals are paid on the basis of their geographic location rather than reclassified location. The difference between Table

II and Column 5 in Table I is that the simulations in Table II incorporate all of the policy changes we are proposing for FY 1995, as well as the statutory changes, before and after reclassification. Specifically, Column 5 in Table I does not include the outlier change enacted by section 13501(c) of Public Law 103–66. This change is reflected in the simulations in Table II.

TABLE II.—EFFECTS ON PAYMENTS PER CASE OF GEOGRAPHIC RECLASSIFICATION OF HOSPITALS UNDER CURRENT RECLASSIFICATION POLICIES

	Number of hospitals	(a) Payment per case without reclassification[1]	(b) Payment per case after reclassification	(c) Percent change in payment per case due to reclassification only[2]
FY 95 reclassifications	699	5,560	5,793	4.2
All reclassified hospitals:				
Standardized amount only	298	5,034	5,118	1.7
Wage index only	203	5,263	5,670	7.7
Both	198	6,264	6,489	3.6
All urban reclassified hospitals	236	6,691	6,842	2.3
Standardized amount only	61	6,253	6,285	0.5
Wage index only	24	8,180	8,646	5.7
Both	151	6,613	6,760	2.2
All reclassified rural hospitals	463	4,263	4,588	7.6
Standardized amount only	237	3,987	4,115	3.2
Wage index only	179	4,496	4,888	8.7
Both	47	4,161	4,851	16.6
All nonreclassified hospitals	4,522	6,350	6,312	−0.6
Urban non-reclassified hospitals	2,711	6,771	6,729	−0.6
Rural non-reclassified hospitals	1,811	3,958	3,940	−0.5

[1] This column shows payments without regard to any previous MGCRB reclassification decision. All other FY 1995 policy changes are included.

[2] This column only shows the percentage change in payments resulting from decisions of the MGCRB for FY 1995. All other FY 1995 policy changes are included in both simulation models.

Table II shows the changes in payments per case for all FY 1995 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). It illustrates that the large impact for reclassified rural hospitals is due to reclassifications for both the standardized amount and the wage index. These hospitals receive a 16.6 percent increase. In addition, rural hospitals reclassified for the wage index only receive an 8.7 percent payment increase. The overall impact on reclassified hospitals would be to increase their payments per case by an average of 4.2 percent for FY 1995.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that were not reclassified, the overall impact of hospital reclassifications would be an average decrease in payments per case of about 0.6 percent, approximately the geographic reclassification budget neutrality factor. Rural nonreclassified hospitals decrease slightly less, experiencing a 0.5 percent decrease. This occurs because the wage index values in some rural areas increase after reclassified hospitals are excluded from the calculation of those index values.

The number of reclassifications for the standardized amount have not declined from FY 1994. This is surprising because, with the elimination of the separate rural amount, rural hospitals would seem to have less to gain from reclassifying for the standardized amount. Of course, some of them are hospitals reclassifying for the large urban amount, thereby receiving a payment rate even higher than they would receive from the other national amount. Rural hospitals also may wish to reclassify for the standardized amount even though they are only eligible to reclassify to an other urban area in order to either meet the lower eligibility requirements for DSH payments, or to receive higher DSH payments. The payment impact upon hospitals reclassified for the standardized amount only, however, is significantly lower than it is for hospitals reclassifying for either the wage index alone, or for both the wage index and the standardized amount.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by March 30 of this year. As previously noted, there will be changes to some MGCRB decisions through the appeals and review process. The outcome of these cases may affect the final results of our analysis, which we will present in the final rule.

G. Outlier Changes (Column 6)

Medicare provides extra payment in addition to the regular DRG payment amount for extremely costly or extraordinarily lengthy cases (cost outliers and day outliers, respectively). Section 13501(c) of Public Law 103–66 requires the Secretary to phase out payment for day outliers in 25 percent increments beginning in FY 1995. This reduction in day outlier payments will be offset by an increase in payments for cost outliers. The statute also requires the Secretary to establish a fixed loss per case threshold for cost outliers instead of a threshold based on a fixed multiple of the DRG payment amount or other fixed dollar amount. For FY 1995, we are proposing that a case would receive cost outlier payment if costs exceed the DRG amount plus $23,300. We are also proposing to increase the marginal cost factor for cost outliers from 75 to 80 percent.

The payment impacts of this change are minimal. The largest impacts appear to be related to geographic location in terms of census divisions. Urban

hospitals in the Middle Atlantic census division have payment reductions of 0.5 percent per case. Rural Middle Atlantic hospitals have a 0.3 percent decline. In New England, both urban and rural hospitals experience decreases of 0.2 percent. Since the changes to outlier policy result in a shift in payments from cases paid as day outliers to cases paid as cost outliers, this indicates that these areas have higher percentages of day outliers. This is consistent with our previous analysis indicating above average impacts related to day outlier policy changes in the northeastern portion of the country (see the June 4, 1992 proposed rule, 57 FR 23824).

The largest negative impact occurs among hospitals for which we could not determine Medicare utilization rates. This group experiences a 1.4 percent fall in payments per case. This appears to be primarily attributable to 9 hospitals whose outlier payment percentages fall by more than 20 percent.

H. All Changes (Column 7)

Column 7 compares our estimate of payments per case for FY 1995 to our estimate of payments per case in FY 1994. It includes all of the changes discussed in the previous columns. It also includes the impacts of statutory differences from FY 1994 to FY 1995. These differences were noted in the introduction. Specifically, they are: an increase in DSH payments to urban hospitals with 100 or more beds and to rural hospitals with 500 or more beds, and the elimination of the MDH provision. This column also displays the impact of the 1.1 percent lower than estimated outlier payments during FY 1994, also described in the introduction and the Addendum.

Another change from FY 1994 is that there is no budget neutrality adjustment to account for midyear wage index corrections. Last year's adjustment factor was 0.998188. In addition, a single geographic reclassification budget neutrality factor was applied to the proposed FY 1995 standardized amounts of 0.993814. The FY 1994 factors applied to the urban and rural amounts, respectively, were 0.992529 and 0.999472. Finally, the budget neutrality adjustment factor for the updated wage index and the DRG recalibration is 0.997647, compared to the FY 1994 factor of 0.999003. Although the net effect of these changes are small, they have an effect on the payment differences shown in this column.

Column 7 also reflects the 1.1 percent updates to the urban standardized amounts. The increase in differential payments to rural hospitals that results from eliminating the rural amount is shown in Column 1. 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 7 may not equal the sum of the previous columns plus the other impacts that we are able to identify. We also note that the percent changes associated with geographic reclassification decisions by the MGCRB shown in Column 5 are not included in the percent changes shown here, since Column 5 reflects the impacts of geographic reclassifications relative to the FY 1995 baseline rather than the FY 1994 reclassifications. The impacts of FY 1994 geographic reclassifications relative to the payment impacts of FY 1995 reclassifications are shown in Column 5.

The impact on all hospitals is a 3.0 percent increase in payments from FY 1994. The net change in total payments due to the proposed changes for FY 1995 shown in columns 1 through 6 is 0.7 percent, due to the elimination of the rural standardized amount. After accounting for the 1.1 percent update to the urban standardized amounts, the move to a single outlier offset, and a smaller overall geographic reclassification budget neutrality factor, the difference between the FY 1994 final standardized amounts and the FY 1995 proposed standardized amounts is 1.5 percent. As described in the discussion of the impacts of eliminating the rural amount, the portion of this increase due to the smaller outlier offset is already reflected in the changes shown in Column 1. In addition, the update to the hospital-specific rate for SCHs is 1.4 percent in FY 1995. The average increase in payments due to updates that is shown in Column 7 and not in Column 1 is about 1.2 percent.

Other significant changes that have not been isolated in the previous columns include the following:

- A 1.1 percent higher level of outlier payments is estimated for FY 1995.
- The increase in the DSH formula for FY 1995 results in approximately a 0.1 percent increase in total payments.
- The effect of eliminating the MDH provision is a 3.1 percent decline in payments for this group of hospitals, and a 0.2 percent decline for rural hospitals. The impact on total payments is essentially zero.

As a geographic group, hospitals in rural areas experience the largest payment increase, a 3.8 percent rise in payments per case over FY 1994. The increase in estimated outlier payments over FY 1994 for rural hospitals is 0.4 percent, below the 1.1 percent difference for all hospitals. As we noted in the discussion of Column 5, eliminating the rural amount would be expected to reduce the numbers and effects of geographic reclassification. While the number of FY 1995 reclassifications does not appear to have fallen, however, the payment effects are less than they would have been without eliminating the rural amount. One sees this effect in Column 7 when examing the rows containing rural hospitals reclassified during both FY 1994 and FY 1995 and rural hospitals reclassified during FY 1994 only. The 295 hospitals in the former category experience an overall increase of 2.7 percent, closer to that of urban hospitals, and the 149 hospitals in the latter category experience a 3.6 percent decline in payments per case.

Hospitals in large and other urban areas experience 2.9 percent and 3.0 percent increases, respectively. Urban hospitals are affected the most by the change in outlier payments from FY 1994 to FY 1995, a 1.2 percent increase. They also receive the bulk of the increase in DSH payments, a 0.1 percent increase. Urban hospitals receive a net increase due to FY 1995 geographic reclassifications relative to FY 1994 reclassifications. Again, examining the rows grouping hospitals by their reclassification status for FY 1994 and FY 1995, urban hospitals reclassified for both years have payment increases above those of rural hospitals, and urban hospitals reclassified for FY 1994 but not FY 1995 do not lose as much as rural hospitals.

Among urban bed size groups, Column 7 shows changes in payments ranging from 2.4 percent for the smallest hospitals to 3.4 percent for the largest hospitals. The relatively smaller increases for the smaller urban hospitals appears to be due to the negative impacts of the new wage data, as shown in Column 3. Larger urban hospitals appear to benefit from the large increase due to geographic reclassifications in FY 1995 for 4 hospitals that were not reclassified in FY 1994.

The reverse occurs for rural hospitals. Among the smallest rural hospitals (fewer than 50 beds), the effects of changes in reclassification from FY 1994 to FY 1995 are negated by similar numbers of hospitals gaining and losing reclassification from one year to the next. The payment changes for larger rural hospitals are smaller primarily because they do not benefit to the same extent from the elimination of the rural standardized amount. They do, however, tend to benefit from geographic reclassification in FY 1995 compared to FY 1994.

TABLE III.—IMPACT ANALYSIS OF FINAL OPERATING COST PROSPECTIVE PAYMENT SYSTEM CHANGES FOR FY 1995

	No. of hospitals	Average FY 1994 payment per case	Average FY 1995 payment per case	All changes
	(1)	(2)	(3)	(4)
(By Geographic Location):				
All Hospitals	5,248	6,051	6,235	3.0
Urban Hospitals	2,947	6,549	6,739	2.9
Large Urban Areas (Populations Over 1 Million)	1,616	7,064	7,268	2.9
Other Urban Areas (Populations of 1 Million or Fewer)	1,331	5,877	6,050	3.0
Rural Areas	2,301	4,005	4,158	3.8
Bed Size (Urban):				
0–99 Beds	733	4,476	4,586	2.4
100–199 Beds	922	5,555	5,699	2.6
200–299 Beds	610	6,049	6,213	2.7
300–499 Beds	493	6,925	7,130	3.0
500 or More Beds	189	8,468	8,754	3.4
Bed Size (Rural):				
0–49 Beds	1,187	3,326	3,475	4.5
50–99 Beds	687	3,717	3,870	4.1
100–149 Beds	227	4,159	4,304	3.5
150–199 Beds	106	4,212	4,364	3.6
200 or More Beds	94	4,893	5,054	3.3
Urban by Region:				
New England	170	6,855	7,084	3.3
Middle Atlantic	440	7,278	7,484	2.8
South Atlantic	436	6,207	6,414	3.3
East North Central	491	6,301	6,504	3.2
East South Central	167	5,728	5,913	3.2
West North Central	198	6,216	6,379	2.6
West South Central	383	6,037	6,175	2.3
Mountain	120	6,399	6,496	1.5
Pacific	493	7,443	7,669	3.0
Puerto Rico	49	2,582	2,461	−4.7
Rural by Region:				
New England	53	4,747	4,887	2.9
Middle Atlantic	85	4,530	4,616	1.9
South Atlantic	298	4,096	4,318	5.4
East North Central	310	4,017	4,142	3.1
East South Central	286	3,651	3,843	5.3
West North Central	536	3,749	3,886	3.6
West South Central	359	3,702	3,789	2.4
Moutain	224	4,276	4,418	3.3
Pacific	145	4,888	5,065	3.6
Puerto Rico	5	1,899	1,885	−0.8
(By Payment Categories):				
Urban Hospitals	3,252	6,450	6,640	2.9
Large Urban Areas (Populations Over 1 Million)	1,830	6,910	7,118	3.0
Other Urban Areas (Populations of 1 Million or Fewer)	1,422	5,723	5,884	2.8
Rural Areas	1,996	3,978	4,126	3.7
Teaching Status:				
Non-Teaching	4,197	5,002	5,156	3.1
Fewer Than 100 Residents	829	6,497	6,680	2.8
100 or More Residents	222	10,037	10,367	3.3
Disproportionate Share Hospitals (DSH):				
Non–DSH	3,341	5,355	5,517	3.0
Urban DSH:				
100 Beds or More	1,355	7,111	7,323	3.0
Fewer Than 100 Beds	143	4,257	4,389	3.1
Rural DSH:				
Sole Community (SCH)	133	3,826	3,972	3.8
Referral Centers (RRC)	47	4,915	5,063	3.0
Other Rural DSH Hosp.:				
100 Beds or More	66	3,724	3,886	4.4
Fewer Than 100 Beds	163	3,168	3,371	6.4
Urban Teaching and DSH:				
Both Teaching and DSH	645	8,106	8,347	3.0
Teaching and no DSH	361	6,685	6,894	3.1
No Teaching and DSH	853	5,669	5,841	3.0
No Teaching and no DSH	1,393	5,192	5,331	2.7
Rural Hospital Types:				
Nonspecial Status Hospitals	845	3,493	3,678	5.3

TABLE III.—IMPACT ANALYSIS OF FINAL OPERATING COST PROSPECTIVE PAYMENT SYSTEM CHANGES FOR FY 1995—Continued

	No. of hospitals	Average FY 1994 payment per case	Average FY 1995 payment per case	All changes
	(1)	(2)	(3)	(4)
RRC	138	4,701	4,826	2.7
SCH	578	4,040	4,199	3.9
Medicare-Dependent Hospitals (MDH)	415	3,357	3,389	0.9
SCH and RRC	54	4,760	4,899	2.9
Type of Ownership:				
Voluntary	3,282	6,177	6,362	3.0
Proprietary	753	5,523	5,688	3.0
Government	1,213	5,769	5,961	3.3
Medicare Utilization as a Percent of Inpatient Days				
0–25	305	8,114	8,351	2.9
25–50	1,471	7,150	7,373	3.1
50–65	2,244	5,479	5,648	3.1
Over 65	1,162	4,827	4,955	2.7
Unknown	66	9,367	9,572	2.2
Hospitals Reclassified by the Medicare Geographic Review Board:				
Reclassification Status During FY94 and FY95:				
Reclassified During Both FY94 and FY95	484	5,714	5,882	2.9
Urban	189	6,639	6,841	3.0
Rural	295	4,499	4,621	2.7
Reclassified During FY 95 Only	215	5,076	5,547	9.3
Urban	47	6,315	6,846	8.4
Rural	168	4,093	4,516	10.3
Reclassified During FY94 Only	209	5,588	5,473	−2.1
Urban	60	7,173	7,112	−0.9
Rural	149	4,375	4,218	−3.6
FY 95 Reclassifications:				
All Reclassified Hosp	699	5,544	5,792	4.5
Urban	236	6,568	6,842	4.2
Rural	463	4,370	4,588	5.0
All Nonreclassified Hospitals	4,522	6,138	6,312	2.8
Urban	2,711	6,547	6,729	2.8
Rural	1,811	3,818	3,940	3.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	27	4,314	4,407	2.1

Table III presents the projected average payments per case under the changes for FY 1995 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments for FY 1995 with the average estimated per case payments for FY 1994. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. That is, the percentage changes shown in the last column of Table I equal the percentage changes in average payments from October 1, 1993 to October 1, 1994.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have data that were unavailable in previous impact analyses. Specifically, we have cost report data for the first year of the capital prospective payment system (cost reports beginning in FY 1992) available through the December 1993 update of the Hospital Cost Report Information System (HCRIS). We also have information on the aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of such information affects 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 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. Under § 412.302(c), a hospital was required to notify its intermediary that it has obligated capital, no later than 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. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met 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. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital

expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of aggregate projected obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments to be used in the FY 1995 capital cost projections. We discuss in Appendix B the assumptions and computations we employ to generate the amount of obligated capital commitments for use in the FY 1995 capital cost projections.

In Table IV of this appendix, we present the redistributive effects that are expected to occur between "hold-harmless" hospitals and "fully prospective" hospitals in FY 1995. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of FY 1995 capital payment policies by the standard 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 and cost report data for most hospitals, we need to generate randomly numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. This means that we continue to be unable to predict accurately an individual hospital's FY 1995 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.

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 the aggregate impact of the FY 1995 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 Based on the Proposed FY 1995 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1994 to FY 1995 using a capital acquisition model. The FY 1995 model, described in Appendix B of this proposed rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have available capital cost data from cost reports beginning in FY 1989, FY 1990, FY 1991 and FY 1992 received through the December 1993 update of the Hospital Cost Reporting Information System (HCRIS), interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through January 1, 1994 in the Provider-Specific file. We used this data to determine the proposed FY 1995 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1992, and we age that capital by a formula described in Appendix B. We therefore need to generate randomly only new capital acquisitions for any year after FY 1992. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 1995 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will increase at the following rates during these periods:

AVERAGE PERCENTAGE INCREASE IN CAPITAL

Fiscal year	Costs per discharge
1994	4.65
1995	5.70

- The Medicare case-mix index will increase by 1.5 percent in FY 1994 and FY 1995, and 2.0 percent in FY 1996 and later.
- The Federal capital rate as well as the hospital-specific rate will be updated by the 2-year moving average increase in Medicare capital costs per case, net of case-mix change increase, between FY 1990 and FY 1992. The proposed FY 1995 update for inflation is 2.22 percent (see Addendum, Part III).
- Consistent with the budget neutrality constraints provided in section 1886(g)(1)(A) of the Act, estimated aggregate Medicare payments for capital costs in FY 1995 will equal 90 percent of the amount that would have been payable on a reasonable cost basis. The budget neutrality adjustment factor will be applied to the Federal and hospital-specific rates only and not to the hold-harmless state payment for old capital.

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1994 to FY 1995. To show the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals, we are presenting separately in Table IV the results of our simulation for these hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY

Type of hospital	Percent of hospitals	FY 1995 percent of discharges	FY 1995 percent of capital costs	FY 1995 percent of capital payments
Low Cost Hospital	64	59	48	50
High Cost Hospital	36	41	52	50

A low capital 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 (within the limits established in § 412.302(e) for putting obligated capital in use for patient care). 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 became a hold-harmless payment hospital as a result of a redetermination, we have continued to show these hospitals as low capital cost hospitals in Table IV.

Assuming no behavioral changes in capital expenditures, Table IV displays the percentage change in payments from FY 1994 to FY 1995 using the above described actuarial model.

TABLE IV.—NPRM CAPITAL BUDGET NEUTRALITY FOR FY 1994–1995

[Impact of Proposed Changes for FY 1995 on Capital Payments per Discharge]

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment
FY 1994 Payments Per Discharge								
Low Cost Hospitals	3,331	6,075,449	$188.43	31.44	$256.05	$38.19	$4.79	$487.46
Fully Prospective	1,983	3,674,477	180.29	30.00	379.22		1.75	461.26
Rebase—Fully Prospective	1,065	1,889,463	178.10	30.00	280.31		10.98	469.38
Rebase—100% Federal Rate	113	201,450	587.19	100.00				587.19
Rebase—Hold Harmless	170	310,059	88.75	14.29		748.25	6.28	843.28
High Cost Hospitals	1,893	4,176,293	317.53	51.81		410.64	3.43	731.60
100% Federal Rate	737	1,722,137	622.83	100.00				622.98
Hold Harmless	1,156	2,454,156	103.30	17.05		698.79	5.74	807.83
Total hospitals	5,224	10,251,742	241.02	39.85	151.74	189.91	4.24	586.92

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
FY 1995 Payments Per Discharge									
Low Cost Hospitals	3,331	6,075,449	$233.89	40.06	$209.78	$48.20	$10.66	$502.54	3.09
Fully Prospective	1,983	3,674,477	230.42	40.00	228.76		3.07	462.25	0.21
Rebase—Fully Prospective	1,065	1,889,463	228.05	40.00	229.67		26.82	484.54	3.23
Rebase—100% Federal Rate	115	204,758	564.42	100.00			1.90	566.32	−3.55
Rebase—Hold Harmless	168	306,752	90.90	15.03		954.72	7.87	1,053.48	24.93
High Cost Hospitals	1,893	4,176,293	329.84	54.88		407.48	4.67	742.00	1.42
100% Federal Rate	758	1,788,585	611.51	100.00			0.14	611.65	−1.82
Hold Harmless	1,135	2,387,708	118.85	20.04		712.72	8.07	839.64	3.94
Total hospitals	5,224	10,251,742	272.98	46.60	124.32	194.56	8.22	600.09	2.24

Under section 1886(g)(1)(A) of the Act, aggregate payments under the capital prospective payment system for FY 1992 through 1995 respectively, are to equal 90 percent of what would have been payable on a reasonable cost basis in each year. (See Addendum, Part III for a full discussion of the capital budget neutrality provision.) Currently, we project that in FY 1994 aggregate payments under the capital prospective payment system will be 93.05 percent of reasonable costs, or 3.05 percentage points higher than the 90 percent target. We also estimate an increase in capital cost per case of 5.70 percent from FY 1994 to FY 1995. To achieve budget neutrality in FY 1995, we estimate there would be an aggregate 2.24 percent increase in FY 1995 Medicare capital payments over the FY 1994 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 3.09 percent, and high capital cost hospitals will experience an average increase of 1.42 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 30 percent to 40 percent and the hospital-specific rate payment percentage will decrease from 70 to 60 percent in FY 1995.

The Federal rate payment percentage for a hospital paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for those hospitals receiving a hold-harmless payment for old capital will increase from 17.05 percent to 20.04 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 39 percent to 40 percent.

The average hospital-specific rate payment per discharge falls from $151.74 in FY 1994 to $124.32 in FY 1995. A decline in the average hospital-specific rate payment per discharge from FY 1994 to FY 1995 is to be expected because of the reduction in the hospital-specific rate blend percentage and the 5.76 percent decrease in the hospital-specific rate from FY 1994 to FY 1995.

We are proposing no changes in our exceptions policies for FY 1995. As a result, the minimum payment levels would 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 exceptions payments will increase from 0.7 percent of payments in FY 1994 to 1.37 percent of payments in FY 1995. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1995 EXCEPTIONS PAYMENTS

Type of hospital	No. of hospitals	Percent of exceptions payments
Low Capital Cost	280	77
High Capital Cost	100	23
Total	380	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table V presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

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	5,224	24.9	16.7	58.3
Large urban areas (populations over 1 million)	1,603	29.1	21.6	49.2
Other urban areas (populations of 1 million or fewer)	1,322	31.4	19.2	49.4
Rural areas	2,299	18.3	11.8	69.9
Urban hospitals	2,925	30.2	20.5	49.3
0–99 beds	713	28.6	19.6	51.8
100–199 beds	920	36.4	20.1	43.5
200–299 beds	610	29.5	20.5	50.0
300–499 beds	493	24.3	22.9	52.7
500 or more beds	189	22.8	20.1	57.1
Rural hospitals	2,299	18.3	11.8	69.9
0–49 beds	1,185	13.1	9.4	77.6
50–99 beds	687	22.6	13.0	64.5
100–149 beds	227	26.4	18.9	54.6
150–199 beds	106	22.6	15.1	62.3
200 or more beds	94	28.7	13.8	57.4
By Region				
Urban by Region	2,925	30.2	20.5	49.3
New England	170	12.9	20.0	67.1
Middle Atlantic	440	18.6	24.8	56.6
South Atlantic	436	37.8	22.7	39.4
East North Central	489	23.1	14.9	62.0
East South Central	167	43.7	13.8	42.5
West North Central	197	32.0	17.3	50.8
West South Central	371	49.9	25.3	24.8
Mountain	120	28.3	31.7	40.0
Pacific	487	27.9	18.7	53.4
Puerto Rico	48	18.8	12.5	68.8
Rural by Region	2,299	18.3	11.8	69.9
New England	53	17.0	11.3	71.7
Middle Atlantic	85	12.9	20.0	67.1
South Atlantic	298	23.2	10.7	66.1
East North Central	310	16.8	8.1	75.2
East South Central	285	24.2	16.8	58.9
West North Central	536	12.3	9.7	78.0
West South Central	358	18.2	17.0	64.8
Mountain	224	20.5	9.8	69.6
Pacific	145	22.8	5.5	71.7

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(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 Payment Classification				
All hospitals	5,224	24.9	16.7	58.3
Large urban areas (populations over 1 million)	1,817	29.2	21.0	49.9
Other urban areas (populations of 1 million or fewer)	1,413	30.2	17.9	51.9
Rural areas	1,994	17.4	12.0	70.7
Teaching Status:.				
Non-teaching	4,174	25.3	16.2	58.5
Fewer than 100 Residents	828	24.9	19.0	56.2
100 or more Residents	222	17.6	18.0	64.4
Disproportionate share hospitals (DSH):				
Non-DSH	3,320	24.1	15.2	60.8
Urban DSH:				
100 or more beds	1,355	29.0	21.5	49.4
Less than 100 beds	140	28.6	17.1	54.3
Rural DSH:				
Sole Community (SCH)	133	14.3	6.8	78.9
Referral Center (RRC)	47	17.0	19.1	63.8
Other Rural:				
100 or more beds	66	24.2	18.2	57.6
Less than 100 beds	163	16.6	14.7	68.7
Urban teaching and DSH:				
Both teaching and DSH	645	22.5	19.1	58.4
Teaching and no DSH	360	23.9	19.4	56.7
No teaching and DSH	850	33.9	22.7	43.4
No teaching and no DSH	1,375	31.9	18.0	50.1
Rural Hospital Types:				
Non special status hospitals	843	16.8	13.0	70.1
RRC	138	25.4	15.9	58.7
SCH	54	27.8	13.0	59.3
Medicare-dependent hospitals (MDH)	415	8.4	11.3	80.2
SCH and MDH	54	27.8	13.0	59.3
Type of Ownership:				
Voluntary	3,260	24.1	16.6	59.3
Proprietary	751	43.9	26.1	30.0
Government	1,213	15.4	11.3	73.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	305	32.5	18.7	48.9
25–50	1,471	29.0	17.9	53.2
50–65	2,244	23.6	16.8	59.6
Over 65	1,162	20.8	14.5	64.6

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 24 of the 5,248 hospitals in our data base. Consequently, the payment methodology distribution is based on 5,224 hospitals. This data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) geographic location, (2) region, and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and under the hold-harmless methodology.

Table V indicates that 58.3 percent of hospitals are paid under the fully prospective payment methodology. (This figure, unlike the figure of 64 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (69.9 percent and 73.3 percent, respectively) are being paid under the fully prospective methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 30 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had 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 1995 actuarial model to estimate the potential impact of our proposed changes for FY 1995 on total capital payments per case, using a universe of 5,224 hospitals. The individual hospital payment parameters are taken from the best available data, including: the January 1, 1994 update to the Provider-Specific file, cost report data, and audit information supplied by intermediaries. Table VI presents a comparison of payments per case for FY

1994 and FY 1995. It also presents the portion of total percentage change in payments that can be attributed to Federal rate changes alone. Federal rate changes include the 6.47 percent decrease in the Federal rate, a 1.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the Medicare Geographic Classification Review Board. The residual increase over the change attributable to the Federal rate changes can be attributed to the effects of transition changes, which include: the change from 30 percent to 40 percent 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 (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) geographic location and (2) payment classification and payment region.

The simulation results show that, on average, payments per case can be expected to increase 2.2 percent in FY 1995. The results show that the effect of the Federal rate changes alone is to decrease payments by 1.3 percent. However, the decrease attributable to the Federal rate changes is more than offset by a 3.5 percent increase attributable to the effects of transition changes and budget neutrality.

Our comparison by geographic location shows that urban and rural hospitals experience similar rates of increase (2.2 percent and 2.3 percent, respectively). Urban hospitals will lose slightly less than rural hospitals (−1.3 percent compared to −1.6 percent) from the Federal rate changes. Urban hospitals will also gain slightly less than rural hospitals (3.5 percent compared to 3.9 percent) from the effects of transition changes.

By region, rural hospitals of the New England region have the highest rate of increase (12.3 percent, of which −1.9 percent is due to Federal rate changes and 14.2 percent to the effects of transition changes). Puerto Rico hospitals fare worst: these hospitals will experience a 2.5 percent decline in payments, of which −3.4 percent is attributable to Federal rate changes and 0.9 percent to the effects of transition changes.

By type of ownership, government hospitals are projected to have the highest rate of increase (3.3 percent, of which −1.5 percent is due to Federal rate changes and 4.8 percent to the effects of transition changes). Payments to proprietary hospitals will decrease 0.2 percent (−1.2 percent due to the Federal rate changes and 1.0 percent attributable to the effects of transition changes) and payments to voluntary hospitals will increase 2.5 percent (−1.3 percent due to Federal rate changes and 3.8 percent to the effects of transition changes).

Section 1886(d)(10) of the Act established the Medicare Geographic Review Board (MGCRB). Hospitals may apply for reclassification for the purpose of the wage index, standardized payment amount, or both. 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 that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 1995 compared to the FY 1994 effects of reclassification, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1995 reclassifications, we are indicating those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified during FY 1995 as a whole are projected to experience a 2.3 percent increase in payments (−1.0 attributable to Federal rate changes and 3.3 percent attributable to the effects of transition changes). Nonreclassified hospitals will gain slightly less (2.2 percent) than reclassified hospitals (2.3 percent) overall. While nonreclassified hospitals will lose slightly more (−1.4 percent compared to −1.0 percent) than reclassified hospitals from the Federal rate changes, they will gain more (3.6 percent to 3.3 percent) from the effects of transition changes.

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1994 Payments Compared to FY 1995 Payments]

	Number of hospitals	Average FY 1994 payments/case	Average FY 1995 payments/case after OBRA	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	5,224	587	600	2.2	−1.3
Large urban areas (populations over 1 million)	1,603	673	688	2.4	−1.4
Other urban areas (populations of 1 million or fewer)	1,322	588	600	2.1	−1.1
Rural areas	2,299	385	394	2.3	−1.6
Urban hospitals	2,925	636	650	2.2	−1.3
0–99 beds	713	480	487	1.3	−1.6
100–199 beds	920	581	589	1.4	−1.4
200–299 beds	610	604	611	1.2	−1.4
300–499 beds	493	646	660	2.2	−1.4
500 or more beds	189	780	815	4.4	−0.8
Rural hospitals	2,299	385	394	2.3	−1.6
0–49 beds	1,185	279	286	2.2	−2.1
50–99 beds	687	356	359	0.8	−1.8
100–149 beds	227	426	439	3.1	−1.7
150–199 beds	106	397	402	1.1	−1.7
200 or more beds	94	493	513	4.0	−0.9
By Region:					
Urban by Region	2,925	636	650	2.2	−1.3

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1994 Payments Compared to FY 1995 Payments]

	Number of hospitals	Average FY 1994 payments/case	Average FY 1995 payments/case after OBRA	All changes	Portion attibutable to Federal rate change
New England	170	589	616	4.6	−1.5
Middle Atlantic	440	662	681	2.8	−1.7
South Atlantic	436	650	661	1.7	−1.0
East North Central	489	582	590	1.3	−1.1
East South Central	167	595	612	2.8	−0.7
West North Central	197	627	639	2.0	−1.1
West South Central	371	675	681	0.9	−0.8
Mountain	120	664	654	−1.5	−2.3
Pacific	487	701	731	4.2	−1.5
Puerto Rico	48	235	229	−2.5	−3.4
Rural by Region	2,299	385	394	2.3	−1.6
New England	53	523	587	12.3	−1.9
Middle Atlantic	85	397	408	2.8	−2.1
South Atlantic	298	402	405	0.9	−1.1
East North Central	310	374	388	3.7	−1.3
East South Central	285	366	370	1.0	−1.3
West North Central	536	351	359	2.3	−2.3
West South Central	358	369	373	1.1	−2.2
Mountain	224	423	425	0.5	−1.3
Pacific	145	428	444	3.6	−1.4
By Payment Classification:					
All hospitals	5,224	587	600	2.2	−1.3
Large Urban areas (populations over 1 million)	1,817	663	678	2.4	−1.3
Other urban areas (populations of 1 million or fewer)	1,413	571	582	1.9	−1.2
Rural areas	1,994	378	388	2.6	−1.6
Teaching Status:.					
Non-teaching	4,174	515	520	0.8	−1.5
Fewer than 100 Residents	828	619	636	2.7	−1.1
100 or more Residents	222	854	901	5.5	−1.2
Disproportionate share hospitals (DSH):					
Non-DSH	3,320	549	561	2.1	−1.3
Urban DSH:					
100 or more beds	1,355	657	673	2.5	−1.3
Less than 100 beds	140	410	408	−0.6	−1.9
Rural DSH:					
Sole Community (SCH)	133	339	338	−0.3	−1.9
Referral Center (RRC)	47	425	433	1.8	−1.4
Other Rural:.					
100 or more beds	66	366	363	−0.6	−2.3
Less than 100 beds	163	288	290	0.6	−2.0
Urban Teaching and DSH:					
Both teaching and DSH	645	713	738	3.5	−1.3
Teaching and no DSH	360	652	678	3.9	−1.0
No teaching and DSH	850	572	577	0.8	−1.4
No teaching and no DSH	1,375	564	567	0.4	−1.4
Rural Hospital Types:					
Non special status hospitals	843	335	341	1.8	−2.0
RRC	138	463	474	2.3	−1.3
SCH	578	372	380	2.1	−1.7
Medicare-dependent hospitals (MDH)	415	282	283	0.2	−2.3
SCH and MDH	54	476	514	8.0	−0.9
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY94 and FY95:					
Reclassified During Both FY94 and FY95	484	586	592	1.1	−1.6
Reclassified During FY95 Only	215	500	532	6.4	0.8
Reclassified During FY94 Only	189	508	514	1.2	−3.5
FY95 Reclassifications:					
All Reclassified Hospitals	699	563	576	2.3	−1.0
All Nonreclassified Hospitals	4,498	591	605	2.2	−1.4
All Urban Reclassified Hospitals	236	671	687	2.4	−1.1
Urban Nonreclassified Hospitals	2,689	632	647	2.2	−1.3
All Reclassified Rural Hospitals	463	439	448	2.2	−0.8
Rural Nonreclassified Hospitals	1,809	358	366	2.4	−2.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	27	421	424	0.8	−1.7
Type of Ownership:					
Voluntary	3,260	599	614	2.5	−1.3
Proprietary	751	619	618	−0.2	−1.2

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued
[FY 1994 Payments Compared to FY 1995 Payments]

	Number of hospitals	Average FY 1994 payments/case	Average FY 1995 payments/case after OBRA	All changes	Portion attibutable to Federal rate change
Government	1,213	481	496	3.3	−1.5
Medicare Utilization as a Percent of Inpatient Days:					
0–25	305	667	699	4.8	−1.6
25–50	1,471	680	704	3.4	−1.2
50–65	2,244	542	549	1.3	−1.3
Over 65	1,162	504	510	1.3	−1.5

E. Cross-Sectional Analysis of Changes in the Federal Rate

The analysis in Table VII examines the impact of the following changes in the Federal rate set forth in section III of the addendum to this proposed rule—

- The effects of eliminating the separate operating prospective payment system rural standardized amount, as required under section 1886(d)(3)(A) of the Act (column 3).
- The effects of the annual reclassification of DRGs and recalibration of the DRG weights required by section 1886(d)(4)(C) of the Act (column 4).
- The effects of the annual update of wage survey data on the capital geographic adjustment factor (column 5).
- The effects of the proposed changes in transfer policy (column 6).
- The effects of FY 1995 reclassifications by the MGCRB (column 7).
- The effects of changes in outlier policy (column 8).
- The effects of all proposed FY 1995 changes affecting the Federal rate, including those displayed in columns 3 through 8, compared to FY 1994 payments based on the Federal rate (column 9).

To estimate the effects of these changes, we simulated payments based on 100 percent of the Federal rate. As a result, the simulation in Table VII has two significant limitations. The simulation necessarily employs the FY 1994 and the proposed FY 1995 Federal rates. However, the FY 1994 and FY 1995 Federal rates were determined on the basis of the transition rules in which hospitals are paid various portions of the Federal rate. (Fully prospective hospitals receive 30 percent of the Federal rate in FY 1994 and 40 percent in FY 1995. Hold-harmless hospitals receive a portion of the Federal rate based on the hospital-specific ratio of new Medicare capitals costs to total Medicare capital costs. Approximately 16.7 percent of hospitals will be paid 100 percent of the Federal rate in FY 1995.) In particular, the budget neutrality adjustment required to assure that aggregate payments equal 90 percent of reasonable costs would require revision if all hospitals were paid 100 percent of the Federal rate. Thus, the simulation of 100 percent Federal rate payments is based on rates that would be different if payments were actually based on 100 percent of the Federal rate.

Furthermore, the simulation does not necessarily reflect accurately changes in capital prospective payment system payments from FY 1994 to FY 1995. Rather, it reflects the percentage change in payments that hospitals would experience if all hospitals were paid 100 percent of the Federal rate. In fact, as previously noted, hospitals will receive varying portions of their amounts on the basis of the Federal rate in FY 1995. Section 412.308(c)(4)(ii) requires that estimated aggregate payments based on the Federal rate for any year after any changes from DRG reclassification and recalibration and the geographic adjustment factor equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. Appendix B explains that the varying portions of the Federal rate paid to each hospital are taken into account in determining the aggregate Federal rate payment amounts used to compute the DRG/GAF budget neutrality adjustment. The aggregate Federal rate payments used to determine the budget neutrality adjustment would be different if all hospitals were paid based on 100 percent of the Federal rate. Thus, Table VII represents the change in payments under circumstances unlike those for which the DRG/GAF budget neutrality adjustment is computed. As a result, it is to be expected that the full effects of that budget neutrality requirement will not be precisely reflected in Table VII.

The simulation in Table VII is not representative of changes in capital prospective payment system payments from FY 1994 to FY 1995. Rather, it reflects the percentage change in payments for hospitals receiving 100 percent of the Federal rate. For other hospitals, it reflects the percentage change in the Federal rate portion of payments, holding the Federal rate portion constant. (Of course, for those other hospitals, the Federal rate portion changes in almost all cases from FY 1994 to FY 1995.) Unlike the Federal rate payment change in Table VI, the analysis in Table VII also does not include any increase in Federal rate payments attributable to anticipated increases in the case-mix index.

Because of the limitations on the simulation presented in Table VII, we are considering whether to omit this table in future impact statements. We welcome comments on the utility of this table and its continued use in future impact statements.

The table shows that Federal rate payments can be expected to decrease 4.5 percent overall prior to consideration of any increase in the case-mix index. This decrease is due to the 6.5 percent decrease in the Federal rate, which is partially offset by the 1.9 percent increase in outlier payments.

The table also shows the distributional effects of the changes in Federal rate payments from the changes noted above. We modeled the effects of the changes in all columns, except column 7, in the same manner as in Table I above. Thus, column 3 displays the payment changes resulting from eliminating the rural standardized amount, modeled by comparing simulated 100 percent Federal rate payments using our FY 1995 baseline model (as described in the operating portion of this impact analysis) to simulated payments after eliminating the separate rural amount. The changes in Federal rate payments from eliminating the rural standardized amount are, as is to be expected, insignificant. The 0.1 percent gain for other urban hospitals reflects the

spillover effect of an increase in outlier payments for urban hospitals.

Column 4 presents the change in Federal rate payments of the combined effects of the revised DRG classification system, and the subsequent recalibration of DRG weights incorporating these revised DRGs, as discussed in section II of this proposed rule. The DRG changes are expected to produce only minimal effects on the distribution of Federal rate payments. The highest gain from DRG reclassification and recalibration is projected at 0.1 percent (for several classes of hospitals), while the largest loss is projected at −0.3 percent (for urban disproportionate share hospitals with 100 beds or less).

As with the previous two columns, the impact of the new wage data in Federal rate payments is isolated in column 5 by holding the other payment parameters constant in the two comparison simulations. That is, the percentage changes demonstrate the changes in Federal rate payments from our FY 1995 baseline—using the FY 1994 wage index before geographic reclassifications based on 1990 wage survey data, after elimination of the separate rural rate and incorporating the FY 1995 GROUPER—to a model substituting the FY 1995 pre-reclassification wage index based on data submitted for hospital cost reporting periods beginning in FY 1991. The only significant changes from the use of new wage data on the capital geographic adjustment factor are on hospitals in Puerto Rico. Urban Puerto Rico hospitals experience a decrease of 7.4 percent and rural Puerto Rico hospitals experience a decrease of 10.7 percent. As is the case with similar decreases in operating prospective payment system payments, these effects are attributable to improved reporting by hospitals.]

Column 6 illustrates the effects of the proposed transfer policy changes relative to a baseline simulation based on current transfer policy. The effects of the changes in transfer policy are similar to those in operating prospective payment system payments. The transfer changes increase Federal rate payments to rural hospitals by 0.5 percent, and decrease Federal rate payments to urban hospitals by 0.1 percent. As is the case with operating prospective payments, this result is due to the fact that rural hospitals benefit from changing the per diem methodology.

Column 7 displays the impact of the FY 1995 decisions by the MGCRB compared to FY 1994 reclassification decisions. It includes all of the changes proposed for FY 1995 discussed up to this point. Therefore, in examining the changes for particular hospital groups, the impacts discussed previously appear here as well (for example, the large decreases in Puerto Rico due to the new wage data). This comparison corresponds with the methodology used to determine the GAF/DRG budget neutrality adjustment factor. To accomplish this comparison, we have replaced the FY 1995 proposed capital Federal rate with the FY 1994 Federal rate adjusted by the 1.00115 proposed GAF/DRG budget neutrality factor.

Column 8 shows the incremental effects of outlier changes alone. The changes shown in this column closely reflect the changes in operating prospective payments shown in Table 1.

Column 9 displays the combined changes from the previous columns, as well as the effects of other factors affecting Federal rate payments, compared to FY 1994 Federal rate payments. The other factors include: the change in the standard Federal rate from FY 1994, the effect of geographic reclassifications on large urban status, and a 1.9 percent increase in outlier payments. As noted in the previous discussion, the effects of changes in geographic reclassification decisions from FY 1994 to FY 1995, in addition to the changes discussed in columns 3 through 6, are shown in column 7. These effects are included in column 9 as well, along with the changes in outlier policy and the changes in the Federal rate and outlier payments. Thus, only the last column reflects the effects of all quantifiable policy changes on simulated FY 1995 Federal rate payments.

TABLE VII.—Impact Analysis of Proposed Changes for FY 1995 CAPITAL PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Federal Payments Per Case]

	No. of Hosps.[1]	Pymt. per case FY 1994	Pymt. per case FY 1995	Elim. rural stand. amount	DRG recalibration	New wage data	Transfer policy changes	MGCRB reclassification	OBRA 1993 outlier changes	All FY 1995 changes
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
(By Geographic Location):										
All Hospitals	5,248	595	569	0.0	0.0	0.1	−0.1	0.0	0.0	−4.5
Urban Hospitals	2,947	643	615	0.0	0.1	0.1	−0.1	−0.1	0.0	−4.4
Large Urban	1,616	687	655	0.0	0.0	0.2	−0.2	−0.1	0.0	−4.6
Other Urban	1,331	586	561	0.1	0.1	0.0	−0.1	−0.1	0.2	−4.2
Rural Areas	2,301	400	380	0.0	0.0	0.3	0.5	0.7	−0.2	−4.8
Bed Size (Urban):										
0–99 Beds	733	462	440	0.1	−0.1	−0.3	0.4	0.1	0.0	−4.7
100–199 Beds	922	558	532	0.0	0.0	−0.2	0.0	−0.2	0.1	−4.6
200–299 Beds	610	609	581	0.0	0.0	0.0	−0.1	−0.2	−0.1	−4.6
300–499 Beds	493	676	645	0.0	0.1	0.2	−0.2	−0.2	0.0	−4.5
500 or More Beds	189	796	764	0.0	0.1	0.3	−0.4	0.1	0.2	−3.9
Bed Size (Rural):										
0–49 Beds	1,187	333	316	0.0	−0.1	0.4	1.0	1.1	−0.2	−5.0
50–99 Beds	687	374	355	0.0	−0.1	0.2	0.7	0.5	−0.1	−5.1
100–149 Beds	227	418	396	0.0	0.0	0.3	0.5	0.1	−0.2	−5.2
150–199 Beds	106	423	403	0.0	0.0	0.4	0.3	0.9	−0.3	−4.7
200 or More Beds	94	476	458	0.0	0.1	0.3	0.1	1.0	−0.1	−3.9
Urban by Region:										
New England	170	668	636	0.0	0.1	1.1	−0.2	0.7	−0.4	−4.8
Middle Atlantic	440	695	660	0.0	0.1	0.4	−0.2	−0.3	−0.6	−5.1
South Atlantic	436	615	592	0.0	0.1	0.2	0.0	0.3	0.2	−3.7

TABLE VII.—Impact Analysis of Proposed Changes for FY 1995 CAPITAL PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Federal Payments Per Case]

	No. of Hosps.[1]	Pymt. per case FY 1994	Pymt. per case FY 1995	Elim. rural stand. amount	DRG recalibration	New wage data	Transfer policy changes	MGCRB reclassification	OBRA 1993 outlier changes	All FY 1995 changes
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
East North Central	491	620	594	0.0	0.0	0.4	−0.1	0.3	0.1	−4.3
East South Central	167	568	548	0.1	0.1	0.0	−0.1	0.0	0.6	−3.5
West North Central	198	628	599	0.0	0.1	−0.1	−0.1	−0.2	0.1	−4.6
West South Central	383	605	584	0.1	0.0	−1.0	−0.3	−1.3	0.9	−3.5
Mountain	120	648	611	0.0	0.1	−0.9	−0.3	−1.5	−0.1	−5.7
Pacific	493	726	693	0.0	0.0	−0.1	−0.1	0.1	0.1	−4.6
Puerto Rico	49	268	239	0.0	0.1	−7.4	0.2	−8.6	0.7	−10.6
Rural by Region:										
New England	53	467	439	0.0	0.1	0.3	0.4	−0.2	−0.5	−6.0
Middle Atlantic	85	445	422	0.0	0.1	0.4	0.3	0.3	−0.5	−5.1
South Atlantic	298	411	396	0.0	0.0	0.3	0.5	1.5	0.0	−3.7
East North Central	310	402	383	0.0	0.0	0.9	0.6	1.2	−0.2	−4.6
East South Central	286	364	348	0.0	−0.1	0.0	0.5	1.2	0.0	−4.4
West North Central	536	378	357	0.0	0.0	0.4	0.7	0.5	−0.2	−5.4
West South Central	359	374	350	0.1	−0.1	−0.1	0.5	−1.1	0.0	−6.3
Mountain	224	414	395	0.1	0.0	0.2	0.5	0.2	−0.2	−4.5
Pacific	145	479	455	0.0	0.0	0.2	0.5	0.5	−0.2	−5.0
Puerto Rico	5	218	184	0.0	−0.2	−10.7	0.3	−11.4	0.3	−15.6
(By Payment Categories):										
Urban Hospitals	3,252	634	606	0.0	0.1	0.1	−0.1	−0.1	0.0	−4.4
Large Urban	1,830	675	645	0.0	0.0	0.2	−0.2	−0.1	0.0	−4.5
Other Urban	1,422	569	545	0.1	0.1	−0.1	0.0	−0.1	0.1	−4.3
Rural Hospitals	1,996	395	375	0.0	0.0	0.3	0.5	0.4	−0.2	−5.0
Teaching Status:										
Non-Teaching	4,197	509	486	0.0	0.0	0.0	0.2	0.0	0.0	−4.6
Less Than 100 Res	829	644	615	0.0	0.1	0.2	−0.2	−0.1	0.0	−4.4
100+ Residents	222	895	856	0.0	0.1	0.5	−0.6	0.1	0.1	−4.3
Disproportionate Share Hospitals (DSH):										
Non-DSH	3,341	552	527	0.0	0.1	0.1	0.2	0.0	−0.1	−4.6
Urban DSH:										
100 Beds or More	1,355	671	641	0.0	0.0	0.2	−0.3	0.0	0.1	−4.4
Fewer Than 100 Beds	143	422	403	0.1	−0.3	−0.1	0.4	0.4	0.1	−4.6
Rural DSH:										
Sole Community (SCH)	133	352	331	0.0	−0.1	0.2	0.7	−0.2	0.0	−5.9
Referral Centers (RRC)	47	455	439	0.0	0.0	0.2	0.0	1.5	0.2	−3.6
Other Rural DSH Hosp:										
100 Beds or More	66	380	356	0.0	−0.1	0.1	0.6	−0.9	−0.3	−6.3
Fewer Than 100 Beds	163	325	309	0.0	−0.2	0.2	0.9	0.8	0.1	−4.9
Urban Teaching and DSH:										
Both Teaching and DSH	645	746	713	0.0	0.1	0.3	−0.4	−0.1	0.1	−4.5
Teaching and no DSH	361	680	651	0.0	0.1	0.2	−0.1	−0.1	0.0	−4.3
No Teaching and DSH	853	561	537	0.0	0.0	−0.1	−0.1	0.0	0.2	−4.3
No Teaching and no DSH	1,393	545	520	0.0	0.0	−0.1	0.2	−0.2	−0.1	−4.6
Rural Hospital Types:										
Nonspecial Status Hospitals	845	366	346	0.0	−0.1	0.3	0.7	0.1	−0.2	−5.5
RRC	138	469	448	0.0	0.1	0.3	0.1	0.4	−0.1	−4.7
SCH	578	374	355	0.0	0.0	0.2	0.8	0.4	−0.2	−5.2
Medicare-Dependent Hospital	415	336	319	0.0	−0.1	0.4	0.9	0.9	−0.1	−5.1
SCH and RRC	54	447	429	0.0	0.1	0.5	0.2	1.2	−0.3	−4.0
Type of Ownership:										
Voluntary	3,282	610	582	0.0	0.1	0.2	−0.1	0.0	0.0	−4.5
Proprietary	753	562	540	0.1	−0.1	−0.5	0.0	−0.4	0.3	−3.8
Government	1,213	539	513	0.0	0.0	0.3	0.0	0.4	−0.1	−4.8
Medicare Utilization as a Percent of Inpatient Days:										
0–25	305	723	688	0.0	0.0	−0.1	−0.4	−0.3	0.3	−4.9
25–50	1,471	682	652	0.0	0.1	0.2	−0.3	0.0	0.1	−4.4
50–65	2,244	555	530	0.0	0.1	0.1	0.1	0.0	0.0	−4.5
Over 65	1,162	496	473	0.0	0.0	0.1	0.2	0.1	−0.1	−4.7
Unknown	66	767	716	−0.1	−0.1	0.5	−0.5	−0.4	−1.7	−6.7
Hospitals Reclassified by the Medicare Geographic Review Board:										
Reclassification Status During FY94 and FY95:										

TABLE VII.—Impact Analysis of Proposed Changes for FY 1995 CAPITAL PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Federal Payments Per Case]

	No. of Hosps.[1]	Pymt. per case FY 1994	Pymt. per case FY 1995	Elim. rural stand. amount	DRG recalibration	New wage data	Transfer policy changes	MGCRB reclassification	OBRA 1993 outlier changes	All FY 1995 changes
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Reclassified During Both FY94 and FY95	484	571	543	0.0	0.0	0.1	0.1	−0.5	0.0	−4.9
Urban	189	659	627	0.0	0.0	0.0	−0.1	−0.9	0.1	−4.8
Rural	295	455	432	0.0	0.0	0.4	0.3	0.2	−0.2	−5.1
Reclassified During FY95 Only	215	504	511	0.0	0.1	0.4	0.1	6.8	0.0	1.3
Urban	47	632	635	0.1	0.1	0.3	−0.1	5.2	0.1	0.6
Rural	168	403	412	0.0	0.0	0.5	0.4	8.6	−0.2	2.2
Reclassified During FY94 Only	209	551	497	0.0	0.0	0.1	0.2	−5.4	−0.3	−9.8
Urban	60	699	643	0.0	0.1	0.2	0.0	−3.4	−0.4	−8.0
Rural	149	438	386	0.0	0.0	0.0	0.4	−7.8	−0.2	−12.0
FY 95 Reclassifications:										
All Reclassified Hosp	699	553	534	0.0	0.0	0.2	0.1	1.2	0.0	−3.4
Urban	236	653	629	0.0	0.1	0.0	−0.1	0.4	0.1	−3.7
Rural	463	439	426	0.0	0.0	0.4	0.4	2.7	−0.2	−3.0
All Nonreclassified Hospitals	4,522	603	575	0.0	0.0	0.1	−0.1	−0.2	0.0	−4.6
Urban	2,711	642	613	0.0	0.1	0.1	−0.2	−0.2	0.0	−4.5
Rural	1,811	379	357	0.0	0.0	0.3	0.6	−0.4	−0.2	−5.8
Other Reclassified Hospitals (Section 1886(d)(8)(B))	27	444	418	0.1	0.0	0.3	0.5	−0.2	−0.3	−5.7

Appendix B: Technical Appendix on the Capital Acquisition Model and Budget Neutrality Adjustment

Section 1886(g)(1)(A) of the Act requires that for FY 1992 through FY 1995 aggregate prospective payments for operating costs under section 1886(d) of the Act and prospective payments for capital costs under section 1886(g) of the Act be reduced each year in a manner that results in a 10 percent reduction 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 reduction 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 each year from FY 1992 through FY 1995 equal 90 percent of Medicare inpatient capital costs in each year.

To calculate the budget neutrality adjustment, we must 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 include depreciation, lease, interest expenses, and other capital-related costs defined in § 412.302 for depreciable assets that are in use for patient care or obligated on or before December 31, 1990.)

In developing the FY 1992 prospective payment rates, there were 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).

We now have cost report data for the first year of the capital prospective payment system. These cost reports begin in FY 1992 (PPS–9) and provide a break-out of old and new capital for the first time. We used the December 1993 update of the PPS–9 cost reports, the January 1, 1994 update of the provider specific file, and the December 1993 update of the intermediary audit file as data sources.

The available data still lack certain items that are required for the determination of budget neutrality, including a hospital's projected new capital costs for each year, its projected old capital costs for each year, and the projected obligated capital amounts that will be put in use for patient care services and recognized as old capital each year.

For FY 1993 and FY 1994, we implemented 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 we now have data for FY 1992, we no longer need to use the integrated model, and, consequently, we are no longer using the model that developed the FY 1992 rates.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland and hospitals in the Finger Lakes Area Hospital Corporation in New York) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We first developed FY 1992, FY 1993, and FY 1994 hospital-specific rates using the provider-specific file, the intermediary audit file, and when available, cost reports. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We also ensured that the FY 1993 increase in the hospital-specific rate was at least 0.62 percent (the net FY 1993 update) and that the FY 1994 hospital-specific rate was at least as large as the FY 1993 hospital-specific rate decreased by 2.16 percent (the net FY 1994 update). We were able to match hospitals to the files as shown in the following table.

Source	No. of hospitals
Provider Specific File Only	47

Source	No. of hospitals
Provider Specific and Audit File	5201
Total	5248

Forty-five of these hospitals had unusable or missing data. We were able to back-fill a hospital-specific rate for 21 of these hospitals from the cost reports as shown in the following table.

Source	No. of hospitals
PPS–5 Cost Reports	1
PPS–7 Cost Reports	2
PPS–8 Cost Reports	1
PPS–9 Cost Reports	17
Total	21

We did not have data for 24 hospitals, and had to drop them from the capital analysis. Most of these dropped hospitals are new hospitals or hospitals with very few Medicare admissions. This leaves us with 5224 hospitals and should not affect the precision of the budget neutrality determination.

We then determined old and new capital amounts for FY 1992 using the PPS–9 cost reports as the first source of data. Since we matched only 4,653 PPS–9 cost reports, we also used the provider-specific file for old capital information. Even in cases where a cost report was available, the break out of old and new capital was not always available. In these cases, we used the old capital amounts and new capital ratios from the provider-specific file. If these were missing we derived the old capital amount from the hospital specific rate.

Finally, we used the intermediary audit file to develop obligated capital amounts. Some hospitals had indicated that they could not bring the obligated capital on line before the expiration of this provision, so we excluded the obligated amounts for these hospitals from the budget neutrality determination. Since the obligated amounts are aggregate projected amounts, we computed a Medicare capital cost per admission associated with these amounts. We adjusted the aggregate amounts by the following factors:

(1) Medicare inpatient share of capital. This was derived from cost reports and was limited to the Medicare share of total inpatient days. It was necessary to limit the Medicare share because of data integrity problems. Medicare share of inpatient days is a reasonably good proxy for allocating capital. However, it may be understated if Medicare utilization is high, and may be overstated because it ignores the outpatient share of capital.

(2) Capitalization factor. This factor allocates the aggregate amount of obligated capital to depreciation and interest amounts. Consistent with the assumptions in the capital input price index, we used a 25-year life for fixed capital and a 10-year life for movable capital, and an average projected interest rate of 6.7 percent. We also assumed that fixed capital acquisitions are about one-half of total capital. In conjunction with the useful life and interest rate assumptions, the resulting capitalized fixed capital is about one-half of total capitalization. This is consistent with the allocations between fixed and movable capital found on the cost reports. The ratio we developed is 0.137, which produces the first year capitalization based on the aggregate amount.

(3) A divisor of Medicare admissions to derive the capital per discharge amount. Since we must project capital amounts for each hospital, we continued to use a Monte Carlo simulation to develop these amounts. The Monte Carlo simulation is now used only to project capital costs per discharge amounts for each hospital. We analyzed the distributions of capital increases, and noted a slightly negative correlation between the dollar level of capital per admission, and the rate of increase in capital. To determine the rate of increase in capital cost per admission, we multiplied the lesser of $3,000 or the capital cost per admission by .00006 and subtracted this result from 1.2. (Increases for capital levels over $3,000 were not influenced by the level of capital, so this part of the calculation was capped at $3,000.) We selected a random number from the normal distribution, multiplied it by 0.17 (the standard deviation) and added it to −0.04 (the mean) and then added 1 to create a multiplier. This random result was multiplied by the previous result to assign a rate of increase factor which was multiplied by the prior year's capital per discharge amount to develop a capital per discharge amount for the projected year.

To model a projected year, we used the old and new capital for the prior year multiplied by 0.96 (aging factor). The 0.96 aging factor is the average of changes in capital over its life. The aged new and old capital is subtracted from the projected capital described in the previous paragraph. The difference represents newly acquired capital. We assume that the hospital would accrue only a half year of costs for newly acquired capital in the year in which the capital comes on line. This is because, on average, new capital will come on line in the middle of the year. We make the same assumption for obligated capital. If the hospital has obligated capital, the lesser of one half of the adjusted costs (as described in the succeeding paragraph) for newly acquired capital or one half of the costs for obligated capital are deemed to apply to the current year. The full year's costs for new or obligated capital are assumed to apply for the following year. For FY 1994, one half of the costs for any outstanding obligated capital were deemed to apply to FY 1994; a full year's costs were deemed to apply to FY 1995. With the exception of certain hospitals about whom we have information to the contrary, we assume that hospitals would meet the expiration dates provided under the obligated capital provision. The on-line obligated amounts are added to old capital and subtracted from the newly acquired capital to yield residual newly acquired capital, which is then added to new capital. The residual newly acquired capital is never permitted to be less than zero.

Next, 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 newly acquired capital amounts proportionately, so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor), 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 indicated in the PPS–9 cost reports or 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 1993 MedPAR file using the proposed FY 1995 DRG relative weights published in

this rule. The case-mix index is increased each year after FY 1993 consistent with the continuing trend in case-mix increase.

We analyzed the case-mix increases for the recent past and found that case-mix increases have decelerated to about 1.55 percent in FY 1992 and 0.83 percent in FY 1993. It is too early to reliably determine a case-mix increase for FY 1994 from the discharge data. Since case-mix increases appear to be decelerating, we have reduced our projected long-term increase of 2 percent to 1.5 percent for both FY 1994 and FY 1995. We will continue to monitor case-mix increases and make appropriate adjustments to our projections. (Since we are using FY 1993 cases for our analysis, the FY 1993 increase in case mix has no effect on the FY 1995 Federal rate. It does affect the estimated update for the FY 1996 Federal rate displayed in the projection table in this appendix.)

Changes in geographic classification 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 13501(a)(3) of Public Law 103–66 requires that, for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent. Consequently, the model reduces the unadjusted standard Federal rate by 7.4 percent effective in FY 1994. Because of the budget neutrality provisions in effect through FY 1995, this provision does not reduce aggregate payments for capital in FY 1994 and FY 1995.

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 DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 1994, the budget neutrality adjustment factor was 1.0033. To determine the factor for FY 1995, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1995 based on its applicable payment methodology. We then compared estimated aggregate Federal rate payments based on the FY 1994 DRG relative weights and FY 1994 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1995 relative weights and the FY 1995 geographic adjustment factor. In making the comparison, we held the FY 1995 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 DRG classifications and relative weights, an incremental budget neutrality adjustment of 1.00115 for FY 1995 should be applied to the previous cumulative FY 1994 adjustment of 1.0033 (the product of the FY 1993 incremental adjustment of .9980 and the FY 1994 incremental adjustment of 1.0053), yielding a cumulative adjustment of 1.00445 through FY 1995.

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 the amount that 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 accounted for 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 estimated aggregate payments under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the budget neutrality and exceptions adjustments factors must be determined through iteration. Further, these two factors interact with each other so that they must be determined simultaneously. We successfully determined values for these factors so that the exceptions adjustment factor is correct, and estimated payments under the capital prospective payment system equal 90 percent of estimated Medicare inpatient capital costs.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FY 1992, FY 1993, and FY 1994, the proposed factors for FY 1995, and the estimated factors that would be applicable through FY 1999. We caution that, except with respect to FY 1992, FY 1993, FY 1994, and the proposed FY 1995, 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 cumulative DRG/GAF adjustment factor will remain at 1.00445 for FY 1995 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1995.

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	1.87	N/A	0.9813	0.9602	415.59
1993	1.17	6.07	.9756	.9162	[2] 417.29
1994	3.11	3.04	.9485	.8947	[3] 378.34
1995	4.14	2.22	.9797	.7986	[4] 353.87

Fiscal year	Increase in cost per discharge [1]	Update factor	Exceptions reduction factor	Budget neutrality factor	Federal rate (after outlier reduction)
1996	3.87	1.52	.9912	N/A	455.12
1997	4.10	2.13	.9844	N/A	461.63
1998	4.29	3.62	.9723	N/A	472.46
1999	4.36	4.00	.9562	N/A	483.22

[1] Note: Adjusted for estimated 1.55 percent annual increase in case mix for FY 1992, 0.83 percent for FY 1993, 1.5 percent for FY 1994 and FY 1995, and 2.0 percent for FY 1996 and later.

[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 0.9496 in FY 1993.

[3] Note: Includes the 7.4 percent reduction in the unadjusted standard Federal rate. Also includes the DRG/GAF adjustment factor of 1.0033 and the change in the outlier adjustment from 0.9496 in FY 1993 to 0.9454 in FY 1994.

[4] Note: Includes the DRG/GAF adjustment factor of 1.00445 and the change in the outlier adjustment from 0.9454 in FY 1994 to 0.9372 in FY 1995. Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Appendix C

May 10, 1994.

The Honorable Albert Gore, Jr.,
President of the Senate, Washington, DC 20510

Dear Mr. President: Section 1886(e)(3)(B) of the Social Security Act (the Act) requires that the Secretary of Health and Human Services report to Congress the initial estimate of the applicable percentage increase for FY 1995 that she will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Our recommendations are consistent with the provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1993. For FY 1995, we recommend an average update for all hospitals subject to PPS equal to the percentage increase in the hospital market basket (an index of inflation in goods and services used by hospitals) minus 1.4 percentage points. We currently estimate that the market basket rate of increase for FY 1995 will be 3.6 percent. The average update for all PPS hospitals would equal 2.2 percent (the market basket percentage increase of 3.6 percent minus 1.4 percent).

We are recommending the updates for urban and rural hospitals that are provided under current law. Under our recommendation and OBRA 1993, urban PPS hospitals would receive the market basket rate of increase minus 2.5 percentage points, or a 1.1 percent increase. Rural PPS hospitals would receive the market basket rate of increase plus 4.8 percentage points, or 8.4 percent. We currently have separate PPS payment rates for large urban, other urban and rural hospitals. However, the law requires us to eliminate the separate rural rate and to establish a single rate for rural and other urban hospitals beginning in FY 1995. The higher update for rural PPS hospitals eliminates the difference between the rate paid to other urban and rural PPS hospitals.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection to maintain access to services for Medicare beneficiaries. SCHs are paid the higher of a hospital-specific rate or the Federal rate. Under our recommendation and OBRA 1993, the update to hospital-specific rates will equal the market basket rate of increase minus 2.2 percentage points or 1.4 percent.

Hospitals and units that are excluded from PPS are paid based on reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Consistent with current law, we recommend an increase in the TEFRA limit equal to the rate of increase in the excluded hospital market basket (3.7 percent) minus 1.0 percentage points, or 2.7 percent.

Our recommendation for the updates is based on current projections of relevant data, and is consistent with the President's budget. A final recommendation on the appropriate percentage increases for FY 1995 will be made nearer the beginning of the new Federal Fiscal Year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Prospective Payment Assessment Commission (ProPAC).

Section 1886(d)(4)(C)(iv) of the Act requires that the Secretary include in her report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time, we do not anticipate recommending any adjustment to the DRG weighting factors for FY 1995.

I am pleased to provide my recommendations to you.

Sincerely,

Donna E. Shalala

May 10, 1994.

The Honorable Thomas S. Foley,
Speaker of the House of Representatives, Washington, DC 20515.

Dear Mr. Speaker: Section 1886(e)(3)(B) of the Social Security Act (the Act) requires that the Secretary of Health and Human Services report to Congress the initial estimate of the applicable percentage increase for FY 1995 that she will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Our recommendations are consistent with the provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1993. For FY 1995, we recommend an average update for all hospitals subject to PPS equal to the percentage increase in the hospital market basket (an index of inflation in goods and services used by hospitals) minus 1.4 percentage points. We currently estimate that the market basket rate of increase for FY 1995 will be 3.6 percent. The average update for all PPS hospitals would equal 2.2 percent (the market basket percentage increase of 3.6 percent minus 1.4 percent).

We are recommending the updates for urban and rural hospitals that are provided under current law. Under our recommendation and OBRA 1993, urban PPS hospitals would receive the market basket rate of increase minus 2.5 percentage points, or a 1.1 percent increase. Rural PPS hospitals would receive the market basket rate of increase plus 4.8 percentage points, or 8.4 percent. We currently have separate PPS payment rates for large urban, other urban and rural hospitals. However, the law requires us to eliminate the separate rural rate and to establish a single rate for rural and other urban hospitals beginning in FY 1995. The higher update for rural PPS hospitals eliminates the difference between the rate paid to other urban and rural PPS hospitals.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection to maintain access to services for Medicare beneficiaries. SCHs are paid the higher of a hospital-specific rate or the Federal rate. Under our recommendation and OBRA 1993, the update to hospital specific rates will equal the market basket rate of increase minus 2.2 percentage points or 1.4 percent.

Hospitals and units that are excluded from PPS are paid based on reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Consistent with current law, we recommend an increase in the TEFRA limit equal to the rate of increase in the excluded hospital market basket (3.7 percent) minus 1.0 percentage points, or 2.7 percent.

Our recommendation for the updates is based on current projections of relevant data, and is consistent with the President's budget. A final recommendation on the appropriate percentage increases for FY 1995 will be made nearer the beginning of the new Federal Fiscal Year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Prospective Payment Assessment Commission (ProPAC).

Section 1886(d)(4)(C)(iv) of the Act requires that the Secretary include in her report recommendations with respect to adjustments to the diagnosis-related group

(DRG) weighting factors. At this time, we do not anticipate recommending any adjustment to the DRG weighting factors for FY 1995.

I am pleased to provide my recommendations to you.

Sincerely,

Donna E. Shalala

Appendix D: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Social Security Act (the Act) address the setting of update factors for services furnished in FY 1995 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(X) of the Act sets the FY 1995 percentage increases in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 2.5 percentage points for prospective payment hospitals located in urban areas. For hospitals located in rural areas, section 1886(b)(3)(B)(i)(X) requires the Secretary to apply an update so as to make the rural national average standardized amounts equal to the other urban national average standardized amount. Section 1886(b)(3)(B)(iv) sets the FY 1995 percentage increase to the hospital-specific rate applicable to sole community hospitals equal to the rate of increase in the hospital market basket minus 2.2 percentage points. Section 1886(b)(3)(B)(ii) of the Act sets the FY 1995 percentage increase in the rate-of-increase limits for hospitals excluded from the prospective payment system equal to the rate of increase in the excluded hospital market basket minus a reduction factor (not to exceed 1.0 percent) depending on the provider's operating costs and target amounts.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the average standardized amounts, the hospital-specific rates and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the currently forecasted market basket increase of 3.6 percent for hospitals subject to the prospective payment system, the proposed updates in the standardized amounts are 1.1 percent for hospitals in urban areas and approximately 8.4 percent for hospitals in rural areas. The proposed update in the hospital-specific rate applicable to sole community hospitals is 1.4 percent (that is, the market basket rate of increase of 3.6 percent minus 2.2 percentage points). The proposed update for hospitals excluded from the prospective payment system is based on the percentage increase in the excluded hospital market basket (currently estimated at 3.7 percent) minus a reduction factor (not to exceed 1.0 percent).

Sections 1886(e)(2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1, 1994 an update factor that takes into account changes in the market basket rate of increase index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

In its March 1, 1994 report, ProPAC recommended update factors to the standardized amounts equal to the percentage increase in the market basket minus 1.5 percentage points for urban hospitals and the market basket rate of increase plus 1.6 percentage points for hospitals located in rural areas. Based on its market basket rate of increase estimate of 3.7 percent, ProPAC's recommended updates to the standardized amounts equal 2.2 percent for hospitals located in urban areas and 5.3 percent for hospitals located in rural areas. ProPAC recommended that the update for the hospital-specific rates applicable to sole community hospitals be equal to the average update for all hospitals (that is, equal to the percentage increase in the market basket minus 1.0 percentage point, or 2.7 percent based on a market basket rate of increase estimate of 3.7 percent). The components of ProPAC's update factor recommendations are described in detail in the ProPAC report, which is published as Appendix F to this document. We discuss ProPAC's recommendations concerning the update factors and our responses to those recommendations below.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for FY 1995 that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the recommended FY 1995 update factors that are provided for under section 1886(e)(4) of the Act. Accordingly, this appendix provides our recommendations of appropriate update factors, our analysis of the derivation of the amount of the update factors, and our responses to the ProPAC recommendations concerning the update factors.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that the standardized amounts be increased by an average amount equal to the market basket rate of increase minus 2.5 percentage points for hospitals located in urban areas and the market basket rate of increase plus 4.8 percentage points for hospitals located in rural areas (before the effects of adjustments for outlier, geographic reclassification and recalibration of the DRG relative weights). Our recommendation for a higher update to the rural standardized amount is intended to eliminate the differential between the standardized amounts for other urban and rural hospitals, as required by section 1886(b)(3)(B)(i)(X) of the Act. We are also recommending an update of the market basket rate of increase minus 2.2 percentage points to the hospital-specific rate for sole community hospitals. These figures are consistent with the President's budget recommendation, given the new market basket forecast of 3.6 percent.

We recommend that hospitals excluded from the prospective payment system receive an update equal to the percentage increase in the market basket that measures input price increases for services furnished by excluded hospitals minus 1.0 percentage point. That market basket rate of increase is currently forecast at 3.7 percent. Subtracting 1.0 percentage point would result in an update for hospitals excluded from the prospective payment system of 2.7 percent.

As required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC in setting these recommended update factors. Our responses to the ProPAC recommendations concerning the update factors are discussed below.

III. ProPAC Recommendation for Updating the Prospective Payment System Standardized Amounts

For FY 1995, ProPAC recommends that the standardized amount be updated by the following factors:

- The projected rate of increase in the hospital market basket (which was estimated to be 3.7 percent in ProPAC's March 1, 1994 report) with an adjustment of 0.0 percentage points to account for the different wage and salary price proxies used for the ProPAC market basket rate of increase.
- A correction of −1.1 percent to reflect the forecast error in the FY 1993 market basket rate of increase.

• A discretionary adjustment factor of −0.4 percent composed of an allowance of 0.3 percent for scientific and technological advancement and an allowance of −0.7 percent for productivity improvement.

• An adjustment for case-mix change of 0.0 percent.

• A differential update of 3.1 percent for hospitals located in rural areas to reflect the phasing out of the differential in the standardized amounts between rural and other urban hospitals.

Overall, the net increase employing the above factors is the percentage increase in the hospital market basket minus 1.5 percentage points for urban hospitals and the market basket percentage increase plus 1.6 percentage points for rural hospitals. Based on the market basket rate of increase estimate of 3.7 percent used in its March 1, 1994 report, ProPAC recommends that urban hospitals receive a 2.2 percent update and rural hospitals receive a 5.3 percent update.

Response: We are recommending an update that is consistent with the Administration's budget proposal and the requirements of section 1886(b)(3)(B)(i) of the Act, as amended by section 13501(a) of Public Law 103–66. Our recommendation is that: 1) the average update for prospective payment system hospitals located in urban areas for FY 1995 be equal to market basket rate of increase forecast minus 2.5 percentage points, 2) the update to the rural standardized amounts be sufficient to equate the rural with the other urban standardized amounts. Based on HCFA's current forecast of the market basket rate of increase (3.6 percent), we recommend an update for FY 1995 for urban hospitals equal to 1.1 percent (the market basket rate of increase minus 2.5 percentage points), and for rural hospitals equal to 8.4 percent (the market basket percentage increase plus 4.8 percentage points). Under these recommendations, we now estimate that the average update for all prospective payment system hospitals would be the market basket minus 1.4 percentage points, or approximately 2.2 percent. As we have explained in section II of the Addendum to this proposed rule, our recommended updates would be applied to the unadjusted FY 1994 standardized payment amounts. That is, the FY 1994 standardized payment amounts published in our September 1, 1993 final rule (at 58 FR 46362) would be increased to remove the effects of adjustments made for outliers and geographic reclassification before the recommended updates would be applied.

Our recommendation is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix:

• *Productivity:* Service level productivity is defined as the ratio of total service output to full time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, non-labor material and capital inputs), we use a labor productivity measure in our 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 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.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. ProPAC has also estimated cumulative service productivity growth to be 4.9 percent from 1985–1989 or 1.2 percent annually. At the same time, they estimate total service growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35. Our MedPAR analysis indicates total Medicare service output (charges per admission, adjusted for CPI change) increased 20.9 percent from 1985–1993, or an approximate average annual increase of 2.4 percent. Since it is not possible at this time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 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 our framework, the recommended update is 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 rate of increase. This method estimates 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. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low, and higher in years that 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 the product of the expected change in intensity (0.0 percent), projected admissions change (3.2 percent for 1995) and projected real case-mix growth (1.0 to 1.4 percent for 1995), or 4.2 to 4.6 percent. The share of direct labor services in the hospital market basket rate of increase (consisting of wages and 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 to 1.0 percent.

ProPAC also believes hospitals should be given an incentive for additional productivity improvement. ProPAC measures productivity as the ratio of hospital admissions (adjusted for case mix and outpatient services) per FTE employee (adjusted for changes in skill mix). ProPAC includes in its productivity measurement the effect of changes in practice patterns. We treat practice pattern changes as a portion of our intensity adjustment, described below. This year, ProPAC assumes a productivity gain of at least 1.4 percent and recommends a −0.7 percentage point adjustment on the basis that any productivity gains should be shared equally by Medicare and hospitals.

• *Intensity*: We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, 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 1995, we recommend an adjustment of 0.0 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level of 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.

The quality enhancing technology component is intended to recognize the use of services which 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 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. 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 more carefully consider the cost-effectiveness of medical care. This component of the framework also accounts for real within-DRG change, since that should be directly reflected in the CMI- adjusted growth in real charges per case.

We note that, since 1985, the 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. Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, ProPAC 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 a five-year average using FY 1988–1993 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 CPI 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 1.4 percent per year. If we assume that real case-mix change is 1.4 percent per year, we estimate case-mix constant intensity to have declined by an average of 0.4 percent each year during the FY 1988–1993 period, a cumulative decrease of 2.1 percent. If we assume that real case-mix has been growing at 1.0 percent annually, case-mix constant intensity has declined by an average of 0.1 percent annually, for a cumulative decrease of 0.6 percent. We note that regardless of which real case-mix number we assume (1.0 or 1.4), we used the observed case-mix increase for FY 1993 of 0.8 percent to calculate the real case-mix constant intensity. Since we estimate that intensity has declined during the FY 1988–1993 period, we are recommending a 0.0 percent intensity adjustment for FY 1995.

- *Quality Enhancing New Science and Technology:* Project Hope, under contract with ProPAC, annually estimates the incremental operating costs of specific cost-increasing technologies. However, we know of no definitive studies that establish an appropriate level or range for this factor. ProPAC's adjustment is for the cost-increasing effect of new technologies only, and this year assumes the estimated costs for these technologies at only 0.3 percent.

We believe there may be several shortcomings with ProPAC's recommendations with regard to technology. First, the estimate does not account for offsetting changes in revenue due to changes in DRG assignment. Second, it is not clear that all of the new technologies listed in ProPAC's study significantly enhance health status. To the extent the new technologies are not quality enhancing, an adjustment is inappropriate. Finally, some of the technologies have considerable potential for cost savings relative to the technologies they are replacing.

- *Change in Case Mix:* Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 1995 update recommendation, we are projecting a 1.5 percent increase in the case-mix index. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. We estimate that 1.0 to 1.4 percent of the projected case-mix increase of 1.5 percent will be real. This estimate is supported by past studies of case-mix change by RAND Corporation. The most recent study by the RAND Corporation, "Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988" by G.M. Carter, J.P. Newhouse and D.A. Relles, R–4098–HCFA/ProPAC (1991), uses medical records from subsequent Federal fiscal years using consistent standards to determine real case-mix change. The study specifically suggests that real case-mix change is not dependent on total change, but instead is a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to more completely document medical records so as to improve payment. The resulting adjustment to account for changes in case mix during FY 1993, the most recent year for which data are available, is −0.1 to −0.5 percent (subtracting the projected case-mix of 1.5 percent and adding real case mix change of 1.0 to 1.4 percent). The 0.9 percent figure used in the ProPAC framework represents ProPAC's projection for observed case-mix change, and its projection for real case-mix change, including within-DRG case complexity change, during FY 1994. Consistent with ProPAC's framework, we are using a projection for case-mix change in our recommendation.

- *Effect of FY 1993 Reclassification and Recalibration:* We estimate that DRG reclassification and recalibration for FY 1993 resulted in a 0.1 percent decrease in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. ProPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation (we note that Congress asks the Secretary for an estimate of these effects in our update recommendation).

- *Correction for Market Basket Forecast Error:* The FY 1993 estimated market basket percentage increase used to update the payment rates was 4.1

percent. Our most recent data indicate the actual FY 1993 increase was 2.9 percent, reflecting that the actual increase in wages was lower than projected. The resulting forecast error in the projected FY 1993 market basket rate of increase forecast is 1.2 percentage points. Our policy has been to make a forecast error correction if our estimate is off by 0.25 percentage points or more. Therefore, we are recommending an adjustment of −1.2 percentage points to reflect this overestimation of the FY 1993 market basket rate of increase. The following is a summary of the update ranges supported by our analyses compared to ProPAC's framework.

TABLE 1.—COMPARISON OF FY 1995 UPDATE RECOMMENDATIONS

	HHS	ProPAC
Market Basket	MB	MB
Difference Between HCFA & ProPAC Market Baskets		+0.0
Subtotal	MB	MB
Policy Adjustment Factors:		
Productivity	−0.8–−1.0	−0.7
Intensity	0.0	
Science and Technology		+0.3
Intensity		(1)
Real Within DRG Change		(2)
Subtotal	−0.8–−1.0	+0.3
Case Mix Adjustment Factors:		
Projected Case Mix Change	−1.5	−0.9
Real Across DRG Change	1.0–1.4	+0.7
Real Within DRG Change	(3)	+0.2
Subtotal	−0.1–−0.5	0.0
Effect of 1993 Reclassification and Recalibration	+0.1	
Forecast Error Correction	−1.2	−1.1
Total Recommended Update	MB−2.0–MB−2.6	MB−1.5

(1) Included in ProPAC's Productivity Measure.
(2) Included in ProPAC's Case Mix Adjustment.
(3) Included in HHS' Intensity Factor.

The above analysis supports our recommended update to the urban standardized amounts of the market basket rate of increase (that is, 3.6 percent) minus 2.5 percentage points, or 1.1 percent. In addition, we believe a differential update for the standardized amount applicable to rural hospitals is appropriate in order to phase out the differential between the rural and other urban standardized amounts, as required by section 1886(d)(3)(A)(iii) of the Act. We are recommending that the rural standardized amount be updated by the market basket plus 4.8 percentage points for a total update of 8.4 percent. This recommendation is consistent with the President's budget, which includes an update to the standardized amounts for rural hospitals of the market basket rate of increase plus the amount necessary to eliminate the differential between the rural and other urban standardized amounts.

We recommend that the hospital-specific rates applicable to sole community hospitals be increased by the update factor that approximates that applicable for urban hospitals. We believe that the considerations used to develop the update recommendations for the rural standardized amounts that would eliminate the difference between the rural and other urban standardized amounts are not a relevant consideration for the hospital-specific rates. Therefore, we are recommending an update to hospital-specific rates of the market basket rate of increase minus 2.2 percentage points, which is consistent with current law and the President's budget.

IV. ProPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

ProPAC recommends an update factor equal to the market basket rate of increase minus 1.0 percentage point for excluded hospitals and units. The 1.0 percentage point reduction represents a reduction of 1.0 percentage point to account for the forecast error in the FY 1993 market basket rate of increase for excluded units, no increase to reflect the different compensation price proxies used by ProPAC, and no allowance for new technology. ProPAC no longer recommends an additional allowance based on the year the hospital or unit was excluded from the prospective payment system, pending our report to Congress on payment reform for excluded hospitals and units as mandated by Public Law 101- 508.

Response: We recommend that hospitals excluded from the prospective payment system receive an update equal to the percentage increase in the market basket that measures input price increases for services furnished by excluded hospitals minus 1.0 percentage point. The reduction is consistent with the updates provided under current law and in the President's Budget. The market basket rate of increase for excluded hospitals is currently forecast at 3.7 percent. Subtracting 1.0 percentage point would result in an update of 2.7 for excluded hospitals and units.

Appendix E: 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. The regulations provide that, beginning in FY 1996, 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 changes in capital requirements resulting from development of new technologies and other factors (such as the diffusion of existing technologies and existing hospital capacity and utilization). The objective of the capital update framework is to determine a rate of increase in aggregate capital prospective payments that, along with a rate of increase in DRG operating 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 series of preliminary models, using available data and concepts, of an update framework for the prospective payment system for hospital inpatient capital-related costs. We have presented a series of models in our FY 1992, FY 1993, and FY 1994 rulemaking documents. We received no comments on the most recent model of the framework, which appeared in the September 1, 1993 final rule (58 FR 46489). Below we discuss the current version of the model, based on our previously published version and our continued analysis of the data and concepts incorporated into the framework.

The model update framework includes a capital input price index (CIPI) that parallels the operating input price index. The CIPI measures the pure price changes associated with changes in capital-related costs (prices x "quantities"). The composition of capital-related costs is maintained at base-year FY 1987 proportions in the CIPI. As such, the composition of capital reflects the underlying capital acquisition process. We selected FY 1987 as the base year for this preliminary CIPI for consistency with the operating 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 CIPI below illustrates the methodology we propose to employ.

The model capital update framework, like the revised operating update framework, incorporates several policy adjustments in addition to the CIPI. We would adjust for case-mix index-related changes, for intensity, and for the efficient and cost-effective use of capital (such as movable equipment, buildings and fixed equipment) in the hospital industry, as well as for error in the capital input price index forecast.

In developing the model framework, we are attempting as much as possible to maintain consistency with the current operating framework, in order to facilitate the eventual development of a single prospective payment system update framework. We are also concerned with promoting the goals that motivated the adoption of the capital prospective payment system, 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 continue to encourage submission of comments and recommendations for further improvements. We are interested in suggestions regarding the CIPI, the proposed policy adjustment factor for intensity, and alternative methodologies for deriving the factors. We also welcome information concerning empirical studies and sources of data that could be useful in developing the framework. We will consider comments and recommendations on any aspect of the model framework in making further developments for presentation in the next version of the model. Our plan is to consider comments received on this model for inclusion in one further preliminary model to be included in this year's final rule for the prospective payment system. We will then formally propose an analytical update framework for implementation in FY 1996 during the rulemaking process for that year.

II. ProPAC Recommendation for Updating the Capital Prospective Payment System Federal Rate

ProPAC recommends the use of an update framework that includes a capital market basket component that measures 1-year changes in the purchase prices of a fixed basket of capital goods purchased by hospitals (Recommendation 10). The ProPAC framework also includes several policy adjustment factors. A forecast error correction factor adjusts payment rates so that the effects of past errors are not perpetuated. A financing policy adjustment accounts for the effects of substantial deviations from long-term trends in interest rates on hospital capital costs. The capital update framework also includes adjustments for scientific and technological advances, productivity, and case-mix change similar to those employed in the ProPAC operating update framework.

In Recommendation 11, ProPAC also recommends the development and use of a combined update framework for the prospective payment systems for operating and capital-related costs for FY 1995.

Response: Our long-term goal is to develop a single prospective payment system update framework. Currently, the regulations provide for the determination of the capital prospective payment update by means of a lagged 2-year average of actual Medicare capital cost increases. Once we have completed work on an analytical framework for the capital prospective payment update, we will begin to study development of a unified framework. In the meantime, we will continue to maintain consistency as much as possible with the current operating framework in order to facilitate the eventual development of a unified framework.

The basic objectives of the ProPAC and HCFA update frameworks are compatible. The goal of each framework is to provide a rate of increase in capital prospective payments that, along with the rate of increase in operating prospective payments, will ensure a flow of capital and operating resources that will allow for efficient and effective care for Medicare patients. Both frameworks are designed to provide increases for the purchase of quality-enhancing new technologies. Both frameworks provide for case-mix adjustments to remove the effects of upcoding and to adjust for changes in within-DRG severity. Both frameworks also seek to encourage efficient capital spending behavior and to adjust the overall size of capital stock to appropriate levels. Although the frameworks adopt different methodologies for promoting some of these goals, they are philosophically compatible to the degree that they share these goals.

However, there is one significant philosophical difference between the ProPAC and HCFA frameworks. ProPAC's framework is based on the premise that capital prospective payments are for future capital purchases. Thus, ProPAC's proposed capital market basket reflects the projected increase in the purchase price of capital goods from one year to the next. To put it another way, the market basket under the ProPAC framework reflects the price of replacing current capital stock at future prices.

HCFA's framework is based on the premise that capital prospective

payments are for hospitals' future capital-related expenses rather than for future capital-related purchases. That is, HCFA's framework addresses the expenses associated with hospitals' given stock of capital in a particular fiscal year; ProPAC's framework ignores hospitals' present stock of capital and focuses on costs of capital purchases that hospitals will make in a particular fiscal year.

There is a sound economic reason why the current purchase price of capital assets alone is an inadequate measure of the price of capital. The crucial distinguishing feature of capital assets is that they are consumed over time. A satisfactory measure of the change in capital input prices must therefore account for this fact. Consideration of the costs for all capital currently in use for patient care, not just the costs for current capital purchases, is necessary for this purpose. The ProPAC index cannot adequately capture this aspect of changes in capital input prices.

In addition to our disagreement with ProPAC over the basic purpose of the CIPI, we also disagree over the treatment of interest. The pure price aspects of interest costs (that is, the interest rate and the purchase price that is represented in the amount of loan principal) are beyond the control of the hospital industry. To be sure, the actual decision to purchase capital assets or acquire debt is a "quantity" decision and typically is discretionary for a particular span of time. However, measuring the actual expected price per unit of real capital, independently of any evaluation of the propriety of any actual purchase decisions, is essential to recognize that the industry has control over the amount of capital it purchases but no control over the price it pays for capital. Thus, the pure price aspect of interest cost changes must be incorporated into the CIPI. Otherwise, the CIPI will not accurately reflect the prices faced by hospitals who must borrow to finance necessary capital acquisitions. Limitations on the quantity of capital are appropriately implemented through policy adjustment factors. The ProPAC approach artificially eliminates pure price changes related to interest costs from the CIPI and incorporates them into a discretionary adjustment factor. The HCFA CIPI retains all price components of increase in interest costs as one measure of inflation in capital-related expenses. It thereby keeps price and quantity aspects distinct, allowing separate analysis of each factor of increases in capital expenses.

We provide further comments on particular ProPAC recommendations in sections III and IV of this appendix. The ProPAC recommendations concerning the methodology for recognizing increases due to quality-enhancing new technology and the case-mix index adjustment are discussed in Appendix D in the context of the update recommendation for the prospective payment system for operating costs.

III. Measurement of Capital Input Price Increases

A. Introduction

HCFA proposed a capital input price index as one component in developing future update factors for the Federal rate in the September 1, 1992 **Federal Register** (57 FR 40016). We have presented revised versions of the capital input price index in the May 26, 1993 (58 FR 30448) and September 1, 1993 (58 FR 46490) issues of the **Federal Register**. The developing capital input price index parallels the operating input price index. Both the developing capital input price index and the operating input price index are designed to measure input price changes for hospitals' current year expenses, that is, to separate pure price changes from quantity and expenditure changes. The operating sector input price index measures input price changes for operating-related expenses. The capital input price index measures input price changes for capital-related expenses. Capital-related expenses include depreciation, interest, and other expenses (taxes and insurance related to capital goods.)

B. Review of the HCFA Capital Input Price Index Methodology

The current version of the CIPI is based on the following assumptions:

- The Federal rate is based on the concept of capital-related expenses of capital assets used for patient care in the fiscal year and, therefore, any change in the Federal rate should take into account expected changes in the input price aspects of capital-related expenses;
- Capital-related expenses are defined as the sum of depreciation expense, capital-related interest costs, and other capital-related costs, including taxes, insurance, and leases; and
- The input prices related to capital-related expenses are beyond the control of the hospital industry (that is, the hospital is a price-taker, not a price-setter).

These assumptions lead directly to a definition of a CIPI that takes into account the price aspects of changes in depreciation expense, interest costs, and other capital-related costs. Further, the assumptions lead directly to input prices for depreciation expense and interest costs which, unlike operating costs, have a time dimension that must be captured in the CIPI. HCFA includes three categories of capital-related expenses in the CIPI: depreciation expense, interest costs, and other capital-related costs (taxes and insurance).

Current depreciation expenses represent the summed depreciation charges for all past purchases of fixed capital assets that are still depreciable in the current period. The input prices associated with these depreciation expenses are the purchase prices attached to all past and current capital purchases for capital still depreciable in the current period. A weighted average of these purchase prices thus represents the input price associated with depreciation expenses in the current period. Thus, the depreciation input price for the current period measures price aspects of current depreciation expenses for capital just as the operating input price index for the current period measures price aspects of current operating expenses for labor and non-capital goods and services. The depreciation input price differs from the operating input price in that the depreciation input price is a composite of all past capital purchase prices while the operating index input price measures purchase prices for current periods only.

Current interest expenses represent the total interest charges for all still-active past debt instruments associated with the purchase of fixed capital assets. The input prices associated with these interest expenses are the interest rates attached to all past debt instruments that are still active in the current period. A weighted average of these interest rates thus represents the input price associated with interest expenses in the current period. Thus, the interest input price for the current period measures price aspects of current interest expenses just as the operating input price index for the current period measures price aspects of current operating expenses for labor and non-capital goods and services. The interest input price differs from the operating input price in that the depreciation input price is a composite of all past interest rates for debt instruments still active while the operating index input price measures purchase prices for current periods only.

Current year capital-related expenses for taxes and insurance have an annual time dimension and, therefore, prices associated with these expenses are, like operating input prices, current year prices only.

C. Revisions to the Depreciation Component of the CIPI

A commenter on a previous version of the CIPI recommended that constant annual weights for capital price proxies be replaced by variable annual weights that reflect the vintage purchases of capital. The commenter pointed out that annual purchases of real capital tend to increase over time. As annual purchases of capital increase, the later years in the moving average of depreciation costs should be weighted more heavily than the earlier years.

We agree with this comment. Accordingly, a special data base was prepared to provide appropriate historical weights for depreciation and interest input prices. The data base starts with financial variables from the American Hospital Association (AHA) Panel Survey. These are enhanced with data from Medicare cost reports and from the Department of Commerce Capital Expenditure Survey. The data base provides annual estimates of nominal purchases for building and fixed equipment and for movable equipment. Leasing amounts were converted to nominal purchases using the same relationships as appear for owner-operated capital. Nominal purchases were then converted to annual real (that is, constant dollar) purchases by dividing nominal expenditures by an appropriate purchase price proxy.

Expected life for building and fixed equipment and for movable equipment were derived from Medicare cost reports by dividing book value of assets by current year depreciation amounts. The relative distribution of real capital purchases within the respective life for building and fixed equipment (25 years) and for movable equipment (10 years) were derived from the special data base. These relative distributions are shown in Table 1. Relative distributions for a number of different time periods were averaged to obtain the distributions in Table 1. These distributions were all very similar regardless of the periods chosen and, therefore, we selected an average of the distributions in order to simplify the calculations.

TABLE 1.—RELATIVE WEIGHTS FOR CAPITAL PRICE PROXIES DEPRECIATION

Building and Fixed Equipment Expected Life: 25 years	
1	0.015
2	0.019
3	0.022
4	0.024
5	0.023
6	0.022
7	0.020
8	0.021
9	0.025
10	0.030
11	0.033
12	0.034
13	0.034
14	0.035
15	0.038
16	0.043
17	0.049
18	0.053
19	0.056
20	0.057
21	0.060
22	0.066
23	0.071
24	0.075
25	0.077
Total	1.000
Movable Equipment Expected Life: 10 years	
1	0.064
2	0.072
3	0.077
4	0.085
5	0.095
6	0.101
7	0.109
8	0.122
9	0.132
10	0.142
Total	1.000
Interest Expected Life: 22 years	
1	0.007
2	0.009
3	0.010
4	0.011
5	0.013
6	0.015
7	0.017
8	0.020
9	0.023
10	0.027
11	0.032
12	0.038
13	0.043
14	0.050
15	0.057
16	0.064
17	0.074
18	0.083
19	0.090
20	0.098
21	0.105
22	0.114
otal	1.000

Source: Health Care Financing Administration, Office of the Actuary.

Table 2 shows the historical percentage changes in the capital price proxies employed in the CIPI. These proxies are: the building cost index maintained by the Engineering News-Record (ENR) for the costs of fixed assets; the machinery and equipment component of the Producer Price Index (PPI–11) for moveable equipment; the average yield on domestic municipal bonds from the Bond Buyer index of 20 bonds (Muni); the average yield on Moody's corporate bonds (AAA); a composite of Muni and AAA indexes (Combined Muni/AAA); and the residential rent component of the Consumer Price Index (CPI Rent) for other capital costs.

We applied the relative weights from Table 1 to the appropriate historical percent changes in capital price proxies listed in Table 2 to generate the current year prices for the CIPI depreciation sector listed in Table 3. For example, the FY 1995 moveable equipment index component percentage change of 1.9 percent in Table 3 represents the average of the percentage changes in the moveable equipment price proxy (PPI–11 in Table 2) for the previous 10 years (that is, FY 1985 through 1994), weighted by the relative weights listed for movable equipment in Table 1.

TABLE 2.—ANNUAL PERCENT CHANGES FOR CAPITAL INPUT PRICE PROXIES, 1949 TO 1999 [1]

PROXY NAME: ENRBCI—BUILDING COST INDEX—AVERAGE OF 20 U.S. CITIES PPI–11—MACHINERY AND EQUIPMENT MUNI—AVERAGE YIELD ON DOMESTIC MUNICIPAL BONDS—BOND BUYER (20 BONDS) AAA—AVERAGE YIELD ON MOODY'S AAA CORPORATE BONDS CPI (ALL URBAN)—RESIDENTIAL RENT

Fiscal year	ENRBCI	PPI–11	Percent changes			
			Muni	AAA	Combined muni/AAA	CPI rent
1949	5.08	7.35	−4.43	−3.14	−4.20	4.41
1950	2.79	0.46	−9.36	−4.16	−8.43	3.87
1951	9.96	13.64	−5.81	7.10	−3.39	3.73

TABLE 2.—ANNUAL PERCENT CHANGES FOR CAPITAL INPUT PRICE PROXIES, 1949 TO 1999 [1]—Continued

PROXY NAME: ENRBCI—BUILDING COST INDEX—AVERAGE OF 20 U.S. CITIES PPI–11—MACHINERY AND EQUIPMENT MUNI—AVERAGE YIELD ON DOMESTIC MUNICIPAL BONDS—BOND BUYER (20 BONDS) AAA—AVERAGE YIELD ON MOODY'S AAA CORPORATE BONDS CPI (ALL URBAN)—RESIDENTIAL RENT

Fiscal year	ENRBCI	PPI–11	Percent changes			
			Muni	AAA	Combined muni/AAA	CPI rent
1952	2.43	1.60	12.93	5.70	11.43	4.25
1953	4.20	0.79	25.86	7.29	22.21	4.70
1954	3.67	2.73	−8.20	−6.32	−7.87	4.79
1955	4.37	1.90	−0.41	1.08	−0.15	1.43
1956	5.26	7.46	7.82	7.65	7.79	1.69
1957	3.55	7.99	24.03	18.02	22.96	1.94
1958	4.55	3.22	−3.73	−1.10	−3.29	1.90
1959	4.53	1.56	11.54	13.29	11.85	1.33
1960	2.67	1.53	1.71	4.93	2.28	1.58
1961	1.49	−0.30	−3.14	−3.24	−3.16	1.30
1962	1.93	0.00	−6.42	0.81	−5.11	1.28
1963	2.18	0.00	−3.43	−2.82	−3.31	1.01
1964	3.21	0.91	3.23	3.30	3.25	1.00
1965	2.32	0.60	−0.50	1.55	−0.10	0.99
1966	3.65	2.69	16.52	11.02	15.44	1.23
1967	2.90	3.78	2.41	8.26	3.51	1.69
1968	6.22	2.80	14.68	14.50	14.64	2.38
1969	10.25	3.27	21.50	9.83	19.20	2.79
1970	5.43	4.22	22.18	17.95	21.41	4.07
1971	11.52	4.30	−13.93	−4.94	−12.34	4.78
1972	12.53	2.18	−5.81	−3.77	−5.42	3.53
1973	8.78	2.61	−1.76	0.81	−1.26	4.01
1974	5.76	9.95	12.58	12.46	12.56	4.82
1975	8.04	19.37	19.17	7.95	16.94	5.33
1976	8.97	6.70	−1.15	−3.23	−1.53	5.24
1977	8.55	5.95	−15.84	−6.37	−14.13	5.80
1978	8.74	7.49	1.12	5.59	2.00	6.74
1979	7.98	8.85	7.27	8.90	7.60	7.05
1980	8.12	11.47	26.89	22.89	26.07	8.64
1981	7.04	10.65	32.94	20.74	30.49	8.84
1982	7.41	7.03	16.17	5.46	14.18	8.00
1983	6.46	3.23	−22.52	−17.72	−21.69	6.23
1984	2.83	2.25	4.76	6.85	5.14	5.06
1985	0.18	2.20	−5.27	−7.13	−5.61	5.87
1986	1.87	1.50	−18.08	−19.64	−18.36	6.18
1987	2.42	1.48	−5.49	−5.31	−5.46	4.45
1988	2.48	2.18	7.12	9.94	7.62	3.85
1989	1.42	3.47	−6.67	−4.78	−6.33	3.79
1990	2.67	3.18	−1.19	−2.04	−1.34	4.18
1991	1.52	2.25	−2.67	−2.60	−2.65	3.87
1992	2.80	0.49	−7.39	−8.18	−7.54	2.60
1993	5.10	0.50	−10.60	−8.90	−4.00	2.33
1994	3.80	1.10	−6.10	−7.50	3.00	3.15
1995	2.60	2.40	3.80	4.80	−0.56	5.06
1996	3.20	2.50	−5.30	−0.80	−1.76	3.21
1997	3.80	2.30	3.10	1.00	2.82	3.23
1998	3.60	2.20	9.30	6.90	0.18	3.42
1999	3.00	2.30	5.30	5.50	0.09	2.69

Source: Data Resources Inc.

TABLE 3.—HCFA CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1979 TO 1999 [1]

Fiscal Year	Total	Total	Depreciation building and fixed equipment	Movable equipment	Interest	Other
Weight	1.0000	0.6510	0.3054	0.3456	0.3274	0.0216
Price Changes						
1979	6.3	7.8	6.9	8.6	3.4	7.0
1980	7.3	7.9	7.0	8.7	6.0	8.6
1981	8.0	7.7	7.0	8.3	8.8	8.8

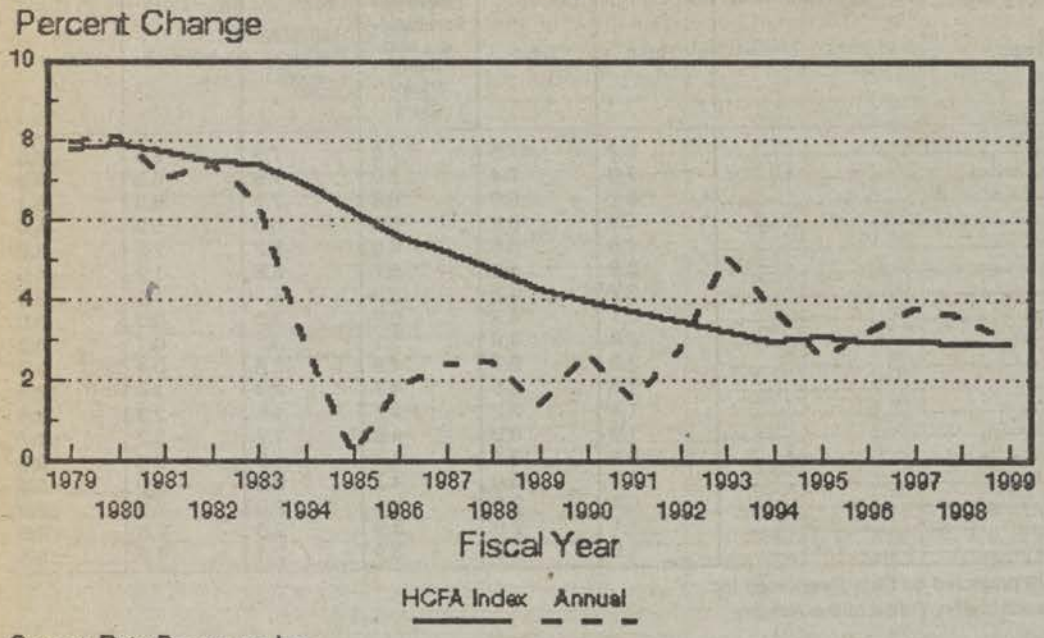
TABLE 3.—HCFA CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1979 TO 1999 [1]—Continued

Fiscal Year	Total	Total	Depreciation building and fixed equipment	Movable equipment	Interest	Other
1982	8.2	7.5	7.0	7.9	9.6	8.0
1983	7.0	7.4	7.0	7.6	6.3	6.2
1984	6.7	6.9	6.8	7.1	6.3	5.1
1985	5.8	6.2	6.3	6.0	5.0	5.9
1986	4.5	5.6	6.0	5.2	2.3	6.2
1987	3.8	5.2	5.7	4.6	1.2	4.5
1988	3.7	4.8	5.5	4.1	1.6	3.9
1989	3.1	4.3	5.2	3.5	0.6	3.8
1990	2.8	4.0	5.1	3.1	0.1	4.2
1991	2.3	3.7	4.9	2.6	−0.4	3.9
1992	1.8	3.5	4.7	2.4	−1.4	2.6
1993	1.4	3.2	4.7	1.8	−2.2	2.4
1994	1.0	3.0	4.6	1.7	−3.2	1.7
1995	0.9	3.1	4.4	1.9	−3.6	2.6
1996	1.1	3.0	4.2	2.0	−3.0	5.4
1997	0.9	3.0	4.1	2.0	−3.3	2.9
1998	1.1	2.9	3.9	2.0	−2.6	4.6
1999	1.6	2.9	3.9	2.1	−1.2	5.5

[1] Index prices for 1994 through 1999 projected by Data Resources Inc.
Source: Health Care Financing Administration, Office of the Actuary.

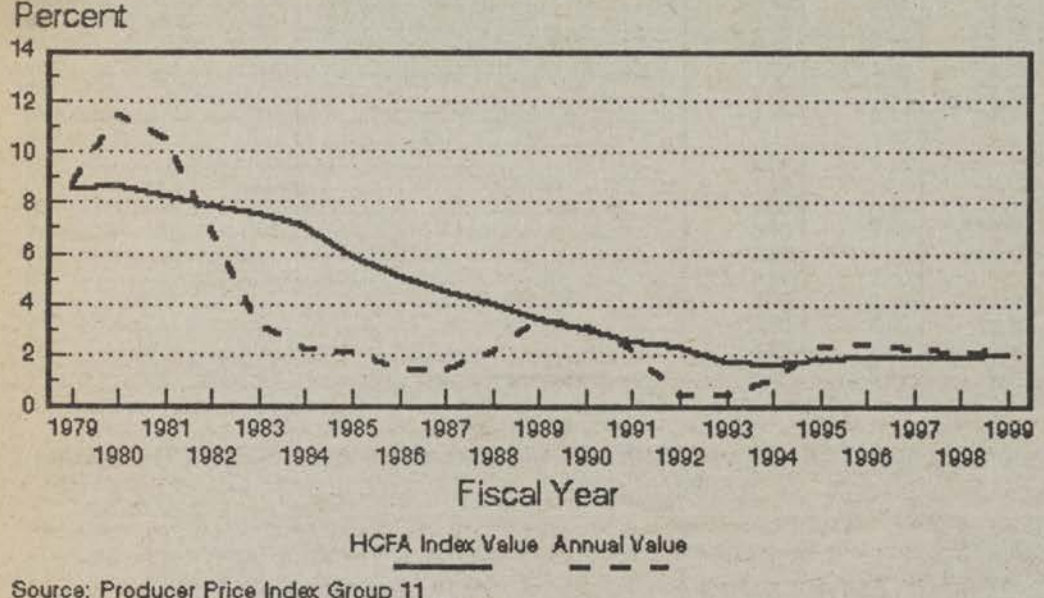
The stability of the HCFA vintage-weighted CIPI compared to annual changes in capital purchase prices is portrayed graphically in Figures 1 and 2. As we have discussed in connection with previous versions of the CIPI, stability is an important criterion for evaluating such an index. This is because excessive volatility in a price index deprives the index of predictability, and thus inhibits the ability of institutions to plan for changes in capital payments resulting from changes in the CIPI.

Figure 1 Building and Fixed Equipment: HCFA Index and Annual Changes, 1979 to 1999



Source: Data Resources Inc

Figure 2 Movable Equipment Price Changes: Annual and HCFA Index, 1979 to 1999



Source: Producer Price Index Group 11 Index. Projections from 1994 to 1999 by Data Resources Inc.

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ProPAC recommends a capital input price index based on annual changes in current capital purchase prices excluding consideration of weighted historical capital purchase prices. We previously argued that the ProPAC index was not logically consistent with the operating input index that is currently used to assist updating DRG payment rates. We would add that the volatility in annual purchase prices shown in Figures 1 and 2 would introduce an unacceptable degree of volatility in prospective capital payments.

D. Revisions to the Interest Price Component of the CIPI

Another commenter on a previous version of the CIPI recommended that data from Securities Data Inc. be incorporated into the CIPI interest computations. This source provides information on hospital issuances of municipal and commercial bonds. From this data base, we incorporated information that shows that the average expected life of hospital bond debt instruments (that is, the time interval between the issue date and the maturation date) was about 13 years for municipal serial bonds and about 25 years for municipal term bonds. The weighted average life for the 2 types of bonds was 22 years.

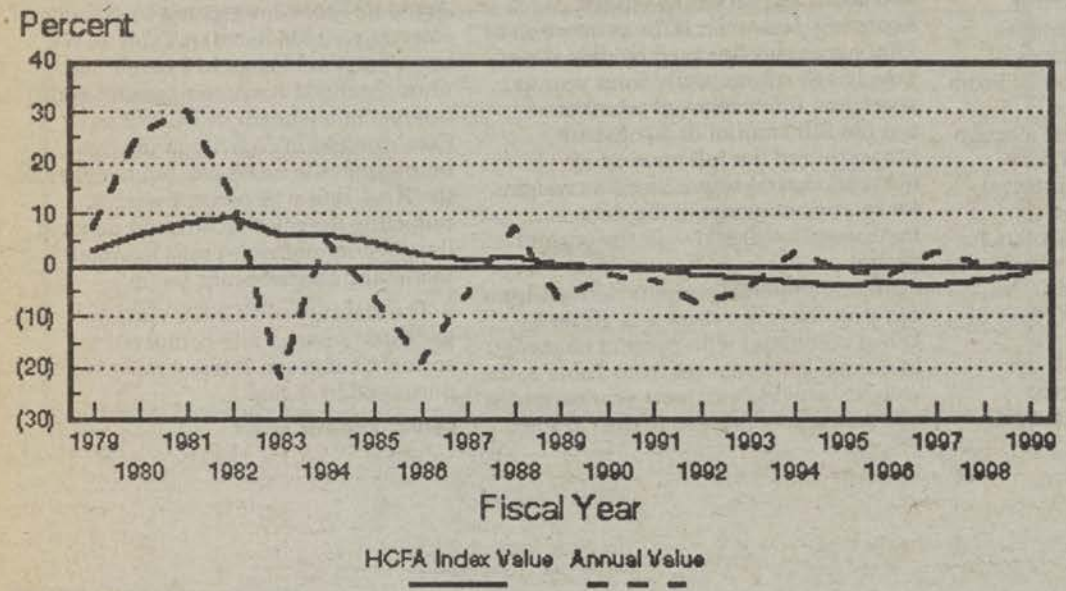
The relative nominal capital purchases within various 22-year periods provided appropriate annual weights for annual changes in interest rates. Not all capital purchases are funded by debt. Medicare cost reports suggest that about 80 percent of new capital acquisitions are financed by debt and about 20 percent by equity financing. However, if the proportion of total purchases financed by debt does not change substantially from year to year, then it is irrelevant whether we use the full amount or a constant proportion of the full amount of nominal capital acquisitions as weights for relative amounts of the debt instruments still active in the current period.

Relative interest weights derived from our procedure are shown in Table 1. When combined with percent changes in annual interest rates from Table 2, the weights provide a current year estimates of interest rate changes in the CIPI in Table 3. Thus, for example, the interest rate component change of −3.2 percent in Table 3 for FY 1995 represents the average of the previous 22 years in the interest rate proxy (Combined Muni/AAA) in Table 2, weighted by the interest weights listed in Table 1. We use a percent change in a combined municipal and AAA commercial bond interest rate (shown in Table 2 as Combined Muni/AAA), giving the municipal rate an 85 percent weight and the AAA rate a 15 percent weight, reflecting the relative hospital debts of the government/non-profit hospital sector and the for-profit sector.

The stability of HCFA's vintage-weighted interest rate compared to annual changes in interest rates is portrayed in Figure 3.

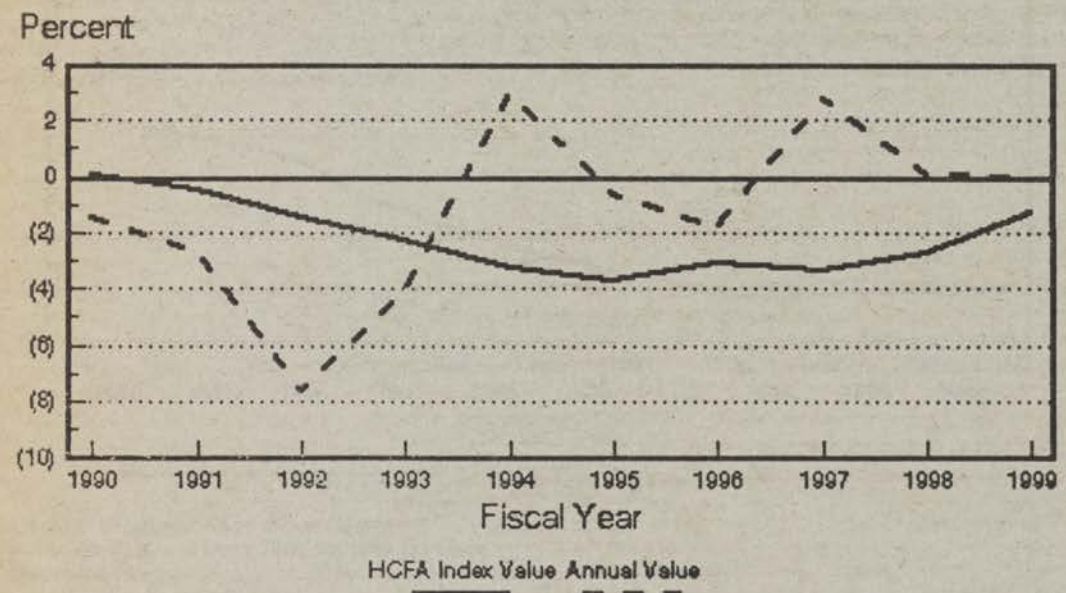
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Figure 3 Interest Rate Percent Changes: Annual Interest Rate and HCFA Index Rate, 1979 to 1999



Source: Data Resources Inc.

Figure 3 (Inset) Interest Rate Changes Annual Interest Rate and HCFA Index Rate, 1990 to 1999



Source: Data Resources Inc.

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As we have discussed in connection with previous versions of the model, stability is an important criterion for evaluating the CIPI because it provides an important degree of predictability to the index.

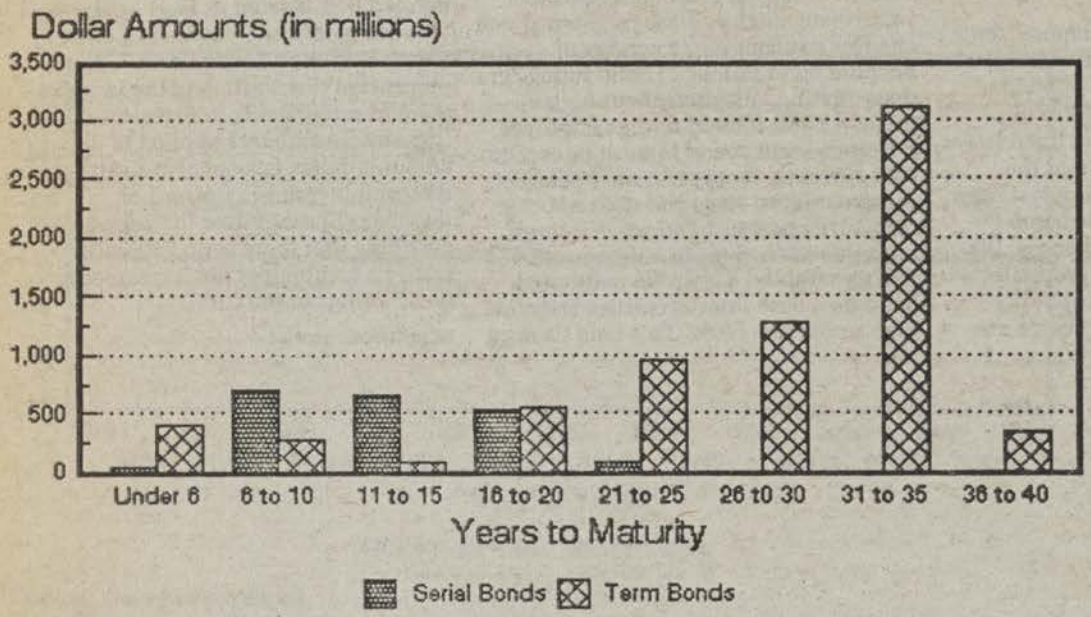
Although Medicare cost reports show that only 60 percent of current hospital debt is in the form of notes or bonds (about 40 percent is in the form of mortgages), we assumed that the relative annual weights for all debt and the relative annual changes in interest rates for all debt were the same as bond-related weights and price changes. We are still searching for an appropriate source of information on hospital commercial mortgage data. We do not expect that the discovery of such data will materially alter our current conclusions about trends in effective interest rates over time.

A third commenter on a previous version of the CIPI recommended that we investigate the effects on interest rate changes of changing structures of hospital bond ratings. If bond ratings are deteriorating, hospitals incur higher interest rates; if bond ratings improve, hospitals incur lower interest rates. Our CIPI currently recognizes only changes in pure interest rates and does not recognize changes in effective interest rates due to changes in bond ratings.

We examined a hospital municipal bond data base from Securities Data Inc. to examine this issue. This data showed that serial bonds dominated short-term bonds and term bonds dominated long-term bonds (Figure 4). We classified all bond amounts by ratings found in the data base for the years 1980 to 1992. We defined bonds rated as Baa1 or above as "Investment Grade" bonds; all others were "Non-Investment Grade". The percentage distribution of the issuance-amount-rated bonds in Figure 5 (percentage amounts applied to dollar amount of debt issuance) indicates no discernible trend in upward or downward ratings over the period. We conclude that there is no evidence to justify a component for deteriorating bond ratings in the CIPI.

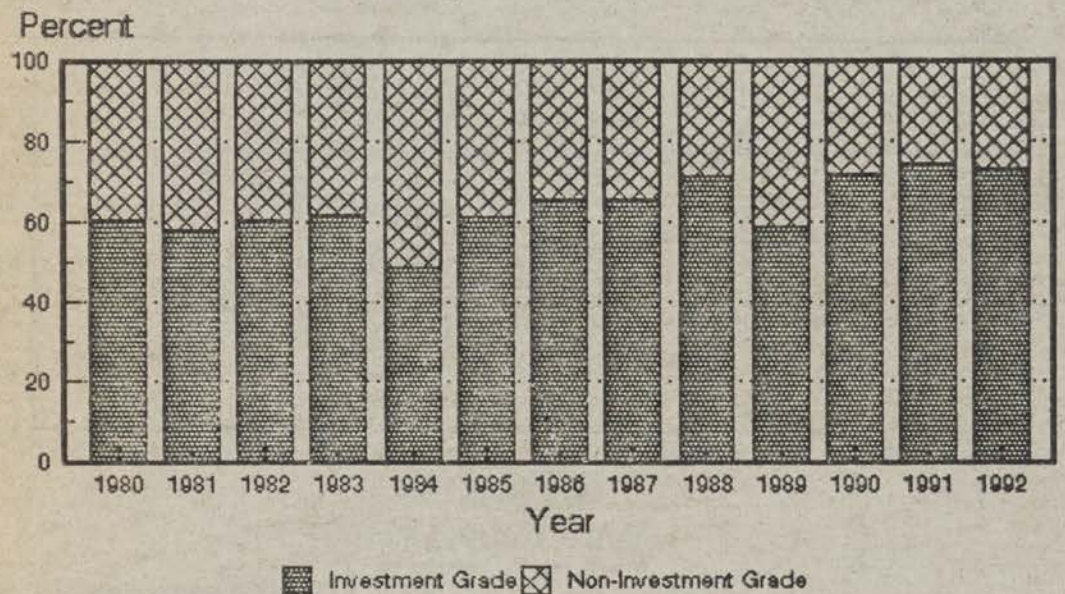
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Figure 4 Dollar Amount of Hospital Municipal Bond Issuance by Type of Bond and by Years to Maturity, 1992



Source: Securities Data Inc

Figure 5 Percentage Distribution of Hospital Municipal Bond Amounts by Investment Grade Ratings, 1980 to 1992



Source: Securities Data Corporation

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E. Projection of the CIPI for Fiscal Year 1995

We project a 0.9 percent increase in the CIPI for FY 1995 (Table 3 and Figure 6). This is the outcome of a 3.1 percent increase in projected weighted depreciation prices in FY 1995 offset by a 3.6 percent decline in vintage-weighted interest rates in FY 1995.

F. ProPAC Input Price Index

1. Introduction

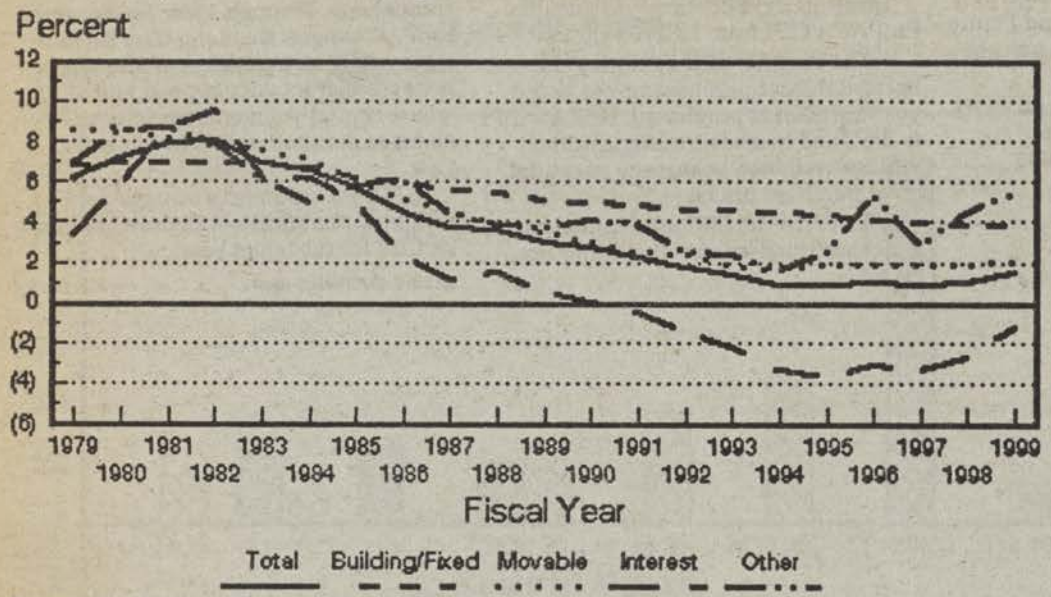
Three major differences distinguish ProPAC's CIPI from HCFA's CIPI:

- The ProPAC CIPI measures changes in capital asset purchase prices in the year the asset is purchased. HCFA's CIPI is designed to measure changes in a vintage-weighted composite of capital asset purchase prices.
- The ProPAC CIPI uses capital asset purchase price proxies that differ from HCFA's.
- The ProPAC CIPI has no interest component. PROPAC treats interest rate changes as a separate update factor component. Through 1995, for example, ProPAC expects that long term interest rates will remain stable and, therefore, believes that it is not appropriate to adjust capital payments for forecasted changes in interest rates in the target year.

HCFA incorporates a vintage-weighted composite of interest rates in its CIPI for the target year.

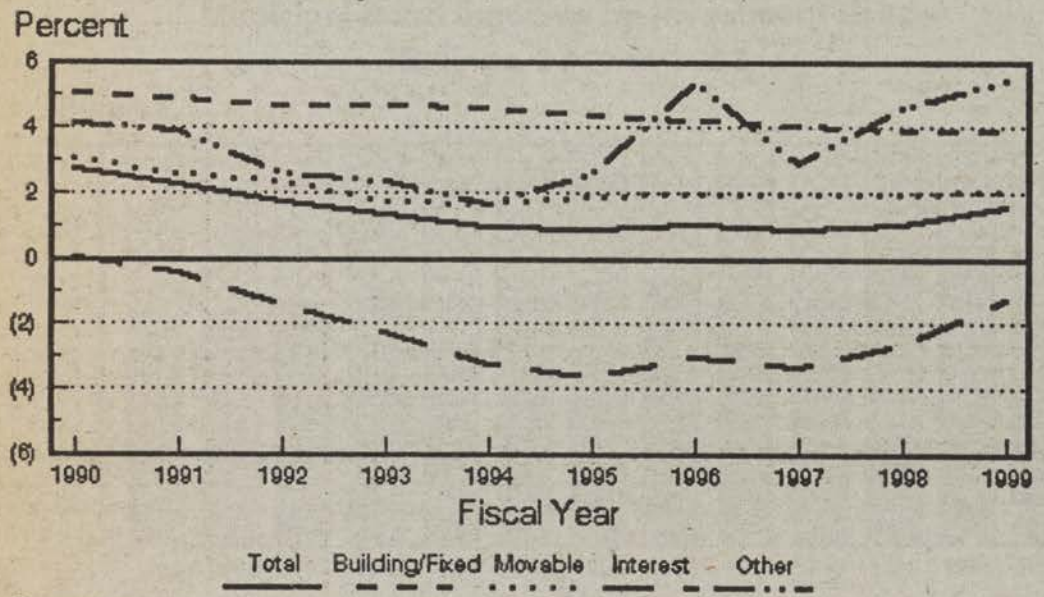
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Figure 6 HCFA Capital Input Price Index: Total and Components, 1979 to 1999



Source: Health Care Financing Administration, Projections for 1994 to 1999 by Data Resources Inc.

Figure 6 (Inset) HCFA Capital Input Price Index Total and Components, Fiscal Years 1990 to 1999



Source: Health Care Financing Administration, Projections for 1994 to 1999 by Data Resources Inc.

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?. Depreciation

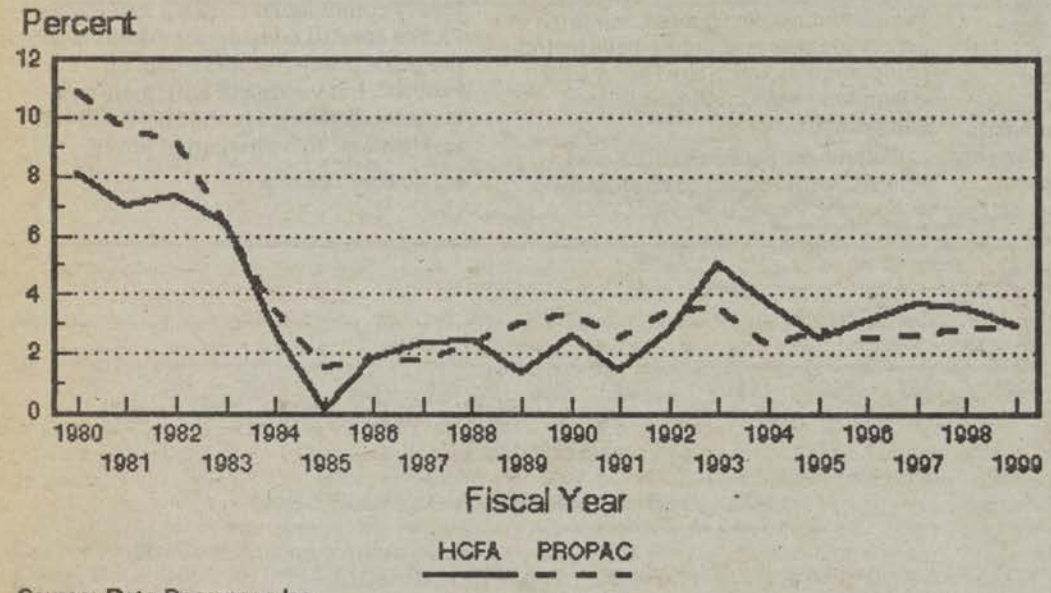
ProPAC states that its CIPI is analogous to the prospective payment operating price index. We disagree. The components of the operating index represent price changes in ongoing hospital expenses for labor and non-capital goods and services. The analogous capital expenses in this context are current depreciation costs, interest costs and other capital-related expenses (taxes and insurance). Current depreciation and interest costs are a cumulative composite of segments of expenses incurred in current and prior periods. Current interest costs are a cumulative composite of segments of past and current year debt costs. Since both depreciation and interest costs have a vintage component, the price aspect of these costs must have a vintage component as well. The HCFA CIPI attempts to capture these vintage components.

Differences between HCFA and ProPAC with respect to choices for annual rates of change in capital purchase price proxies appear to be minimal:

- Changes in alternative price proxies for building and fixed equipment are nearly coincidental (Table 3 and Figure 7). We are still considering adoption of the price proxy recommended by ProPAC, but we do not anticipate any material difference in the HCFA CIPI if we do adopt this alternative proxy.

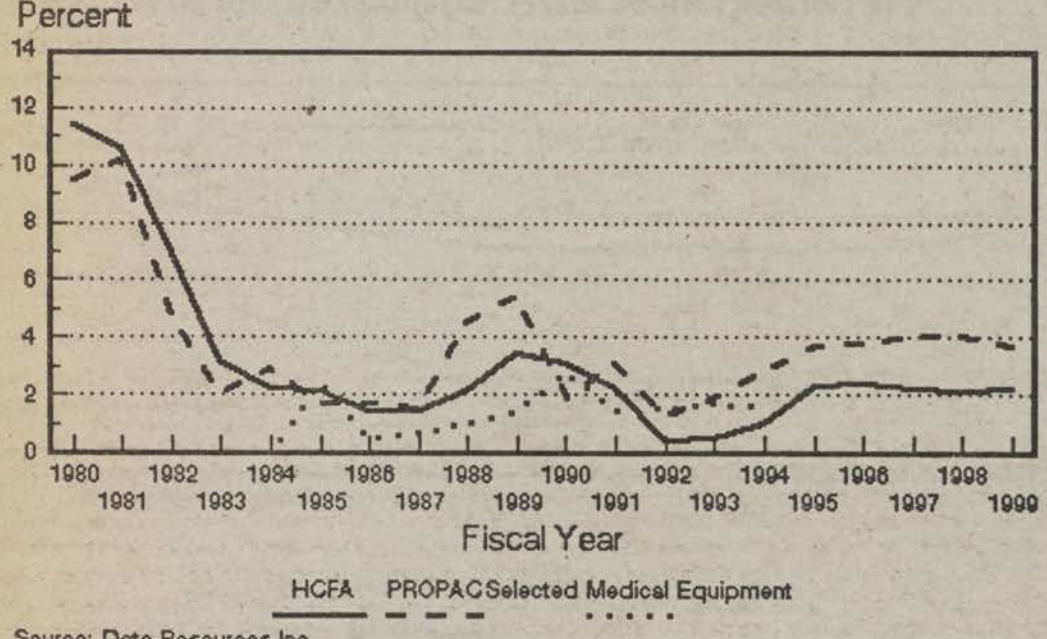
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Figure 7 Alternative Price Indexes for Building And Fixed Equippment: Annual Percent Changes, 1980 to 1999



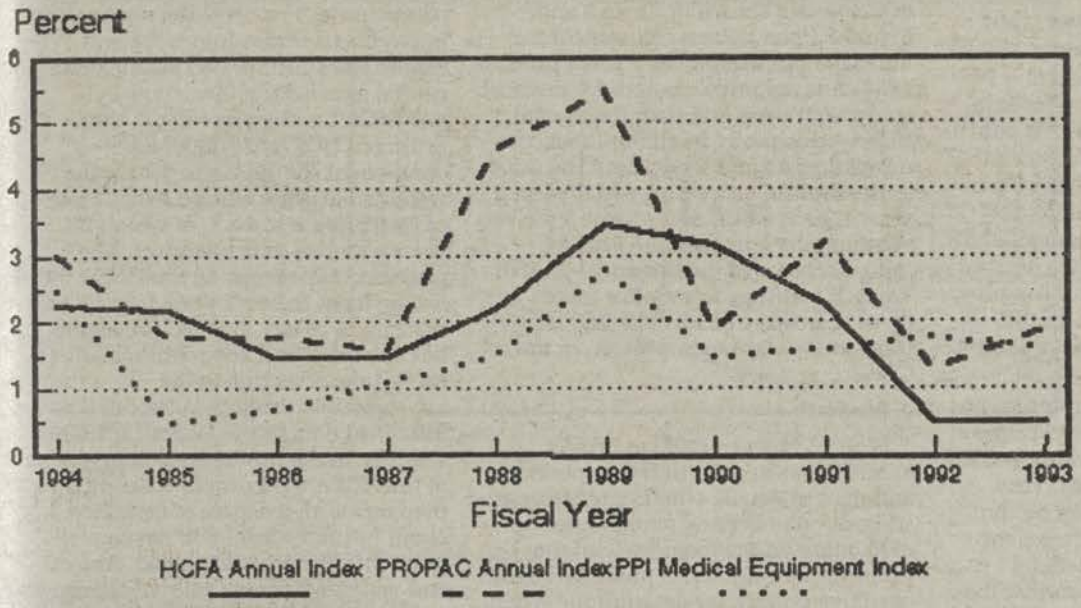
Source: Data Resources Inc.

Figure 8 Alternative Price Indexes for Movable Equipment: Annual Percent Changes, 1980 to 1999



Source: Data Resources Inc.

Figure 8 (Inset) Alternative Price Indexes for Movable Equipment: Annual Percent Change, 1984 to 1993



Source: Data Resources Inc.

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• Changes in alternative price proxies for moveable equipment, although not as close as those for building and fixed equipment, are nevertheless nearly coincidental for much of the historical period (Table 3 and Figure 8).

As noted in our September 1, 1992 final rule, one basic criterion for accepting price proxies is public availability of documentation on data sources and methodology (57 FR 40018–40019). Despite repeated efforts, neither we nor Data Resources Inc. have been able to obtain documentation on the moveable price proxy recommended by ProPAC that explains how it is derived and what sampling frame and sampling error attach to the estimates. In the absence of such information we cannot adopt the ProPAC alternative.

HCFA's assumption is that prices for hospital moveable equipment change at about the same rate as general prices for all machinery and equipment. This assumption is justified in part by the fact that not all moveable equipment purchased by hospitals is medical equipment: it stands to reason that the prices for non-medical equipment purchased by hospitals would change at the same rate as prices for all machinery and equipment. To examine this assumption further, we measured the rate of change in the HCFA moveable price proxy relative to prices for medical equipment only by preparing a composite index of medical prices from the Bureau of Labor Statistics Producer Price Index (PPI) for two commodity categories—medical instruments/equipment and X-ray/electro-medical equipment.

The two PPI commodity indexes were then merged using their respective PPI weights. Price change trends for the period for which information is available are shown in Table 3 and Figure 8 (Inset). Price changes for this index are not available for years prior to 1984. Annual price changes for medical equipment were less than the annual HCFA price proxy in all but the most recent 2 years and were about the same as the ProPAC price proxy in the last 2 years. The medical equipment price was substantially less than the ProPAC index for most of the historical period. We will continue to monitor trends in these indexes to ensure that appropriate price proxies are incorporated in the CIPI.

3. Interest

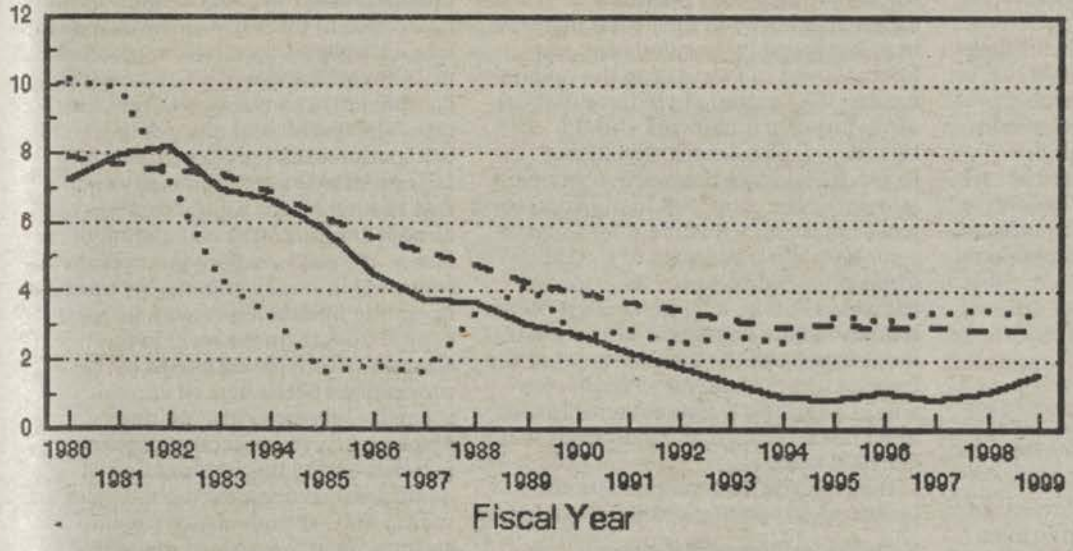
ProPAC has proposed to project annual interest rates to future periods and then to decide whether to allow an add-on to the Federal capital rate depending on the magnitude of the projection. ProPAC has presented no objective criteria for determining when an interest adjustment is appropriate. We previously noted that a single-year projection for interest rates is conceptually inappropriate since interest costs must be vintage-weighted. In addition to this conceptual problem, the ProPAC approach is impractical because future annual interest rates are volatile, vulnerable to unpredictable market forces, and subject to exogenous influences (such as Federal Reserve Board decisions) that are difficult to anticipate. Thus, any projection of future interest rates is likely to be inaccurate, resulting in underpayment or overpayment of the Federal capital rate relative to the capital-related expenses that the rate is supposed to compensate. The resulting uncertainty in payments under future Federal capital rates further complicates future capital expenditure decisions by hospitals. On the other hand, the projected HCFA CIPI interest component for the target year is the weighted average change over 22 years of interest rate history, of which 20 years experience is historical. The projected experience in the HCFA index for the most recent 2 years may be as inaccurate as any ProPAC projection, but any error will have minimal effects on Federal rates due to the appropriately weighted effect of the historical data in the HCFA CIPI. This stability in the interest rate component of the HCFA CIPI provides hospital planners with a degree of certainty about future Federal rate payments, other things remaining equal. Annual and weighted annual rates of change are compared in Table 3.

4. The Composite HCFA CIPI

Annual percentage changes in the historical and projected HCFA and ProPAC CIPIs differ markedly (Figure 9). The ProPAC CIPI is much more volatile than the HCFA CIPI in the historical period through 1993 because it has no vintage-weighted capital input price factors for depreciation.

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Figure 9 Index Percent Changes: HCFA Capital Input Price Index and PROPAC Capital Input Price Index, 1980 to 1999



HCFA Total Index HCFA Depreciation Index PROPAC Index

Source: HCFA and Data Resources Inc.

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Further, the ProPAC CIPI omits interest rates. The cumulative effect of declining interest rates for all debt instruments in recent years has driven the rate of change in the HCFA interest rate component downward, a trend projected into future rate years. The declining interest rate component drags the HCFA CIPI below the ProPAC CIPI in the projection period. Other things being equal, the ProPAC index would result in overpayment through the Federal rate because anticipated actual capital-related expenses will be less than ProPAC projects due to the effects of lower interest rates on capital-related expenses.

IV. 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 CMI 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 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 CMI. 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 1992 DRG reclassification and recalibration as part of our FY 1994 update recommendation.) 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 proposed to adopt this CMI adjustment as well in the capital update framework.

We received no comments on the proposed CMI adjustment.

The current 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 continue to believe that the capital update framework should 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. There is a 2-year lag between the forecast and the measurement of the forecast error. Thus, for example, we would adjust for a forecast error made in FY 1996 through an adjustment to the FY 1998 update.

We received no comments on the proposed forecasting error adjustment.

V. Policy Adjustment Factors

The capital input price index measures the pure price changes associated with changes in capital-related costs (prices x "quantities"). The composition of capital-related costs is maintained at base-year 1987 proportions in the capital input price index. We would address appropriate changes in the amount and composition of capital stock through the policy adjustment factors.

The current 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. Under the revised operating framework, we 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 service productivity factor for the operating update framework reflects a forward-looking adjustment for the changes that hospitals can be expected to make in service-level productivity during the year. A hospital retains any productivity increases above the average.

The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts 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 originally proposed that the intensity adjustment factor in the revised operating framework be adopted in the capital update framework. That factor remains a part of our developing framework. Under the revised operating update framework, we 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. In the absence of 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 assume, as in the revised 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 severity increases and the adoption of quality-enhancing technology.

In our previous discussions of an efficiency adjustment, we suggested that the adjustment should take into account two considerations. One is that capital inputs, unlike operating inputs, are generally fixed in the short run. The productivity target in the revised operating framework operates on a short-term, year-to-year basis. Targets for capital efficiency and cost-effectiveness, however, must operate on a longer term basis. The other consideration is that, prior to the adoption of the capital prospective payment system, 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 markets. A guiding principle in devising an efficiency adjustment is therefore that Medicare capital prospective payment rates should not provide for maintenance of capital in excess of the level that would be produced in an efficiency-oriented competitive market.

As a preliminary examination of this issue, we analyzed the change in actual Medicare capital cost per case for FYs 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 that we were then proposing to include in the framework. (The other adjustment factors are the increase in real case mix and the increase in intensity due to quality-enhancing technological change and within-DRG complexity.) 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.

Economic theory suggests that an industry with a guaranteed return on capital (such as the hospital industry prior to prospective payment for capital-related costs) would have a tendency to be overly capitalized relative to more competitive industries. This is because the incentive for firms in such an industry is to compete on the basis of more capital-intensive production processes than firms in other industries. 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.

Our analysis was designed to examine whether hospitals had in fact 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. The analysis confirmed that volume and intensity of capital acquisition 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 prospective payment system. Even accounting for real CMI increases and increases in intensity attributable to cost-increasing but quality-enhancing new technologies, there remains a large excess of capital-related spending.

The following table shows the results of our most recent analysis, based on the most current data available and the most recent projections. Differences between this table and the tables in previous discussions in the **Federal Register** are due to revised figures for average capital cost per case increases, based on the most recent data and projections, and on our revised CIPI. We have also expanded the analysis incorporated in this table to include FY 1985 and FY 1992, thus encompassing all but 1 year of the period from the implementation of the prospective payment system for operating costs to the implementation of the prospective payment system for capitals costs. (For FY 1984, sufficient data is not available to compute capital cost per case increases and intensity increases.) The results of the analysis in Table 4 are substantially similar to the results of previous analyses. In Table 4 real case-mix increase is assumed to be 1.0 percent annually.

TABLE 4—CUMULATIVE PERCENTAGE CHANGE IN CAPITAL-RELATED COST PER CASE DUE TO INFLATION, REAL CMI, AND INTENSITY, 1986–1991

Year	CIPI [1]	Real CMI [2]	Allowable Intensity [3]	Resulting Increase [4]	Percent change Cost/ Case [5]	Residual [6]
1985	6.2	1.0	3.7	11.2	12.6	1.2
1986	4.3	1.0	2.1	7.5	20.2	11.8
1987	3.6	1.0	2.5	7.3	15.0	7.2
1988	3.7	1.0	1.5	6.3	7.2	0.9
1989	3.1	1.0	0.5	4.7	7.9	3.0
1990	2.8	1.0	0.2	4.0	6.8	2.6
1991	2.4	1.0	0.1	3.5	5.1	1.6
1992	1.6	1.0	-0.7	1.9	3.4	1.5
Cumulative (compounded)	.....	.....	.....	56.5	108.8	33.4

[1] Figures from Table 1, section III.
[2] Assuming that real CMI increase is 1.0 percent annually.
[3] One half of observed intensity increase, as determined by the of the 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 (that is, 1.043x1.01x1.021=1.075 for 1986).
[5] Figures supplied by HCFA's Office of the Actuary.
[6] The actual increase in average cost per case divided by the increase attributable to inflation, real CMI, and allowable intensity (that is, 1.202/1.075=1.118, an 11.2 percent residual for 1986).

We believe that the 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 capital prospective payment system. 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 efficiency adjustment should be designed to give hospitals an incentive to reduce inefficiency and ineffectiveness in capital resources. The analysis in Table 4 suggests that, in order to restore the Federal rate to the level at which it would have been if capital costs had not been excessive in the years before the implementation of capital prospective payment, a cumulative reduction in the rate of 28.2 percent (1.565/2.088=.7495, or -25.0 percent) is justified.

We note that the Administration's Health Security Act contains a proposal for an annual adjustment to the capital update for FY 1996 through FY 2003. This proposal is based in part on our previous analysis of capital spending in the years prior to the implementation of the capital prospective payment system. Section 4103(a)(2)(C) of the proposed Health Security Act provides that the annual update factor applied to the capital prospective payment system rates be reduced by 4.9 percent each year during that period (except that the change factor can never be negative in any year).

Appendix F

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE CONGRESS

March 1, 1994.

Prospective Payment Assessment Commission

Stuart H. Altman, Ph.D., *Chairman*
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Clay D. Edmands
William S. Hoffman, Ph.D.
Clerk E. Kerr
James R. Kimmey, M.D.
David A. Kindig, M.D.
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Colleen M. Tynan
Deborah K. Williams
Jeannette A. Younes

March 1, 1994.

The Honorable Al Gore,
President of the Senate, United States Senate, Washington, D.C. 20510.

Dear Mr. President: I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101–508. This report presents a discussion of major factors that have shaped the evolution of the hospital and discusses possible changes facing the hospital of the future. The report also contains 23 recommendations covering a range of topics, from broad issues concerning Medicare and health care reform to updating Medicare payment rates and refining certain aspects of Medicare payments to hospitals and other facilities. This report reflects the Commission's collective judgment about issues of substantial importance to beneficiaries, hospitals, other providers, and the Medicare program.

Sincerely,

Stuart H. Altman, Ph.D.,
Chairman.

Enclosure

March 1, 1994.

The Honorable Thomas Foley,
Speaker, United States House of Representatives, Washington, D.C. 20515.

Dear Mr. Speaker: I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101–508. This report presents a discussion of major factors that have shaped the evolution of the hospital and discusses possible changes facing the hospital of the future. The report also contains 23 recommendations covering a range of topics, from broad issues concerning Medicare and health care reform to updating Medicare payment rates and refining certain aspects of Medicare payments to hospitals and other facilities. This report reflects the Commission's collective judgment about issues of substantial importance to beneficiaries, hospitals, other providers, and the Medicare program.

Sincerely,

Stuart H. Altman, Ph.D.,
Chairman.

Enclosure

CAPITAL COSTS PER CASE INCREASE FROM COST REPORT DATA

Fiscal year	Number hospitals 1st HCR	Number hospitals 2nd HCR[1]	Unadj-capital cost per case	Increase in cost per case (Unadj.)	Audit adjusted capital cost per case[2]	Increases in adjusted cost per case (Percent)	Average 2-year increase in adjusted cost per case (Percent)	Observed CMI (Percent)	CMI 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)
1990	4251	5412	$543.27	.....	%540.05	.....	.....	.....	.....	.....
1991	4171	5323	584.69	7.62%	567.92	5.16	.....	2.52	2.57	.....
1992	4098	4733	633.80	8.4	587.53	3.45	4.30	1.55	1.87	2.22

[1] Columns 1 and 2 represent the numbers of hospital cost reports used in developing capital costs per case figures in column 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 capital costs per case, adjusted for the anticipated effects of cost report audits and reopenings, from the December 1993 update of HCRIS. The following factors were used in adjusting capital costs 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 1990 0.9256
FY 1991 0.9172
FY 1992 0.9250
Audit Adjustment Applied to Settled Cost Reports
All years 1.0043

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

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Executive Summary

In this report, the Prospective Payment Assessment Commission (ProPAC) discusses major factors that have influenced how hospitals have evolved, looks at how hospitals have responded to changes in the health care environment, and suggests the future direction hospitals may take. The Commission also presents 23 recommendations covering a range of topics, from broad issues concerning Medicare and health care reform to updating Medicare payment rates and refining certain aspects of Medicare payments to hospitals and other facilities. The report is submitted directly to the Congress, although the Secretary of Health and Human Services

is required to respond to the Commission's recommendations.

ProPAC's responsibilities have expanded from its original mandate of advising the Congress and the Secretary on the Medicare prospective payment system (PPS) for hospitals. These additional responsibilities include analyzing and developing prospective payment policies for all facility services furnished to Medicare beneficiaries and examining Medicaid hospital payment rates. In the past year, the Commission has submitted reports to the Congress on Medicare and the American health care system, global budgeting, and Medicaid disproportionate share payment adjustments. ProPAC, however, continues to devote substantial effort to updating and improving Medicare policies for paying hospitals.

The Future of Hospitals

Hospitals—the central institutions in the American health care system—have long been the sole source of technology-oriented acute health care for the most complex cases. But because technological capabilities were limited, until the last 20 years or so one hospital was much like another. Each provided its community with essentially the same range of services and was structured in a similar manner. Today, hospitals offer a rich mix of complex, intensive services to a variety of patients. Relationships among hospitals, other institutional providers, and payers have become more complex, characterized by a broad range of ownership arrangements and the sharing of financial risk. Additionally, the role physicians play in hospitals' operations has evolved markedly.

Two major forces—advances in medical technology and changes in financing mechanisms—have profoundly influenced the evolution of hospitals. Technological innovations not only have expanded the services hospitals furnish, but also have resulted in greater competition from other providers. The emergence of third-party payers has created a stream of revenues that financed these innovations.

As health spending has outpaced inflation, both public and private payers have sought ways to curb this growth. Medicare, for instance, has made radical changes in payment mechanisms to constrain the rise in government payments to hospitals. Private payers, too, have used various strategies to control the growth in payments, but with mixed success. For their part, hospitals have minimized cost-containment pressure by generating additional payments from private payers, a practice called "cost shifting."

How each hospital has evolved in response to technological advances, financing changes, and other developments has depended on its internal and external environments. The end result has been significant diversification in the hospital industry.

Hospitals will continue to encounter technological and financing changes. The greatest unknown, however, is the outcome of the current health care debate and how hospitals will fare under reform. Since they account for the largest portion of total health spending, hospitals will bear much of the pressure to alter the way care is delivered and paid for in the future. Hospitals' responses to these changes will differ, depending on the source and stringency of the pressure, and the circumstances facing each facility.

Summary of Recommendations

In Chapter 2, ProPAC presents 23 recommendations reflecting the Commission's concerns regarding health reform and Medicare payment policies. The Commission believes these proposed changes are necessary for maintaining access to quality health care, encouraging productivity and cost effectiveness in the provision of care, and improving payment equity. The Commission developed its recommendations by setting priorities, analyzing information, and deliberating on the implications of alternative policies. ProPAC also pays close attention to the concerns of the Congress, the Administration, health care providers, third-party payers, enrollees, and the public. The Commission's recommendations are offered to comply with ProPAC's statutory mandate and to contribute to an informed, open debate about Medicare payment policies. For fiscal year 1995, the Commission's recommendations focused on three broad areas:

- Medicare and health care reform,
- Payment updates, and
- Other payment policies.

Medicare and Health Care Reform—The health care industry is facing major challenges as policy makers and legislators struggle to control health care expenditures and expand coverage to people without insurance. Several proposals have been introduced to reform the health care system. Some of these focus on incremental changes in the financing and delivery of health care; others call for fundamental restructuring of the existing system. Most include provisions that would affect the Medicare program.

The Health Security Act introduced by the President would fundamentally change the financing and delivery of health care. Under this proposal, most people under 65 would obtain health insurance coverage through regional or corporate alliances that would negotiate with health plans to provide medical services. Managed competition among plans is expected to control the growth in health care expenditures. As a contingency, however, premium rate increases would be limited if expenditure growth were not contained. Medicare would be retained as a separate program, although it would be subject to a number of changes and cost-saving measures.

In this report, the Commission comments on specific features of the Health Security Act and other health reform activities as they pertain to the Medicare program. This discussion is found in Recommendations 1 through 8.

Payment Updates

Recommendations 9 through 14 present the Commission's recommended updates to the payment amounts to various facilities. These include operating and capital payments to hospitals paid under PPS, operating payments to facilities excluded from PPS, and the composite rate for dialysis services.

In examining each of these Medicare payment systems, the Commission recommends to the Congress an appropriate update amount for fiscal year 1995 payments. In addition, ProPAC considers the appropriateness of the base payment rate to which the update factor would be applied.

The Commission is mandated by law to submit to the Congress each year the appropriate update to the inpatient hospital operating payment rates under PPS. ProPAC considers several factors in developing this update: the hospital market basket index, scientific and technological advances, hospital productivity, case-mix change, and the quality and long-term cost-effectiveness of health care. For fiscal year 1995, the Commission recommends an average update of 2.7 percent to the standardized payment amounts: an increase of 2.2 percent for urban hospitals and of 5.3 percent for rural hospitals.

ProPAC's update recommendation for fiscal year 1995 operating payments is higher than the update already legislated by the Congress. ProPAC used its traditional approach of examining individually the factors that contribute to the update. The Commission believes this process results in an appropriate percentage to update the standardized payment amounts for fiscal year 1995.

In addition, the Commission recommends an update factor for the Federal capital payment rate. ProPAC follows an update framework similar to that used for the operating payment update. For fiscal year 1995, ProPAC recommends a 3.6 percent increase to the Federal capital payment rate for both urban and rural hospitals. When the transition to fully prospective capital payments is complete, a single update factor should be used for adjusting PPS operating and capital payment rates.

The Commission also considers the update for facilities currently excluded from PPS and the update to the composite payment rate for dialysis services. The facilities excluded from PPS are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982. For fiscal year 1995, ProPAC recommends the target rates for these facilities should be updated by 2.7 percent. Finally, the Commission recommends that the composite payment rate for dialysis services should not be increased for fiscal year 1995.

Other Payment Policies—The Commission is concerned with all factors that might affect Medicare payments to facilities. In Recommendations 15 through 23, ProPAC highlights issues affecting Medicare payment specific to the hospital wage index, the nursing facility wage index, the outlier payment policy, the indirect medical education (IME) adjustment, and payment policies for hospital outpatient services.

ProPAC conducted additional analyses related to improving the hospital wage index. It recommends that the wage index be adjusted to remove the effect of occupational mix. Moreover, the implementation of a new wage index using hospital-specific labor market areas based on hospital geographic proximity would improve the accuracy of the wage index. The Commission also reexamined the appropriateness of nursing facility wage index, and recommends collecting data so that such an index can be developed and used to adjust Medicare skilled nursing facility payments.

ProPAC supports the outlier payment provisions of the Omnibus Budget Reconciliation Act of 1993 and makes several additional recommendations to improve the policy for identifying outlier cases and determining outlier payments. The Commission recommends reducing the IME adjustment to PPS operating payments from 7.7 percent to 7.0 percent and retaining the IME adjustment until an alternative system for compensating hospital for these costs is adopted.

The Commission submits four recommendations regarding payment for hospital outpatient services. The need for a prospective payment system is reiterated. Until such a system can be implemented, the current payment formula to calculate hospital payments for ambulatory surgery center-approved procedures, radiology services, and diagnostic services should be revised. In addition, beneficiary liability for hospital outpatient services should be reduced. Finally, the length of hospital outpatient observation stays should be limited.

Recommendations for Fiscal Year 1995

Medicare and Health Care Reform

Recommendation 1: Medicare, Medicaid, and Private Payer Payment and Coverage of the Uninsured

Health care reform will have a major effect on the Medicare and Medicaid programs and the care beneficiaries receive. The Commission believes substantial changes in program policies should be considered only with a health care reform plan that covers the uninsured and pays comparable rates for similar services. As Medicare and Medicaid have constrained payments, providers have obtained additional revenue from private payers rather than by reducing their costs. This increasing reliance on cost shifting concerns ProPAC because it is likely to have a negative effect on access to care for beneficiaries of government programs. Further, possible adverse effects on beneficiaries of slower growth in payments for hospital and other currently covered services must be carefully balanced against desirable effects of increased Medicare spending for new benefits proposed in the Health Security Act.

Recommendation 2: Payments to Hospitals Serving a Large Share of Low-Income Patients

The Health Security Act would substantially reduce Medicare disproportionate share payments, as universal coverage ameliorates many of the problems these payments are intended to address. The Commission believes the timing of any such reduction in Medicare payments should be coordinated with the extension of universal coverage, so that hospitals that provide care to low-income populations are not disadvantaged. As a result, payments would be targeted more effectively to the hospitals that provide care to these populations. Even so, the payments received by different hospitals and the balance between payment levels for Medicare and other patients may be affected significantly. These changes should be structured to ensure that both the level and distribution of payments are appropriate. ProPAC intends to work with the Congress and the Secretary of Health and Human Services to monitor and study this issue.

Recommendation 3: Payments for Additional Patient Care Costs Incurred by Teaching Hospitals

ProPAC supports the explicit recognition by all payers of the higher patient care costs teaching institutions incur. The Commission believes such payments should be separated from patient care rates and paid through a fund similar to the Academic Health Center Account proposed in the Health Security Act. ProPAC is concerned, however, that a sharp reduction in the payments teaching hospitals receive from government payers may result in financial hardships for some of the nation's major hospitals. Constraints on payments from private payers may exacerbate this problem. Therefore, ProPAC recommends that the total level of funding and the formula for distributing payments through such a mechanism should be based on careful analysis of the costs teaching institutions incur in carrying out their functions and how these payments will affect graduate medical education and access to the care these facilities provide.

Recommendation 4: Graduate Medical Education Funding and Payment

ProPAC supports efforts to establish a funding mechanism for graduate medical education training programs that encompasses all payers, including Medicare. The Commission believes this mechanism should be separate from the payment received for patient care services. The level of funding and the distribution of payments should be determined according to the following principles:

- Funding for graduate medical education should be consistent with national work force goals, with respect to both the number of residents trained and their specialty distribution.
- Funding should support training for physician and certain non-physicians medical personnel who contribute to attaining these goals.
- Payment should be made to the training program, whether it is based in a hospital inpatient, hospital outpatient, or other ambulatory setting. The optimal method for allocating and distributing such payments needs to be determined.

• Payment for graduate medical education should be based on a national per resident amount, adjusted to recognize regional differences in residents' salaries and other factors that, upon further study, are found to be appropriate.

In addition, funds should be available to recognize the additional personnel costs of hospitals that operate programs that lose specialty training positions as a result of the process described above.

Recommendation 5: Quality of Care

The Commission believes there must be an effective quality assurance program for Medicare enrollees, especially given health reform's emphasis on cost control and proposed cutbacks in Medicare spending. The Peer Review Organization program should be continued but thoroughly evaluated. It should be replaced only by a program that has been determined to be more effective.

Recommendation 6: Improvement in Premium Risk Adjustment Methods

The Commission recommends that the Secretary undertake the research necessary to substantially improve current risk adjustment methods. Risk adjustment will be needed under many health reform proposals to ensure that the premiums paid to competing health plans accurately reflect the risk composition of their enrollees. Until major improvements can be made, some other mechanism may be needed to limit the potential impact of enrolling individuals whose care proves to be exceptionally costly.

Recommendation 7: Controlling Medicare Spending Across All Sites of Care

Medicare should continue to develop policies to monitor and control total expenditure growth across all sites of care. Payment methods should not unduly favor the choice of one site over another. They should also provide consistent incentives to constrain increases in volume and service intensity across physicians and other providers.

Recommendation 8: Strengthening Medicare's Risk Contracting Program

The Commission recommends that the Secretary improve Medicare's risk-based, managed care program to give more Medicare beneficiaries the option of enrolling in managed care plans. To increase plan participation, deficiencies related to the risk adjustment formula and local differences in payments need to be corrected.

Payment Updates

Recommendation 9: Update Factor for Operating Payments to PPS Hospitals

For fiscal year 1995, the PPS standardized payment amounts should be updated to account for the following:

• The projected increase in the HCFA PPS market basket index, currently estimated at 3.7 percent;

• An adjustment of zero percentage points for the difference between the projected ProPAC and HCFA market baskets;

• A negative adjustment of 1.1 percentage points for substantial error in the fiscal year 1993 market basket forecast;

• A positive adjustment of 0.3 percentage points to reflect the cost-increasing effects of scientific and technological advances;

• A negative adjustment of 0.7 percentage points to encourage hospital productivity improvements; and

• A net adjustment of zero percentage points for case-mix change.

In addition, a positive adjustment of 3.1 percentage points should be made for hospitals in rural areas to complete the phaseout of the differential in standardized amounts between rural and other urban hospitals. ProPAC's recommendation would result in an estimated average update factor of 2.7 percent for fiscal year 1995: an increase of 2.2 percent for urban hospitals and of 5.3 percent for rural hospitals.

Recommendation 10: Update Factor for Capital Payment to PPS Hospitals

For fiscal year 1995, the Commission recommends that a formula-based approach be used to update capital payment rates. The capital update should include the following:

• The projected increase in a capital market basket index that measures one-year changes in a fixed basket of capital goods hospitals purchase, currently estimated at 3.4 percent;

• An adjustment of zero percentage points to correct for past forecast errors;

• An adjustment of zero percentage points to reflect changes in financing costs:

• A positive adjustment of 0.9 percentage points for scientific and technological advances;

A negative adjustment of 0.7 percentage points to encourage hospital productivity; and

• A net adjustment of zero percentage points for case-mix change.

The Commission's recommendation would result in a 3.6 percent increase in the Federal capital payment rate for both urban and rural hospitals.

Recommendation 11: Single Operating and Capital Update Factor

The Commission recommends that when the transition to fully prospective capital payments is complete, a single update factor be used for adjusting PPS operating and capital payment rates. Based on ProPAC's recommended updates to the operating and capital payment rates, the total increase to a fully prospective combined payment rate would be 2.8 percent for fiscal year 1995.

Recommendation 12: Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates

The Commission believes payments based on hospital-specific base-year costs for sole community hospitals should be updated by the average update given to all hospitals.

Recommendation 13: Update Factor for PPS-Excluded Hospitals and Distinct-Part Units

For fiscal year 1995, the target rates for PPS-excluded hospitals and distinct-part units should be updated by 2.7 percent. This recommendation accounts for the following:

• The projected increase in the HCFA PPS-excluded hospital market basket, currently estimated at 3.7 percent;

• An adjustment of zero percentage points for the difference between the projected ProPAC and HCFA market baskets;

• A negative adjustment of 1.0 percentage points for substantial error in the fiscal year 1993 market basket forecast; and

• An adjustment of zero percentage points for scientific and technological advances.

Recommendation 14: Update to the Composite Rate for Dialysis Services

The fiscal year 1995 update recommendation for the composite rate for dialysis services accounts for the following:

• The projected increase in the market basket for dialysis services in fiscal year 1995, estimated at 4.3 percent;

• A positive adjustment of 0.7 percentage points to reflect the additional costs associated with scientific and technological advances;

• A negative adjustment of 1.0 percentage points to encourage productivity improvements; and

• A negative discretionary adjustment of 4.0 percentage points to reflect the relationship between payments and estimated fiscal year 1994 costs.

This results in a net update recommendation of zero percent.

Other Payment Policies

Recommendation 15: Improvements in Hospital Wage Data

The Secretary should develop and implement improved methods for collecting data on employee compensation and paid hours of employment for hospital workers by occupational category. Once these data become available, the Secretary should implement an adjustment to the hospital wage index under PPS. This adjustment would correct the wage index for the inappropriate effects of including geographic differences in the mix of occupations employed.

Recommendation 16: Improvements in the PPS Hospital Wage Index

The Secretary should substantially revise the hospital wage index under PPS for fiscal year 1995. The revised wage index should be calculated using hospital-specific labor market definitions based on hospital geographic proximity measured by the air-mile distances between nearby hospitals. The Congress should repeal the current statutory provisions relating to geographic reclassification for the wage index.

Recommendation 17: Nursing Facility Wage Index

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

Recommendation 18: Improving Outlier Payment Policy

The Commission believes the outlier payment provisions of the Omnibus Budget Reconciliation Act of 1993 will improve the current policy for identifying outlier cases and determining outlier payments under PPS. However, the following changes also should be implemented for fiscal year 1995:

- The estimated cost of the case and the outlier payment amount should no longer be adjusted to reflect the hospital's indirect medical education and disproportionate share status.
- The marginal cost factor for cost outliers should be increased to 80 percent.

These changes would further increase the effectiveness of outlier payment in protecting against the risk of large losses on some cases. They would also improve the distribution of outlier payments across hospitals, including hospitals that receive a large number of transfer cases.

Recommendation 19: Level of the Indirect Medical Education Adjustment to PPS Operating Payments

The Commission recommends that the indirect medical education adjustment to PPS operating payments be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1995. This reduction should be implemented with the anticipated decrease in indirect medical education payments returned to all hospitals through a proportionate increase in the standardized payment amounts. The Commission also recommends continuation of the indirect medical education adjustment to PPS payments until an alternative system of compensating appropriately for the higher costs of patient care in teaching institutions is fully operational.

Recommendation 20: Prospective Payment Method for Outpatient Services

The Commission believes a prospective payment system for outpatient services should be implemented. Outpatient payment reform should result in consistent policies across all sites and providers. Payment should be based on a prospective price per unit of service until other methods can be developed that would appropriately control the volume of services. The payment rate should be adjusted to reflect justifiable cost differences across settings.

Recommendation 21: Revision of the Payment Formula for Outpatient Services

Until prospective payment systems can be implemented for hospital outpatient services, the blend formula used to calculate hospital payments for ambulatory surgery center-approved procedures, radiology services, and diagnostic services should be revised. The formula should subtract beneficiary copayment after the total payment has been calculated. The resulting reduction in Medicare program payments to hospitals should be used to partially offset increases in program expenditures due to reducing beneficiary liability.

Recommendation 22: Beneficiary Liability for Hospital Outpatient Services

Beneficiary coinsurance for hospital outpatient services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, beneficiary copayment would need to be estimated because it is not known at the time of service delivery.

Recommendation 23: Limit the Length of Outpatient Observation Stays

The Commission recommends limiting the length of hospital outpatient observation stays. Further, these changes should be coordinated with Peer Review Organizations so that appropriate short stay admissions are not denied. ProPAC supports HCFA's efforts in this regard.

CHAPTER 1

THE FUTURE OF HOSPITALS

Hospitals—the central institutions in the American health care system—have long been the sole source of technology-oriented acute health care for the most complex cases. But because the capabilities of technology were limited, until the last 20 years or so one hospital was much like another. Each provided its community with essentially the same range of services and was structured in a similar manner.

This is no longer the case. Changes in medical science and technology and the financing of services have required hospitals to become very different entities. Today, hospitals offer a rich mix of complex, intensive services to a variety of patients. Relationships among hospitals, other institutional providers, and payers have become more complex as well, incorporating jointly produced services and financial risk sharing. The role of physicians in hospitals' operations has also evolved. Because of the wider range of services, patients, and institutional arrangements, hospitals are now a much more diverse group of medical care facilities, with as many differences as similarities.

The Prospective Payment Assessment Commission (ProPAC), created in 1983 by the legislation that established the Medicare prospective payment system (PPS) for inpatient hospital services, advises the Congress and the Secretary of Health and Human Services on policies affecting payment for Medicare services in hospitals and other institutional settings. It is thus appropriate that the Commission look at changes that have affected hospitals in recent years and how hospitals have responded. This chapter does just that, providing a context for the recommendations in Chapter 2 on changes to Medicare payment policy. The chapter concludes by examining what lies ahead for hospitals, as government and private payers attempt to curb health care spending and as

comprehensive health reform is debated by the Congress.

Several major factors have influenced how hospitals have evolved. The continuous introduction of new technological capabilities has led to increases in the intensity of inpatient services for the acutely ill. These advances have also allowed services formerly provided only to hospital inpatients to be furnished in ambulatory settings. Consequently, new providers have entered the health care market, competing with hospitals for clients.

Changes in financing, limitations by insurers on using specific services, and increased competition have contributed to unprecedented declines in inpatient hospital utilization. In 1992, for instance, there were 5.5 million fewer hospital admissions than in 1982, despite a 10 percent population increase. The average length of a hospital stay also fell to 6.4 days from 7.2 days, even though the average case was more complex. Total health care expenditures, however, have continued to rise at a dramatic rate, consuming 14 percent of the nation's gross domestic product in 1992. As a result, payers have been pressed to reevaluate their cost-based and charge-based payment practices and to find ways to reduce their financial risk.

Hospitals have responded to the marked declines in inpatient service use and constrained payments from public and private payers by actively seeking new sources of revenue. They have expanded their capacity to furnish ambulatory surgery and other outpatient services and developed specialized units to provide inpatient psychiatric, rehabilitation, and subacute nursing care. In addition, many have begun to offer home health and various community-based services. Others have concentrated on eliminating unprofitable cost centers or turned to more revenue-enhancing activities. Some, for instance, have become specialized facilities like psychiatric or rehabilitation hospitals, while in rural areas, some small hospitals have eliminated inpatient beds and become outpatient centers. Over time, hospitals have modified their relationships with insurers, other providers, and physicians and have attempted to curb expenses to strengthen their market position.

The configuration of the hospital represents a complex interaction between financing, organizing, and providing specific services in a local environment. Recently, for example, insurers and other payers have strengthened efforts to reduce payments to hospitals and other providers, and implemented utilization control activities. These financial pressures have forced hospitals to assume more risk than was the case under charge-based or cost-based reimbursement. Additionally, hospitals have had to take a closer look at whether to add new technologies and services.

Although for the past decade hospitals have been a major target of government cost control—primarily through Medicare and Medicaid payment policy—spending for the services they provide almost tripled between 1980 and 1991, from $102 billion to $289 billion. Total health care expenditures, however, have risen even more rapidly. Consequently, policy makers are currently debating how to reform the health care system to rein in the growth of public and private spending, while also expanding coverage to the nearly 39 million Americans who are uninsured. Even if reform is gradual and not comprehensive, hospitals will be pressured to reduce costs and generate new revenues by expanding service capacity. If comprehensive reform is enacted, the fundamental relationships among payers, physicians, and other types of providers may change markedly. The evolution of individual hospital swill depend heavily on how health reform affects each facility's local market, patient population, payer mix, and regulatory environment.

Factors Affecting how Hospitals Have Evolved

The health care environment has undergone radical changes over the past two decades and is on the threshold of even greater ones. Two major forces—advances in medical technology and financing mechanisms—have profoundly influenced hospitals. Technological innovations have expanded the services hospitals furnish and led to increased competition from other providers. Until recently, a steady stream of revenues from third-party cost-based and charge-based payers financed these innovations. Increasingly, as payment policies have changed hospitals have used higher payments from some payers to cover losses created by lower payments from others. This has allowed the continued expansion of services even as certain payers have attempted to limit expenditures.

Technological Advances

Recent technological advances affecting the hospital industry range from the development of new pharmaceutical and surgical instruments to expensive diagnostic equipment like magnetic resonance imaging devices (MRIs).

During the 1970s and early 1980s, hospitals were quick to adopt new technologies even when clinical indications for their appropriate use were still largely unstudied.[1] Computerized tomography (CT) scanners are illustrative. This technology first appeared in 1973; by 1985, almost all community hospitals with more than 300 beds had a CT unit, even though purchase prices averaged about $500,000.[2] Similarly, in 1981, 14.8 percent of hospitals had cardiac catheterization capacity; by 1992, this had risen to 27.6 percent (see Table 1–1). Hospitals have also increased their magnetic resonance imaging, megavolt radiation therapy, and open-heart surgery capabilities since the beginning of the 1980s.

Because it was so costly, most state-of-the-art equipment traditionally was purchased only by hospitals. But new technological developments, along with advances in medical expertise, have expanded the ability of outpatient providers to offer services in competing sites. The number of ambulatory surgery centers, for example, mushroomed from 239 in 1983 to 1,556 in 1991.[3]

Technological developments not only have allowed hospitals and other providers to offer a broader array of services, but also have enabled more people and conditions to be treated. The expanded volume that accompanies both new and existing technologies contributes more to the rise in health care expenditures than does the cost of the technological devices, themselves. Consequently, if frequently used, even relatively inexpensive innovations can contribute substantially to health care spending. As the supply of technology extends beyond hospitals and the demand for these services increases, utilization may grow more rapidly, thus driving up health care expenditures.

TABLE 1–1.—HIGH-TECHNOLOGY SERVICES PROVIDED BY HOSPITALS, SELECTED YEARS (IN PERCENT)

year	Cardiac catheterization	CT scan	Lithotripsy (ESWL)	Magnetic resonance imaging	Megavolt radiation therapy	Ocean-heart surgery	SPECT
1981	14.8%	21.4%			14.5%	9.6%	
1985	16.8	48.5	0.8%		15.2	11.1	
1990	24.1	61.1	5.4	15.6%	17.0	14.7	16.2%
1992	27.6	65.9	7.2	21.3	17.5	16.0	24.0

Note: CT = computerized tomography. ESWL = extracorporeal shock wave lithotripsy. SPECT = single photon emission computerized tomography. Includes all Federal, nonfederal, general acute care, long-term care, and psychiatric hospitals as well as hospital units of institutions.
Source: American Hospital Association, *Hospital Statics.* 1981, and Annual Survey of Hospitals, 1985, 1990, and 1992.

Financing Changes

Advances in technology have raised the cost of medical care because they have permitted the treatment of more complex cases. As the cost of providing such care exceeded the ability of most individuals to pay, a third party joined the hospital-patient relationship. This third party initially was a private insurance plan that helped individuals share the risk of costly illness. In 1965, the government joined the payer mix with the creation of the Medicare and Medicaid programs. For many years, government and private payers collected funds and distributed payments to hospitals for the care of their beneficiaries, but did not become involved in decisions relating to the services that were provided, the site of care, or the type of provider. Payments to providers were made on the basis of costs or charges, which allowed revenues to increase directly as costs rose.

But with health care expenditures accelerating much more rapidly than general inflation, insurance premiums grew markedly. This not only threatened the ability and willingness of employers to fund higher premiums, but also affected individuals by driving up out-of-pocket payments for many services. Third-party payers responded by seeking ways to slow the growth—particularly that in hospitals because they had high costs per case and accounted for a major share of total health care spending. Responding to skyrocketing government payments. Medicare in the early 1980s replaced cost-based hospital payment with the prospective payment system. This system allowed Medicare to reduce the growth of its hospital payments. While some private insurers were also able to control payment growth, most were not.

Hospitals have attempted to generate revenue to cover losses from uncompensated care and below-cost payments for Medicaid and Medicare patients by raising charges to private insurers. This practice is called "cost shifting." In addition, hospitals have actively sought other sources of revenue. In 1981 net revenue gains from private insurers equaled 5.0 percent of total hospital costs, while in 1991 this figure had risen to 11.6 percent (see Table 1–2). This largely offset losses from Medicare, which increased from 1.0 percent to 4.4 percent, and from Medicaid, which rose from 0.7 percent to 2.3 percent of total costs. Depending on their payer mix, however, hospitals differ in their ability to cost shift. Those with large uncompensated care patient populations and few generously paying privately insured patients, for example, have had limited ability to cost shift. By contrast, other types of hospitals—particularly those with a large proportion of privately insured patients—have found it easier to cost shift.

TABLE 1–2.—HOSPITAL LOSSES AND GAINS AS A PERCENTAGE OF COSTS, BY PAYMENT CATEGORY, SELECTED YEARS

Year	Medicare	Medicaid	Uncompensated care	Private payers
1981	−1.0%	−0.7%	−3.3%	5.0%
1983	−1.2	−0.8	−3.6	7.0
1985	0.4	−1.0	−4.4	6.7
1987	−0.7	−1.7	−4.4	8.2
1989	−3.3	−2.5	−4.4	8.9
1991	−4.4	−2.3	−4.4	11.6

Note: For each payment category, losses or gains are the difference between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payments for uncompensated care patents.
Source: ProPac analysis of data from the American Hospital Association Annual Survey of Hospitals.

The array of providers and payers and the lack of adequate coordination among them also encourages shifts in site of care by driving up use and expanding capacity in those settings that are not experiencing as much pressure to contain costs. For example while prospective payments has slowed the growth of Medicare payments for inpatient care, service utilization in post-acute and ambulatory settings has exploded, with a corresponding increase in expenditures.

Questioning the medical appropriateness and need for many hospital admissions, third-party payers have adopted policies to encourage the use of less costly providers and settings. Many private insurers have turned to managed care arrangements, using financial incentives, preferred provider agreements, and increased utilization review to curb the use of inpatient hospital care. Private payers are also increasingly regulating and limiting what they will cover and how much they will reimburse, giving hospitals incentives to change the mix of services they provide. Government, on the other hand, has focused its efforts on evaluating, through utilization review, whether specific services should be furnished and determining the setting in which services must be provided. Medicare, for example, requires performance of almost all cataract surgery on an outpatient basis. Both public and private payers have attempted to influence the site and provision of services through preadmission certification and

retrospective claims review with possible denial of payment.

Legal and Regulatory Environments

The legal and regulatory environments that hospitals face at both the Federal and state levels also affect their financial condition and organization of service delivery. The Federal government influences hospitals, for example, through antitrust and tax laws. These regulations significantly affect hospitals' ability to respond to financial pressures by acquiring or contracting with other health care providers.

Many states are considering or in the process of enacting comprehensive health reform legislation that will influence how hospitals are paid and which services are provided, even in the absence of Federal health reform.[4] Several states—among them Vermont, North Dakota, Florida, and Minnesota—are crafting cost-containment strategies that include expenditure targets or global caps on health care spending and encourage or mandate the development of managed care networks. Minnesota has established state boards to oversee major capital expenditures and to foster collaboration among providers. Vermont is preparing to implement payment limits for all providers within the state, while providing health insurance to all its residents. Hawaii has had universal health insurance coverage for 20 years. If states successfully lower the rates of increase in health care expenditures, hospitals will see their revenues constrained and their ability to cost shift among payers limited.

Hospital Responses to Changes in the Health Care Environment

How an individual hospital has evolved in response to technological advances, financing changes, and legal or regulatory developments has depended on the hospital's internal and external environments. Among their responses are changes in the services provided; attempts to control cost growth; and innovative arrangements among hospitals, other providers, and insurers. The end result has been significant diversification in the hospital industry.

Services Provided

A combination of fewer admissions and shorter stays has encouraged hospitals to seek alternative sources of revenue. Inpatient admissions for the population 65 and over decreased with the implementation of PPS in 1983, but began growing again in 1986. Among the nonelderly, both the number and rate of inpatient admissions have continued to drop. Average length of stay fell considerably after PPS was introduced and has shown only modest changes since then.

Some hospitals have responded to the decline in acute patient admissions by targeting different patient populations. If hospitals convert to specialty status, they also may be shielded from stringent cost containment. In particular, they are exempt from PPS. Since 1980, the number of general medical and surgical hospitals has decreased by 11.2 percent, while the number of psychiatric hospitals has accelerated by 41.8 percent and the number of other specialty hospitals has grown by 7.3 percent (see Table 1–3).

TABLE 1.3.—U.S. HOSPITALS, BY HOSPITAL CATEGORY, SELECTED YEARS

Hospital category	1980	1985	1990	1992	Percent change 1980–1992
Short term	6,407	6,339	6,141	6,092	−4.9
Long term	558	533	508	447	−19.9
General medical and surgical	6,105	5,961	5,566	5,424	−11.2
Psychiatric	558	629	774	791	41.8
Tuberculosis and other specialty	302	282	309	324	7.3
Community*	5,830	5,732	5,384	5,292	−9.2
Noncommunity	1,135	1,140	1,265	1,247	9.9
6–24 beds	327	267	301	294	−10.1
25–49 beds	1,209	1,134	1,095	1,078	−18.8
50–99 beds	1,674	1,666	1,633	1,595	−4.7
100–199 beds	1,567	1,618	1,562	1,572	0.3
200–299 beds	802	848	830	823	2.6
300–399 beds	484	507	503	489	1.0
400–499 beds	334	301	276	256	−23.4
500+ beds	568	531	449	432	−23.9
Voluntary	3,505	3,544	3,388	3,363	−4.1
Proprietary	891	1,052	1,139	1,134	27.3
Federal government	359	343	337	325	−9.5
Nonfederal government	2,210	1,933	1,785	1,717	−22.3
Residency training	1,257	1,232	1,249	1,223	−2.7
Medical school affiliation	997	1,120	1,238	1,154	15.7
Council of Teaching Hospitals member	406	454	387	381	−6.2
Urban	3,791	3,959	3,937	4,030	1.8
Rural	3,174	2,913	2,712	2,509	−20.5
New England	373	361	341	331	−11.3
Middle Atlantic	800	761	726	710	−11.3
South Atlantic	1,026	1,037	1,050	1,043	1.7
East North Central	1,060	1,022	959	957	−9.7
East South Central	548	547	532	523	−4.6
West North Central	896	883	846	820	−8.5
West South Central	955	972	943	919	−3.8
Mountain	448	462	464	464	3.6
Pacific	859	827	788	772	−10.1
All hospitals	6,965	6,872	6,649	6,539	−6.1%

* Community hospitals include nonfederal short-term general and some specialty hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

The significance of non-inpatient and skilled nursing services also has increased, although it varies by hospital location (see Table 1–4). In 1985 about 40 percent of rural community hospitals reported having any organized outpatient service; by 1992, more than 84 percent had this capability. While 17 percent of rural hospitals surveyed derived more than half of net patient care revenues in 1993 from ambulatory services, this was true for only about 6 percent of urban hospitals (see Table 1–5). These revenues were also a larger share of net patient care revenues for non-teaching than for teaching hospitals.

Skilled nursing services were provided by 34 percent of community hospitals in 1992, compared with 18.8 percent in 1985. Further, a significantly higher proportion of rural, compared with urban, hospitals furnished this care. This may partly reflect the attempts of rural institutions to compensate for reduced inpatient utilization by expanding skilled nursing care capacity. The percentage of rural hospitals with swing beds (beds certified by Medicare as either acute care or skilled nursing beds) has also risen.

TABLE 1–4.—NON-INPATIENT AND SKILLED NURSING SERVICES PROVIDED BY COMMUNITY HOSPITALS, BY LOCATION, SELECTED YEARS (IN PERCENT)

Location year	Any organized outpatient services[a]	Surgery[b]	Psychiatric	Alcohol/drug dependency	Rehabilitation	Home health	Skilled nursing[c]
All hospitals:							
1985	54.1	93.4	15.3	16.1	39.3	29.7	18.8
1990	85.2	94.7	19.6	20.5	51.5	35.6	22.3
1992	88.9	94.4	21.9	21.0	55.0	38.0	34.0
Urban:.							
1985	66.9	95.7	23.6	22.9	54.9	31.8	11.1
1990	90.0	95.0	29.0	28.6	66.2	34.4	18.7
1992	92.6	94.7	31.2	28.8	67.3	35.8	26.0
Rural:.							
1985	39.3	90.7	5.8	8.2	21.3	27.4	27.6
1990	79.6	94.4	8.4	10.8	34.2	37.1	26.4
1992	84.1	94.1	9.9	10.9	39.0	40.9	44.4

[a] Trends in responses may reflect, in part, a change in the survey question between 1985 and 1990.
[b] Hospitals may provide outpatient surgery without having an organized outpatient department.
[c] Data for 1985 reflect the presence of skilled nursing services anywhere in the hospital. Data for 1990 and 1992 reflect the presence of a separate skilled nursing unit.

Source: American Hospital Association Annual Survey of Hospitals.

TALBE 1–5.—HOSPITAL NET PATIENT CARE REVENUES FROM AMBULATORY SERVICES, BY HOSPITAL CATEGORY, 1993 (IN PERCENT)

Hospital category*	Number of hospitals	Net patient care revenues from ambulatory services (in percent)			
		0–10	11–25	26–50	Over 50
Atlantic	400	11.0	37.8	42.0	5.8
East Central	391	6.6	24.0	54.7	11.8
West Central	404	8.9	23.8	50.5	14.4
Far West	300	8.0	24.0	49.3	14.7
Urban	736	9.5	39.8	41.6	5.7
Rural	759	7.9	15.8	56.4	17.0
Teaching	233	13.3	54.0	27.0	3.9
Non-teaching	1,262	7.8	22.7	53.2	12.8
Total	1,495	8.7	27.6	49.1	11.4

Note: Rows may not add to 100 due to survey item non-response.

*Atlantic includes the New England, Middle Atlantic, and South Atlantic Census Division. East Central includes the East North Central and East South Central Census divisions. West Central includes the West North Central and West South Central Census divisions. Far West includes the Mountain and Pacific Census divisions. Teaching hospitals are those with more than 5 percent professional time spent teaching.

Source: Survey of Hospital-Physician Relations conducted by MACRO International Inc., under contract to ProPac.

Hospitals have increasingly added home care capacity as well. Hospital home care visits doubled between 1980 and 1990, from 6.2 million to 12.3 million.[5] Compared with smaller hospitals, larger ones had more visits.[6] The percentage of community hospitals operating home care programs, however, is not growing as rapidly as the use of home care services.

During the 1970s and 1980s, many hospitals expanded their outpatient departments and added ambulatory surgery centers. On average, 37 percent of hospital equipment is devoted to meeting outpatient demand.[7] This expansion has had a major impact on hospital revenues. About 25 percent of hospital revenues, on average, now come from out-patient services (see Table 1–6). While inpatient admissions

have declined by about 14 percent since 1980, nonemergency outpatient visits have more than doubled (see Table 1–7). Similarly, more than half of hospital surgical procedures in 1992 were performed on an outpatient basis, compared with only 16.3 percent in 1980.

Along with expanding their service capacity, hospitals have also increased their labor pool to administer the new services. The number of full-time equivalent personnel (FTEs) per patient has grown steadily since the 1970s (see Table 1–8). In part this reflects the surge in outpatient hospital services, since FTEs employed by hospitals may work in either inpatient or outpatient departments. Nonetheless, labor costs as a percentage of total hospital costs have been decreasing, while capital costs are increasing as a percentage of total costs.

Attempts to Control Growth in Costs

Financial pressures on hospitals have spurred the growth in services to augment revenues and have fostered a greater reliance on cost shifting. As a result of these efforts, in aggregate, hospitals have maintained positive total revenue margins. In 1991, the total margin was 4.3 percent—higher than at any time before the introduction of PPS.

However, as government and private insurers have stepped-up their cost-containment efforts, hospitals are less able to compensate for losses. Therefore, hospitals must increase efforts to reduce costs and indeed have done so. After peaking at 5.0 percent in 1992, annual real growth (above general inflation) in hospital costs per case dropped to 3.2 percent in the first quarter of 1993 and to 1.0 percent in the third quarter. Whether this is a one-time phenomenon or the beginning of a trend is uncertain.

TABLE 1–6.—COMMUNITY HOSPITAL REVENUES, BY TYPE OF SERVICE, SELECTED YEARS

[In Percent]

Year	Inpatient	Outpatient	Other
1980	83.2	12.5	4.3
1985	79.3	16.1	4.6
1990	72.5	22.5	5.0
1992	69.8	25.3	4.9

Source: American Hospital Association National Hospital Panel Survey

Arrangements With Other Hospitals, Facilities, and Insurers

Hospitals have adopted a number of organizational strategies to respond to changes in their operating environment. They have, for instance, merged with, acquired, or contracted with other hospitals and providers. They have also developed more complex relationships with insurers.

During the 1980s, hospitals tended to diversify by acquiring facilities or businesses (such as parking lots or non-health care businesses) that often were unrelated to their basic mission. Many of these investments were unprofitable, partly because hospital administrators lacked the skills to manage non-acute care ventures.[8] In the 1990s, however, hospital diversification efforts have focused on reducing costs and offering a wider range of services to large employers and purchasing coalitions through managed care contracts.[9]

Extensive mergers and acquisitions during the 1980s led to the growth in the number of multihospital systems and in the percentage of institutions that belonged to these systems (see Table 1–9). Between 1979 and 1992, the proportion of hospitals that were members of multihospital systems increased from 27.1 percent to 43.2 percent. These systems were thought to produce economies of scale and scope, but whether they are more efficient is debatable.[10] The fact that the number of formal multihospital systems actually declined between 1990 and 1992 may reflect a trend toward the use of less formal contractual arrangements, as well as mergers of existing systems.

TABLE 1–7.—INPATIENT AND OUTPATIENT USE OF SERVICES IN COMMUNITY HOSPITALS, SELECTED YEARS

Year	Inpatient services (in thousands)		Outpatient visits (in thousands)		Surgical procedures (in percent)	
	Admissions	Days	Emergency	Other	Inpatient	Outpatient
1980	36,143	273,085	77,245	125,064	83.7	16.3
1985	33,449	236,619	74,547	144,169	65.4	34.6
1990	31,181	225,972	86,693	214,636	49.5	50.5
1992	31,034	221,047	90,769	254,772	46.2	53.8
Percent change 1980–1992	−14.1	−19.1	17.5	103.7	.....	.....

ASource: American Hospital Association Annual Survey of Hospitals.

Hospitals have also developed innovative contractual arrangements with other providers. Some rural hospitals, for example, have dealt with declining population bases and the inability to provide high-technology services to the communities they serve by setting up rural networks or establishing telemedicine or computer information linkages with large urban hospitals and other providers. Such linkages have changed the configuration of the rural hospital.

Financial pressures have also stimulated the growth of managed care, which has substantially altered the nature of relationships between hospitals and insurers. For example, hospitals may assume more financial risk under a capitated payment system. Types of managed care arrangements differ substantially, however; the degree of control over physician and other providers decision making—and this utilization—consequently differs. Health maintenance organizations (HMOs) in particular attempt to control expenditures primarily by reducing the use of inpatient hospital care. Staff and group model HMOs exercise more control over their employees than do independent practice associations or preferred provider organizations (PPOs).

TABLE 1–8.—NATIONAL HOSPITAL EMPLOYEE COSTS AND PERSONNEL IN NONFEDERAL SHORT-TERM HOSPITALS, 1971–1991

Year	Total costs for inpatient care (in billions)	Employee costs as a percentage of total costs[a]	Personnel[b]	
			Total (in thousands)	Number per 100 patients
1971	$22.4	63.9	1,999	272
1972	25.5	62.6	2,056	278
1973	28.5	61.8	2,149	280
1974	32.8	60.7	2,289	289
1975	39.1	59.4	2,399	298
1976	45.4	57.9	2,483	304
1977	51.8	57.5	2,581	315
1978	58.3	57.2	2,662	323
1979	66.2	57.0	2,762	328
1980	77.0	56.4	2,879	334
1981	90.7	56.7	3,039	347
1982	105.1	56.7	3,110	353
1983	116.6	56.5	3,102	357
1984	123.6	56.1	3,023	367
1985	130.7	55.2	3,003	385
1986	140.9	53.9	3,032	392
1987	152.9	53.1	3,120	400
1988	168.9	52.9	3,209	404
1989	185.2	53.0	3,307	411
1991	225.2	53.8	3,539	427

[a] Includes employee payroll and benefit costs; excludes contracted labor services.
[b] Full-time equivalent personnel.
[c] Source: National Center for Health Statistics, Health, United States, 1992 (Hyattsville, Maryland: Public Health Service, 1993).

TABLE 1–9.—MULTIHOSPITAL SYSTEMS, 1979–1992

Year	Number of systems	Number of hospitals in systems	Percent of all hospitals
1979	267	1,797	27.1
1980	256	1,877	28.4
1981	256	1,924	29.2
1982	243	1,958	29.8
1983	249	2,050	31.3
1984	250	2,208	33.8
1985	268	2,477	37.9
1986	278	2,514	38.7
1987	303	2,567	39.6
1988	303	2,572	40.0
1989	307	2,901	43.2
1990	311	2,906	43.7
1991	309	2,873	43.3
1992	300	2,826	43.2
Percent change 1979–1992	12.4	57.3	.....

Note: Increases between 1988 and 1989 reflect, in part, inclusion of Federal hospitals in 1989 and thereafter.
Source: American Hospital Association, *Directory of Multihospital Systems*, 1980–1987, *AHA Guide*, 1988–1993, *Financial Growth and Diversification of Hospitals and Multihospital Systems*, 1988, *Data Book on Multihospital Systems*, 1980–1985, *Hospital Statistics*, 1992–93, and Annual Survey of Hospitals, 1992.

The growth in the managed care industry has been well-documented, although the rate of growth has not been uniform throughout the country.[11] In the West Census region in 1992, for instance, 25 percent of the population was enrolled in some sort of HMO, compared with 7.8 percent in the South. The implementation of managed care plans has also differed throughout the country. The average managed care plan in the Pacific Census division contracts with 60 hospitals, while that in New England contracts with 22 hospitals.

As managed care market power has grown, more hospitals have begun contracting with HMOs and PPOs (see Table 1–10). This trend is reflected in the increased importance of managed care as a source of revenue. In 1993, 15.6 percent of hospitals in the Far West and 7.2 percent of hospitals in the East Central part of the country reported that more than 25 percent of their net patient care revenues came from HMOs or PPOs (see Table 1–11). Urban hospitals received more, on average, from HMOs and PPOs than did rural hospitals, although 13.6 percent of rural hospitals reported receiving more than 10 percent of revenues from these sources.

Arrangements With Physicians

While hospitals provide the buildings, equipment, and staff necessary to furnish complex inpatient (and other) services, they cannot operate without the cooperation of physicians, who admit, treat, and discharge patients. Evidence suggests that a large portion of total health care expenditures (an estimated 50 percent to 80 percent or

more) are directly influenced—if not directly controlled—by physicians.[12] In addition, physicians may influence hospitals' nonoperating expenditures by advocating particular types of capital investments.

As hospitals have assumed more financial risk, they have increasingly pressured physicians to control their costs and use of hospital services through internal management strategies and contractual relationships that call for shared financial risk with doctors. How well hospitals and physicians work together to control costs and improve quality is unclear. Reluctant to surrender their autonomy, physicians have largely been able to resist hospitals' efforts to modify their practice styles. Therefore, many hospital administrators concentrated more on maximizing revenues during the 1980s than on engaging physicians as partners in helping them curtail spending. This strategy seems to be changing in the 1990s as hospitals and physicians increasingly recognize their interrelated roles and responsibilities.

The ability of hospitals and physicians to set up joint financial arrangements—in particular to contract with managed care organizations—has affected the way some hospitals deal with doctors. One recent trend is for hospitals to acquire physician practices and try to integrate physicians into hospital management to some degree. In 1993, almost 14 percent of hospitals surveyed had a formal physician/hospital organization (PHO), 7 percent had a management services organization (MSO), and 4 percent had a foundation that negotiated managed care contracts on behalf of the hospital and physicians as a unit (see Table 1–12).[13] Such practice arrangements are less popular in the West Central region than in other parts of the country, and are more common in urban and teaching hospitals. These arrangements, however, are not unheard of in rural hospitals, where 14 percent of hospitals surveyed reported having some type of joint venture with physicians.

TABLE 1–10.—HOSPITALS WITH HEALTH MAINTENANCE ORGANIZATION AND PREFERRED PROVIDER ORGANIZATION CONTRACTS, BY HOSPITAL CATEGORY, SELECTED YEARS

[In Percent]

Hospital Category	HMO			PPO			HOM and/or PPO		
	1985	1990	1992	1985	1990	1992	1985	1990	1992
Community	33.1	48.1	51.9	25.3	52.9	60.4	40.4	62.5	67.9
Urban	52.9	70.8	73.8	39.7	70.3	76.1	61.5	81.3	83.8
Rural	30.6	43.6	47.1	23.1	48.3	55.1	37.2	57.0	61.8
New England	54.7	70.3	71.0	18.2	46.4	56.6	56.7	71.6	72.9
Middle Atlantic	37.3	56.9	64.8	9.3	37.2	48.9	40.5	64.8	72.0
South Atlantic	30.6	42.0	45.6	25.2	56.7	65.4	35.5	60.1	67.7
East North Central	48.8	67.9	69.2	37.2	72.0	76.8	57.0	82.2	84.2
East South Central	14.3	30.0	37.6	27.1	56.9	63.8	32.2	60.1	67.0
West North Central	25.4	37.3	37.4	13.1	34.2	44.2	28.7	45.9	52.8
West South Central	16.5	30.5	35.3	14.8	44.9	54.0	22.6	48.5	56.0
Mountain	25.7	39.9	44.6	27.7	45.4	49.8	34.4	48.5	53.5
Pacific	50.2	66.9	71.0	52.2	74.7	76.8	62.7	81.9	83.2
Voluntary	40.0	57.3	59.9	28.3	56.9	64.3	47.2	69.0	73.7
Proprietary	34.1	46.2	57.8	33.5	62.9	70.7	44.4	67.5	73.7
Government	17.3	28.0	30.4	15.1	39.0	46.7	23.7	45.4	51.5
All hospitals	30.6	43.6	47.1	23.1	48.3	55.1	37.2	57.0	61.8

Note: HMO = health maintenance organization. PPO = preferred provider organization. Trends in responses may reflect, in part, hospitals increasing familiarity with HMO and PPO contracting over time; this may have increased the likelihood of positive survey responses.

Source: American Hospital Association Annual Survey of Hospitals.

Hospitals in the Future

The health care reform debate now under way focuses on the need for and types of reforms necessary to stem runaway health spending and provide universal health insurance coverage. The uncertain outcome of this debate could have a dramatic effect on the hospital of the future. Already, hospitals have responded in a variety of ways to the pressures they face, diversifying the services they offer, pursuing different avenues to control costs, and adopting new strategies that govern their relationships with other providers and physicians. Existing pressures to reduce spending and adapt to changing medical practices will continue. Federal, state, and local governments will further their efforts to bring health care expenditures under control and extend services to vulnerable populations. Private payers will exert similar pressures. Medical practice will advance, adding new treatments and expanding the populations that could benefit from medical services.

The anticipation of health care reform and its ultimate nature, though, will further affect hospitals and their role in health care delivery. Comprehensive reform that alters the structure of financing and delivery systems to control expenditure growth and expand coverage would bring the most dramatic changes. Incremental reforms that modify the existing relationships among payers and providers would likely continue the adaptations hospitals are making now. Regardless of the shape of reform, the critical features that will affect hospitals relate to the type, strength, and source of pressure to control spending.

Health care expenditure control can be achieved through slowing the growth in costs per unit of service, reducing the number and intensity of services provided, managing the mix of services, or all three. Hospitals will be affected differently, depending on which strategy is followed and the strength of the pressure to respond. Likewise, the source of the pressure to control expenditures will affect hospital responses. The impact of the efforts of individual payers—either in the government or private sector—would be quite different from a government mandate for expenditure control applied to all payers. Similarly, whether hospitals are singled out or all health care facilities are subject to controls will affect the response.

TABLE 1–11.—HOSPITAL NET PATIENT CARE REVENUES FROM HEALTH MAINTENANCE ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS, BY HOSPITAL CATEGORY, 1993

[In Percent]

Hospital category*	Number of hospitals	Net patient care revenues from HMOs and PPOs (in percent)			
		0–10	11–25	26–50	Over 50
Total	1,495	64.1	24.5	7.8	0.9
Atlantic	400	65.5	25.5	6.0	2.0
East Central	391	60.6	30.2	7.2	
West Central	404	75.4	14.9	5.9	1.0
Far West	300	51.7	29.0	13.3	2.3
Urban	736	43.6	37.8	14.1	1.5
Rural	759	84.1	11.7	1.6	0.3
Teaching	233	59.7	33.0	3.9	0.9
Non-teaching	1,262	65.0	22.7	8.5	0.9

Note: HMO=health maintenance organization. PPO=preferred provider organization. Rows may not add to 100 due to survey item non-response.

*Atlantic includes the New England, Middle Atlantic, and South Atlantic Census divisions. East Central includes the East North Central and East South Central Census divisions. West Central includes the West North Central and West South Central Census divisions. Far West includes the Mountain and Pacific Census divisions. Teaching hospitals are those with more than 5 percent professional time spent teaching.

Source: Survey of Hospital-Physician Relations conducted by MACRO international Inc., under contract to ProPAC.

Rate-setting approaches to expenditure control involve imposing a payment per unit of service. These rates could be used by all or some payers and could be applied to a range of services and providers. Rate setting would force institutions to gain control over the cost of producing individual services by improving production efficiency. If rates were imposed only for some services or provider types, or only by some payers, shifts among types of services and across settings would continue as a way to avoid cost-containment pressure. Hospitals may also respond to these efforts by focusing on providing those services that are relatively better paid. This could put some services or populations at risk.

A system of global budgets or insurance premium caps could accelerate the movement of hospitals to gain control over the continuum of care. Global budgets are expenditure limits or targets that could be applied to types of providers or services. Premium caps are similar limits that would be enforced by insurers. Hospitals may respond by forming health care networks to control expenditures for an episode of care. Alternatively, hospitals may concentrate on providing a narrow range of services efficiently and marketing these to established networks or payers. Hospitals that fail to coordinate their services with those offered by other providers would be the most vulnerable under this scenario. Unless quality of care is carefully considered, however, needed services could be eliminated in order to stay within the limits.

Under any type of reform, less stringent cost-control efforts would not be as disruptive to health care delivery patterns. Besides having a greater impact on spending growth, intense expenditure control efforts would likely alter institutional arrangements and service delivery patterns.

The sources of pressure to control expenditures may also affect the outcome of reform initiatives, as demonstrated by the responses to the implementation of PPS. Cost shifting from less generous payers (including most public ones) to more generous (largely private) payers has had two major results. First, the gains from private-pay patients have enabled the hospital sector to alleviate the pressure to control costs that public programs have attempted to create. Second, the ability to cost shift has, for many patients, maintained access to services they overwise might not have received.

TABLE 1–12. HOSPITAL-PHYSICIAN ORGANIZATIONS, BY HOSPITAL CATEGORY, 1993

[In Percent]

Hospital category*	Number of hospitals	Organization (in percent)				
		Any joint venture	PHO	MSO	Foundation	IHO
Atlantic	400	33.3	18.3	6.5	5.3	2.3
East Central	391	34.8	13.8	7.2	4.6	2.8
West Central	404	24.3	10.3	5.1	2.4	2.0
Far West	300	32.7	11.3	9.3	4.3	4.3
Urban	736	47.0	21.5	10.7	6.4	4.6
Rural	759	14.0	5.9	3.2	2.0	0.9
Teaching	233	41.2	18.5	6.9	7.7	6.0
Non-teaching	1,262	28.2	12.6	6.8	3.5	2.1
Total	1,495	30.2	13.6	6.9	4.1	2.7

Note: PHO=physician/hospital organization. MSO=management services organization. IHO=integrated health organization.

*Atlantic includes the New England, Middle Atlantic, and South Atlantic Census divisions. East Central includes the East North Central and East South Central Census divisions. West Central includes the West North Central and West South Central Census divisions. Far West includes the Mountain and Pacific Census divisions. Teaching hospitals are those with more than 5 percent professional time spent teaching.

Source: Survey of Hospital-Physician Relations conducted by MACRO International Inc., under contract to ProPAC.

Cost-containment pressure in any form that is applied by some payers but not by others would exacerbate the current disparity in relative payment levels across payers. This would put certain hospitals at a financial disadvantage because of their inability to compete for patients with more generous private insurance coverage. Increasingly, a hospital's financial condition would be determined by its payer mix rather than its efficiency. If the gap in relative payment levels is widened because of different cost-containment measures across payers, many hospitals that provide important services to specific segments of the population may curtail their operations.

Within this climate of health reform to control expenditures and expand coverage, medical technology continues to evolve. New threats to the public's health (such as acquired immune deficiency syndrome) and medical advances in areas like biotechnology and diagnostic imaging will lead to the ongoing development of expensive new drugs, equipment, and procedures. Better understanding of disease processes and medical techniques for combating illness will continue. This will add to the momentum to modify the mix of services and site of delivery. Such changes may enhance the hospital's role, if it has control over the continuum of service delivery. To the extent that these changes allow more providers to compete with the hospital or substitute for some of its functions, its role could diminish.

It is unclear how health care reform will affect the development and diffusion of new technology and the application of medical advances. Cost control may concentrate on innovations that reduce the cost of care. Reform that incorporates rate setting would be more likely to promote innovations that lower the cost of providing services. Global budget or premium cap reform approaches would focus attention on technologies or procedures that diminish costs over an episode of care. Under any reform scenario, public and private payers will continue their efforts to curb spending associated with new or diffusing technologies and the expanded ability to provide services.

The hospital's traditional role as the center of the health care delivery system has changed dramatically and is continuing to evolve. Hospital spending still makes up the largest part of total health expenditures, despite the increasing availability of services outside the inpatient setting and the proliferation of ambulatory care providers. As a result, hospitals will bear much of the pressure to alter the way health care is delivered and paid for in the future. How much of this pressure falls on different hospitals will vary, depending on each hospital's current situation. how each hospital chooses to respond, and how well the hospital can implement its response, will differ as well. What the future holds for each hospital therefore will be determined by a mix of internal and external forces. Facilities thus will be further differentiated in the services they provide and their relationships with other components of the health care financing and delivery system.

Notes to Chapter 1

1. Louise B. Russell and Jane E. Sisk, "Medical Technology in the United States: The Last Decade," *International Journal of Technology Assessment in Health Care* 4(2):269–88, 1988.

2. Ibid.

3. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress, June 1993*, 93.

4. "State Health Reform: Five Trends That Will Transform Hospitals," *Hospitals* 66(19):26–38, October 5, 1992.

5. Sandy Lutz, "Hospitals Continue Move Into Home Care," *Modern Healthcare* 23(4):28–32, January 25, 1993.

6. Frank Cerne, "Homeward Bound: Hospitals See Solid Future for Home Health Care," *Hospitals* 67(4):52–54, February 20, 1993.

7. Howard J. Andersen, "Survey: Equipment Budgets Up; Use in Outpatient Areas Growing," *Hospitals* 66(18):38–44, September 20, 1992.

8. Jay Greene, "Diversification, Take Two," *Modern Healthcare* 23(28):28–32, July 12, 1993.

9. Ibid.

10. Paul Starr, *The Social Transformation of American Medicine* (BasicBooks: 1982); Larry Manheim, Stephen M. Shortell, and Stephanie McFall, "The Effect of Investor-Owned Chain Acquisitions on Hospital Expenses and Staffing," *Health Services Research* 24(4):461–84, October 1989.

Prospective Payment Assessment Commission, *Medicare and the American Health Care System, June* 1993, 139.

12. Jeffrey A. Alexander and Michael A. Morrisey, "Hospital-Physician Integration and Hospital Costs," *Inquiry* 25(3):388–401, Fall 1988; Jeffrey A. Alexander, Michael A. Morrisey, and Stephen M. Shortell, "Physician Participation in the Administration and Governance of System and Freestanding Hospitals: A Comparison by Type of Ownership" in *For-Profit Enterprise in Health Care*, ed. Bradford H. Gray (Washington, DC: National Academy Press, 1986); Stephen Shortell, Michael A. Morrisey, and Douglas A . Conrad, "Economic Regulation and Hospital Behavior: The Effects on Medical Staff Organization and Hospital-Physician Relationships," *Health Services Research* 20(5):597–628, December 1985.

13. The survey conducted by MACRO International Inc., defined a PHO as a joint venture between a hospital and physicians to own and operate ambulatory or ancillary care projects or act as an agent for managed care contracts. A subcategory of a PHO, and MSO is a separate entity; is owned by physicians, the hospital or both; and contracts with solo and group practice physicians to provide administrative services, purchase physician practice assets, and act as the agent of the hospital and physicians in managed care contracts. A foundation is a corporation, usually a hospital affiliate of subsidiary, which acquires all assets of medical group practices. It negotiates and executes managed care contracts on behalf of both the hospital and physicians.

Chapter 2

RECOMMENDATIONS

When the Prospective Payment Assessment Commission (ProPAC) was created by the Congress in 1983, its primary responsibility was to examine issues related to the Medicare prospective payment system (PPS) and make recommendations for updating and improving it. The Congress gradually has expanded ProPAC's mandate to include payment policies for all facility services furnished to Medicare beneficiaries. Accordingly, the Commission has conducted analyses of Medicare payments for skilled nursing facility (SNF), home health agency, and endstage renal disease (ESRD) dialysis facility services.

In addition, at the request of the Congress, the Commission has examined the adequacy of Medicaid hospital payment rates and the use of Medicare payment methods for other payers. It has also analyzed issues related to the design and implementation of a global budgeting system to restrain health care spending. ProPAC continues to devote substantial

effort, however, to updating and improving payment for hospitals under PPS and for those hospitals and distinct-part units excluded from PPS.

Although this report is submitted to the Congress, the Secretary of Health and Human Services is required to consider ProPAC's recommendations and respond to them in the annual notice of PPS rulemaking published in the **Federal Register**. The Commission is always pleased to work with the Secretary to provide additional analysis and information on its recommendations.

ProPAC's recommendations reflect the collective judgment of the 17 Commissioners. By the nature of their subject, some recommendations are reviewed each year, such as the annual update factors. Others address new issues or modify previous recommendations. All incorporate recent research findings. For fiscal year 1995, the Commission's recommendations address broader issues related to Medicare and health care reform, in addition to the recommendations that relate more specifically to Medicare facility payments.

Recommendations for Fiscal Year 1995

The Commission's recommendations center on three areas of concern:

- Medicare and health care reform,
- Payment updates, and
- Other payment policies.

ProPAC's recommendations are intended to improve the equity and effectiveness of Medicare's payments for health care services. In this report, the Commission has considered certain aspects of health care reform that may affect the Medicare program. The recommendations that address payment updates reflect the Commission's view on aggregate spending levels. Finally, other recommendations concern the distribution of Medicare payments or the equity of Medicare's payment formulas.

Medicare and Health Care Reform

The health care industry is facing major challenges this year as legislators and policy makers struggle to control health expenditures and expand coverage to people without insurance. Several legislative proposals have been introduced to reform the health care system. Some of these focus on incremental changes that would affect the financing and delivery of health care. Others call for fundamental restructuring of the existing systems. Most include provisions affecting the Medicare program.

The Health Security Act introduced by the President would fundamentally change the financing and delivery of health care. Under this proposal, most people under 65 would obtain health insurance coverage through regional or corporate alliances. These alliances would negotiate with health plans to provide medical services. The health plans would compete for patients on the basis of quality and costs. This managed competition among plans is expected to control the growth in health expenditures. As a contingency, however, premium rate increases would be limited if expenditure growth were not contained.

Medicare would be retained as a separate program under the President's proposal, although it would be subject to a number of cost-saving measures. Reductions in hospital payment updates are proposed. The disproportionate share (DSH) adjustment would be substantially reduced; however, universal coverage may ameliorate many of the problems this adjustment is intended to address. Medicare's indirect medical education (IME) adjustment would be replaced by an Academic Health Center Account to which Medicare and the alliances would contribute. Medicare's direct medical education payments for the cost of training medical residents would also be replaced by a special account funded by all payers. Although the Act incorporates mechanisms to ensure the quality of health care provided to those enrolled through the alliances, the oversight provided by Medicare's Peer Review Organizations (PROs) would be discontinued.

The Commission believes health care reform would have a major impact on both providers and beneficiaries. The first eight recommendations for fiscal year 1995 reflect the Commission's concerns regarding the effect of health care reform on the Medicare program, providers, and beneficiaries.

Recommendation 1: Medicare, Medicaid, and Private Payer Payment and Coverage of the Uninsured

Health care reform will have a major effect on the Medicare and Medicaid programs and the care beneficiaries receive. The Commission believes substantial changes in program policies should be considered only with a health care reform plan that covers the uninsured and pays comparable rates for similar services. As Medicare and Medicaid have constrained payments, providers have obtained additional revenue from private payers rather than by reducing their costs. This increasing reliance on cost shifting concerns ProPAC because it is likely to have a negative effect on access to care for beneficiaries of government programs. Further, possible adverse effects on beneficiaries of slower growth in payments for hospital and other currently covered services must be carefully balanced against desirable effects of increased Medicare spending for new benefits proposed in the Health Security Act.

The Health Security Act proposed by the President contains a number of complex features that interact and could have a major effect on the services Medicare and Medicaid beneficiaries receive. The Act would slow the growth in Medicare and Medicaid spending for currently covered services, create a new prescription drug benefit, and add coverage for long-term care services for the disabled. It would also use premium limits to curb the rise in private payer spending and extend coverage to the uninsured.

Medicare and, more recently, Medicaid have been important sources of additional revenues for hospitals that treat a disproportionate share of the poor. Substantial reductions in payment levels, such as those proposed in the Health Security Act, could adversely affect access to care for beneficiaries in both programs. Such reductions should be considered only insofar as health reform provides coverage for the uninsured.

Medicare and Medicaid beneficiary access to quality care also depends on whether providers receive appropriate payments from both government programs and private payers. Proposals that would further restrain spending by public payers but that fail to narrow the gap in payment to cost ratios between public and private payers or to provide coverage for the uninsured could make it more difficult for the beneficiaries of public programs and the uninsured to obtain access to necessary care.

As both Medicare and Medicaid have constrained payments in recent years, hospitals have turned to private payers for additional revenue to offset losses, rather than reducing the increase in their expenses. Cost shifting has allowed the Medicare program to curb spending, while permitting beneficiaries to receive services at costs that exceeded payments. It has also enabled many hospitals to maintain their financial position. The ability of hospitals to cost shift, however, has reduced their financial incentive to control expenses and increased the costs for subscribers of private insurance plans. The reliance on cost shifting as a revenue source has also disadvantaged hospitals that provide services to a large share of

Medicare and Medicaid beneficiaries and charity care patients.Further, cost shifting has disadvantaged hospitals where private payers successfully control hospital revenues. Consequently, hospital financial condition and the availability of services increasingly are determined by payer mix rather than by efficiency.

A health care reform plan like the Health Security Act, which would constrain the growth in private payer as well as government spending, could also affect the care received by Medicare beneficiaries. Since hospitals would not be able to obtain additional revenue from private payers, they would have to limit expenses to a level consistent with revenues. The slower rise in payments for current Medicare services, however, would be accompanied by increased spending for a new prescription drug benefit and coverage of certain long-term care services. As the reform debate continues, balancing the effects of a slowdown in spending for hospital and other covered services with an increase in expenditures for new benefits is necessary to avoid untoward effects on Medicare beneficiaries.

Recommendation 2: Payments to Hospitals Serving a Large Share of Low-Income Patients

The Health Security Act would substantially reduce Medicare disproportionate share payments, as universal coverage ameliorates many of the problems these payments are intended to address. The Commission believes the timing of any such reduction in Medicare payments should be coordinated with the extension of universal coverage, so that hospitals that provide care to low-income populations are not disadvantaged. As a result, payments would be targeted more effectively to the hospitals that provide care to these populations. Even so, the payments received by different hospitals and the balance between payment levels for Medicare and other patients may be affected significantly. These changes should be structured to ensure that both the level and distribution of payments are appropriate. ProPAC intends to work with the Congress and the Secretary of Health and Human Services to monitor and study this issue.

The Medicare DSH adjustment was implemented in 1986 to provide additional payments to PPS hospitals that treat a large share of indigent patients. Since then, the amount of DSH payments has grown rapidly, as Congress has increased the number of eligible hospitals and raised the adjustment for many. From fiscal year 1989 to fiscal year 1993, Medicare operating DSH payments grew from $1.1 billion (2.4 percent of all PPS payments) to $2.7 billion (4.1 percent of PPS payments). In addition, beginning in fiscal year 1992, hospitals received a DSH adjustment to their prospective capital payment amount.

Analyses by the Congressional Budget Office, ProPAC, and others have shown that Medicare DSH payments far exceed any additional costs that might be associated with treating Medicare patients in disproportionate share hospitals. As a result, in the eighth year of PPS, the PPS margin for all disproportionate share hospitals was 1.6 percent, compared with −7.2 percent for other hospitals.

The bulk of Medicare DSH payments goes to hospitals that provide a large amount of uncompensated care and other services to the poor. This is often cited as a justification for the magnitude of the payments made under the Medicare DSH provision and the rules that govern how these payments are distributed. Disproportionate share hospitals—particularly those in inner cities—tend to have lower total margins than other hospitals. The Commission is concerned about whether, without Medicare DSH payments, Medicare beneficiaries and other populations would continue to have access to the services these hospitals provide.

However, ProPAC also is concerned about the ability to target Medicare DSH payments effectively to the hospital that need them most. Of all PPS hospitals, the 10 percent with the greatest uncompensated care losses relative to their total costs provided 28 percent of all uncompensated care (net of government subsidies); these hospitals received only 17 percent of all Medicare DSH payments. At the other end of the spectrum, the 10 percent of PPS hospitals with the smallest uncompensated care burdens provided almost no net uncompensated are, yet received almost 9 percent of all Medicare DSH payments.

The Health Security Act eventually would eliminate almost all Medicare DSH payments, lowering Medicare hospital payments by an estimated $430 million in fiscal year 1996. Medicare DSH payments would be $4.8 billion lower than currently projected by fiscal year 2000, amounting to a 3.5 percent reduction in baseline Medicare payments. On the other hand, people who are now uninsured and those who are underinsured would begin to receive coverage. Consequently, hospitals now uncompensated for providing care to these patients would be paid for these services.

Hospitals that serve low-income populations would still face some risk of financial losses, particularly in treating some noncitizens and other individuals who may be unable to meet their financial obligations to providers. To recognize the additional costs of treating low-income patients and to help hospitals furnish inpatient services to poor populations not covered by the standard benefit package, $800 million would be available in each of the first five years following passage of the Act. These funds would be distributed based on the share of total inpatient days accounted for by low-income patients at each eligible hospital.

As with many provisions of the Health Security Act, the impact of the reduction in Medicare DSH payments and the extent to which it is offset by universal coverage is difficult to estimate. In addition to the level of total hospital payments, the distribution of payments also may change significantly. The Commission is concerned by the magnitude of these changes and their potential effects on the availability of necessary services to Medicare beneficiaries and all Americans. In addition, if the timing of the reduction of DSH payments is not coordinated with the extension of universal coverage, hospitals that provide care to low-income populations may be adversely affected.

Preliminary analysis indicates that the financial status of hospitals in the aggregate will depend largely on their ability to hold cost increases below historical rates. ProPAC will continue to examine the implications of health care reform for the distribution of payments. In addition, the technical appropriateness of the proposed changes in the rules that determine Medicate DSH payments will be investigated as part of the Commission's ongoing mandate to analyze, develop, and recommend improvements in Medicare payment for facility-based services.

Recommendation 3: Payments for Additional Patient Care Costs Incurred by Teaching Hospitals

ProPAC supports the explicit recognition by all payers of the higher patient care costs teaching institutions incur. The Commission believes such payments should be separated from patient are rates and paid through a fund similar to the Academic Health Center Account proposed in the Health Security Act. ProPAC is concerned, however, that a sharp reduction in the payments teaching hospitals receive from government payers may result in financial hardships for some of the

nation's major hospitals. Constraints on payments from private payers may exacerbate this problem. Therefore, ProPAC recommends that the total level of funding and the formula for distributing payments through such a mechanism should be based on careful analysis of the costs teaching institutions incur in carrying out their functions and how these payments will affect graduate medical education and access to the care these facilities provide.

The Health Security Act proposes an Academic Health Center Account to support the patient are costs incurred routinely by teaching facilities but not by other institutions. Among these are the costs of reduced faculty productivity, uncompensated costs of clinical research, and higher costs associated with specialized treatment of exceptional cases. Contributions from Medicare and from the regional and corporate alliances would fund the account. The available funds would be distributed by the Secretary of Health and Human Services on the basis of a formula related to the proposed Medicare IME adjustment percentage for fiscal year 1996. Thus, payments for the additional patient care costs insured by teaching hospitals would be separated from payments for patient care services.

Medicare's contributions to the Academic Health Center Account would be less than the IME payments made under the current formula, with estimated budget savings of $17.8 billion over five years (1996 to 2000). This proposed reduction in Medicare payments reflects the Administration's estimate of the amount by which current IME payments exceed the additional patient care costs attributable to teaching activities.

Set at $2.1 billion in fiscal year 1996 and $2.0 billion in fiscal years 1997 and 1998, Medicare's contributions thereafter would rise at the same rate as the consumer price index (CPI) for all urban consumers. The total size of the Academic Health Center Account, including contributions from the regional and corporate alliances as well as Medicare, would be $3.1 billion in fiscal year 1996, increasing to $3.2 billion, $3.2 billion, $3.7 billion, and $3.8 billion in the succeeding years.

Many private payers now pay higher rates to teaching hospitals for patient care services. However, in an environment of heightened price competition, teaching hospitals may not be able to obtain payments that reflect their higher patient care costs. Thus, they will likely be unable to fund these with revenue from patient care services.

The Commission supports the explicit recognition by all payers of the higher costs of treating patients in teaching institutions and the separation of payments for these costs from the basic price of care. However, ProPAC has three concerns about the Academic Health Center Account proposal in the Health Security Act. First, the amount to be distributed through the account should adequately reflect the additional costs teaching institutions face. Relatively little is known about the overall costs associated with the activities that the Academic Health Center Account is intended to support. Both ProPAC and the Health Care Financing Administration (HCFA) have analyzed the relationship between the intensity of hospital-based teaching activities and the cost of treating Medicare inpatients. However, the relationship between teaching intensity and the cost of treating other types of patients—that is, Medicare outpatients and non-Medicare inpatients and outpatients—in hospitals and non-hospital settings is not known. Moreover, existing information may not be applicable in the environment of tight general funding constraints under health care reform. More analysis is needed to ensure that the account has sufficient funds to accomplish its purpose.

Second, the distribution of monies from the Academic Health Center Account should be equitable and encourage the efficient operation of teaching institutions. The proposed application of the Medicare IME adjustment to total patient care revenue may not be the most appropriate way to accomplish this objective. To allow for the proper distribution of available funds, further analysis should focus on what factors determine differences across institutions in terms of the costs these funds are intended to defray.

Finally, the Commission is concerned about how the funding of the academic health center mechanism might affect access to services these facilities provide for Medicare beneficiaries and others. The funds available through the Academic Health Center Account must adequately reflect the additional costs of the services they are intended to support. Substantial reductions in the level of Medicare IME payments should not be made until other components of health reform are fully implemented. (See Recommendation 19). The impact of any changes in the level or distribution of payments among hospitals should be monitored carefully.

In addition, distributing Medicare IME payments through the academic health center mechanism rather than as an adjustment to the Medicare payment rate would mean that the payment received for each Medicare patient would be reduced relative to its current level (which includes the 7.7 percent IME payment adjustment). Medicare payments are a smaller proportion of costs than private payer payments. Although ProPAC's preliminary analysis indicates that the current gap between Medicare and non-Medicare payments relative to costs would narrow rather than widen under the proposed approach, this issue should be examined closely as health care reform is implemented

Recommendation 4: Graduate Medical Education Funding and Payment

ProPAC supports efforts to establish a funding mechanism for graduate medical education training programs that encompasses all payers, including Medicare. The Commission believes this mechanism should be separate from the payment received for patient care services. The level of funding and the distribution of payments should be determined according to the following principles:

- Funding for graduate medical education should be consistent with national work force goals, with respect to both the number of residents trained and their specialty distribution.
- Funding should support training for physicians and certain non-physician medical personnel who contribute to attaining these goals.
- Payment should be made to the training program, whether it is based in a hospital inpatient, hospital outpatient, or other ambulatory setting. The optimal method for allocating and distributing such payments needs to be determined.
- Payment for graduate medical education should be based on a national per resident amount, adjusted to recognize regional differences in residents' salaries and other factors that, upon further study, are found to be appropriate.

In addition, funds should be available to recognize the additional personnel costs of hospitals that operate programs that lose specialty training positions as a result of the process described above.

The Medicare program historically has paid hospitals for the costs associated with operating a residency training program. Costs for residents' salaries, faculty supervision, classroom space, program administration, and other related overhead were, until recently, recognized as a separate expense of which Medicare paid its share. Medicare is essentially the only payer that explicitly recognizes these expenses. Private insurers pay for these

costs implicitly through the higher payments they make to teaching hospitals.

The Consolidated Omnibus Budget Reconciliation Act of 1985 changed Medicare's payment for these expenses to a hospital-specific per resident amount. This amount is equal to the hospital's audited per resident costs for the cost reporting period beginning during fiscal year 1984, updated annually by the increase in the CPI for all urban consumers.

Under the Health Security Act, there would be a fundamental change in financing for graduate medical education (GME). Both Medicare and the health care alliances (the entities responsible for coordinating the purchase of health insurance for the non-Medicare population) would contribute directly to a Health Professions Workforce Account. Initial funding for this account would be set at $3.2 billion in fiscal year 1996, rising to $5.8 billion in 1999 and 2000 and increasing at the same rate as the gross domestic product thereafter.

The Act would establish, within the Department of Health and Human Services, a new National Council on Graduate Medical Education. This council would determine the number and specialty distribution of residency positions to be funded. At least 55 percent of individuals completing eligible programs nationwide would be required to be in primary care, beginning with the class entering training in the 1998–1999 academic year. The primary care specialties to which the act refers are family medicine, general internal medicine, general pediatrics, and obstetrics and gynecology.

Funds would be distributed to the individual residency programs, rather than to the hospital. Each program would receive a per resident payment amount based on the national average per resident cost in the 1992–1993 academic year, trended forward by the CPI and adjusted to reflect regional differences in residents' wages and wage-related costs.

The Act would also establish a program with respect to graduate nurse training that parallels the one for physician training, with funding set at $200 million annually. The Secretary of Health and Human Services would be further required to establish or expand programs to train physicians, nurses, physician assistants, and other health professionals to improve the efficiency and availability of health care across geographic locations and settings.

ProPAC agrees that changes are needed in the way that graduate medical education and other health care training activities are structured and financed. While others have devoted substantial attention to issues related to the supply and distribution of health care personnel, the Commission's focus is on payment policies, particularly as they affect facility-based care provided to the Medicare population and other groups. Consistent with this focus, ProPAC has identified several principles that should be used in determining the level of funding and the distribution of payments to support the training of health care professionals. These principles should be used to guide policies relating to the funding of graduate medical education whether comprehensive health reform is enacted or not.

All-Payer Funding Mechanism.—The Commission believes it is appropriate to include all payers in a mechanism for funding graduate medical education that sets a nationwide level for such funding. Moreover, this mechanism should be separate from the payment received for patient care services.

Currently, payers other than Medicare contribute only implicitly to the support of graduate medical education; Medicare's GME payment is based on each hospital's own historical costs. Consequently, there are unclear and inconsistent incentives related to the total number of residents and their distribution across geographic areas, programs, and institutions, as well as to costs per resident.

An all-payer funding mechanism for graduate medical education would base the level and distribution of payments on a consistent set of criteria. This would provide appropriate incentives for the allocation of resources. It would also ensure that the costs of training physicians would be borne by both the Medicare and the non-Medicare populations. Further, a funding mechanism that recognizes the costs of teaching activities regardless of setting would improve the effectiveness of medical education as well as the equity of payments.

Consistency with National Work Force Goals.—Both the current Council on Graduate Medical Education (COGME) and the Physician Payment Review Commission (PPRC) have extensively examined physician supply and specialty distribution issues. Each of these groups has recommended limiting the number of residents entering training to 110 percent of the number of graduates from U.S. medical schools. ProPAC supports limiting the number of resident positions.

COGME and PPRC differ, however, on how they would approach the issue of specialty distribution. COGME advocates increasing to 50 percent the proportion of primary care residents, which it defines as family practice, general internal medicine, and general pediatrics. PPRC does not recommend a specific percentage for primary care, but endorses the designation of a national body to determine the most appropriate specialty distribution of residents. ProPAC supports proposals that would lead to a more appropriate specialty mix of physicians, including those who serve the special needs of the Medicare population. These issues, however, need to be reexamined periodically, and an independent group should be created to monitor and set future work force goals. The Commission believes graduate medical education funding should be tied to these work force decisions.

Training for Other Categories of Health Care Professionals.—National work force goals should include the appropriate use of both physicians and other categories of health care professionals. The determination of the appropriate roles for specific categories of medical personnel is beyond ProPAC's mandate, however. In any event, the availability and distribution of funding should be consistent with national work force goals.

Payments to Training Programs.—Currently, Medicare pays the hospital for the direct costs of approved graduate medical education programs and direct medical education costs for the training of nurses and allied health personnel. This provides a strong incentive in support of hospital-based training and discourages the use of alternative sites, such as physician offices and other ambulatory settings. The Commission believes GME payments should be made to the training program, rather than to the hospital. This would allow greater flexibility concerning where and how the residents are trained and would simplify fundings for residencies that are provided in several settings.

Although ProPAC favors payment to the program rather than to the hospital, questions arise about the appropriate designation of the entity that would actually receive the payment. These questions need to be addressed before final determination is made concerning the method for allocating and distributing GME payments.

Per Resident Payment Amount.—The Commission believes GME payments should be based on a national per resident payment amount, adjusted for appropriate differences in costs across institutions. The current Medicare per resident payment amounts, which are based on each hospital's own historical costs, vary substantially. Moreover, this

variation in payments does not, as a rule, correspond to observed differences in current costs.

ProPAC has examined some of the reasons for the variation in per resident costs, and has found geographic location to be a significant factor. In addition, some hospital and program characteristics are correlated with per resident costs. However, the allocation of overhead also appears to be related to reported costs. Moreover, the results indicate that the PPS hospital wage index, which measures the cost of all hospital labor inputs, may not be an appropriate adjuster for residents' wage differences.

The Commission believes further work is necessary to identify appropriate adjustments to a national per resident payment amount. ProPAC will continue to examine this issue over the coming year.

Funding for Institutions That Lose Training Positions.—Adequate funding should be available to assist hospitals that lose training positions as a result of the reduction in the total number of positions and the reallocation of these positions across hospitals and other settings. Some of these institutions rely on residents to provide basic patient care, and the loss of these positions should substantially increase their costs. Moreover, many of these facilities are located in areas where it is difficult to recruit other physicians, and many provide care to populations that otherwise might not have access to that care.

Recommendation 5: Quality of Care

The Commission believes there must be an effective quality assurance program for Medicare enrollees, especially given health reform's emphasis on cost control and proposed cutbacks in Medicare spending. The Peer Review Organization program should be continued but thoroughly evaluated. It should be replaced only by a program that has been determined to be more effective.

The Health Security Act eliminates the PRO program and does not replace it with another quality assurance program for Medicare enrollees. The Commission views this as undesirable, especially given that cutbacks in the rate of growth in Medicare spending and cost controls in the private insurance market may adversely affect the quality of care provided to Medicare patients. ProPAC has stressed the importance of a regulatory quality assurance program for Medicare in past recommendations; it believes that both pattern analysis and individual case review should be continued.

The PRO program should not be eliminated until another way to assess quality proves to be superior. In addition, it should be evaluated to see what aspects are most effective in improving quality of care. The Health Care Financing Administration should consider implementing additional quality assurance programs and evaluating them simultaneously with the PRO program to determine the best way to ensure that Medicare beneficiaries receive quality care.

Dramatic changes in the PRO program have reduced the emphasis on punitive case review and incorporated pattern analysis with educational feedback. These changes are consistent with recommendations made by the Institute of Medicine and others. There are no plans, however, to evaluate this new methodology.

The proposed quality assurance program in the Health Security Act depends largely on collecting and disseminating information to purchasers, consumers, and providers on quality of care, access to care, and patient satisfaction. This method of quality assurance is largely untested. Further, under the Act it would not apply to most Medicare enrollees. The Commission recommends that any quality assurance methodology enacted as part of health reform should be evaluated. In addition, the methodology should be appropriate for a Medicare-enrolled population.

Recommendation 6: Improvements in Premium Risk Adjustment Methods

The Commission recommends that the Secretary undertake the research necessary to substantially improve current risk adjustment methods. Risk adjustment will be needed under many health reform proposals to ensure that the premiums paid to competing health plans accurately reflect the risk composition of their enrollees. Until major improvements can be made, some other mechanism may be needed to limit the potential impact of enrolling individuals whose care proves to be exceptionally costly.

Under many health reform proposals, including the President's plan, most individuals would obtain their health coverage from a health plan that participates in local purchasing alliance. Under some proposals, persons eligible for Medicaid, along with Medicare enrollees who choose to obtain coverage through the risk program, also would receive coverage and health services from a health plan that competes in the local alliance. Therefore, the ability to establish equitable premium payments among competing plans will be important for Medicare and Medicaid enrollees, as well as for all other citizens.

The Commission believes payment equity among competing health plans will be critical to preserving the long-term viability of competition within each purchasing alliance. In addition, equitable payment is necessary to promote and maintain equal access to health services among different population groups, including Medicare and Medicaid beneficiaries.

Accurate adjustment of plan premiums to reflect the risk composition of plan enrollment is essential to achieve payment equity among competing health plans. Fair risk adjustment methods are important for two reasons. First, risk adjustment would ensure that all plans are able to provide a comparable quantity and mix of health services to enrollees with comparable needs. In the absence of effective risk adjustment, plans that enroll high-risk persons would be forced to limit access to needed services or take a financial loss. Moreover, such plans would be unable to offer competitive premium rates over the long run. Conversely, plans that enroll low-risk persons would be able to provide a richer mix of services or make windfall financial gains. Consequently, these plans would be able to offer favorable premium rates, thereby securing a competitive advantage. Second, without effective risk adjustment, competing health plans would have a strong incentive to try to attract a favorable selection of enrollees while avoiding high-risk persons. This could lead to unequal access to care.

Current methods of risk adjustment appear to have serious deficiencies. Risk adjustment involves using information about individuals' demographic characteristics, health status, or recent use of health services to predict future expenditures for health care. Research suggests that even the best combination of available risk indicators accounts for only a small proportion of the variability in subsequent expenditures among individuals. Therefore, substantial improvements in these methods and the data to support them are urgently needed.

Until improved risk adjustment methods can be developed, the financial risks and undesirable incentives associated with unfavorable selection could be limited in other ways. This goal could be accomplished by compensating plans for a portion of any large losses they experience in providing care to enrollees with extraordinary medical expenses. This could be done using the traditional

reinsurance mechanisms of the private insurance industry. In this case, health plans could choose to purchase insurance against the occurrence of an adverse claims experience that results in spending that is much higher than expected. Such insurance would relieve some of the undesirable consequences of ineffective risk adjustment.

Alternatively, plans' financial risks could be reduced by a mandatory outlier policy analogous to the outlier payment policy under PPS. Under this policy, all plans' premium revenues would be taxed to provide an outlier payment fund. This fund would be used to make additional payments to any plan that experiences large losses in providing care to individual enrollees with extraordinary expenses. Such payments would cover a high proportion of the loss in excess of a fixed loss threshold. Consequently, this mechanism also would limit plans' losses to the extent that they were attributable to unfavorable selection. Therefore, it also would mitigate the unwanted effects of inadequate risk adjustment.

Recommendation 7: Controlling Medicare Spending Across All Sites of Care

Medicare should continue to develop policies to monitor and control total expenditure growth across all sites of care. Payment methods should not unduly favor the choice of one site over another. They should also provide consistent incentives to constrain increases in volume and service intensity across physicians and other providers.

The Commission endorses the development of prospective payment methods for all services across all sites. These methods should be designed to offer uniform incentives for efficiency as well as make payments across sites more comparable. This is particularly important because many services are available in alternative settings. Prospective methods alone, however, will not address one of the major reasons for expenditure growth: increased volume and intensity of services. Medicare's physician payment method incorporates such incentives through its volume performance standards by adjusting fees to reflect the relationship between actual expenditures and an expenditure target. Other providers are not subject to such direct volume control measures.

Premium caps in the President's proposal provide incentives for health plans to constrain price and service volume across all settings for non-Medicare enrollees. The modifications to Medicare policies included in the Health Security Act do not incorporate similar incentives. While the Medicare provisions of the President's plan generally would reduce the growth in per service payments, spending increases likely would persist due to accelerating volume. The Medicare program, therefore, should continue to develop volume control methods for all sites of care.

The contribution of expanding utilization to expenditure growth is well-illustrated by Medicare's home health program. Home health agency charges per visit increased only 4.7 percent annually between 1988 and 1991, yet Medicare expenditures increased at an average annual rate of 10.8 percent. As another example, the Medicare payment rate for dialysis services has not risen since 1985, yet expenditures increased at an annual rate of 12.4 percent through 1990.

Several strategies for constraining volume have been identified. One approach is to combine, or bundle, separately billable services into a single payment unit. A volume performance standard like the one implemented for physician payment is another method. Finally, managed care arrangements have the potential to control utilization and encourage care in the most appropriate setting. From a policy standpoint, each of these methods provides certain advantages and disadvantages. Each also presents different implementation issues. The Medicare program should develop the most appropriate ways to achieve volume and price control across all services and sites of care. The approaches selected should create consistent incentives for all providers in all settings.

Medicare benefit and payment policies are fragmented and at times inconsistent across sites and providers. Improvements in these policies are needed to ensure stable incentives to slow the growth in spending. These changes should reward efficient resource use while improving the continuum of care for Medicare beneficiaries.

Recommendation 8: Strengthening Medicare's Risk Contracting Program

The Commission recommends that the Secretary improve Medicare's risk-based, managed care program to give more Medicare beneficiaries the option of enrolling in managed care plans. To increase plan participation, deficiencies related to the risk adjustment formula and local differences in payments need to be corrected.

Medicare's risk-based, managed care program has been shown to improve access and, in some cases, to provide a broader array of services to Medicare beneficiaries. The program also may have the potential to be cost effective for Medicare, particularly if evaluated over several years.Furthermore, increased emphasis on risk-based, managed care is consistent with the President's health care reform proposal. Despite these advantages and the growth of managed care in the private sector, only 5 percent of all Medicare enrollees participate in Medicare's managed care program. One reason for the low participation may be the limited availability of managed care options. Health plans have been reluctant to participate in Medicare's risk-based program because of concerns related to Medicare's payment method. The Commission recommends that HCFA step up its efforts to improve the methods for determining payments to risk-based, managed care plans, thereby making this option more available to Medicare beneficiaries.

Participating plans are paid a capitated amount based on 95 percent of each county's average Medicare fee-for-service expenditures. However, Medicare managed care enrollees' utilization and related expenditure patterns differ from those with fee-for-service coverage. Managed care enrollees use fewer hospital days and more ambulatory care. The dissimilarities between the two populations in service use and related spending may not be captured in the current payment method.

Further, payments based on county-level fee-for-service expenditures are even less representative of the average spending in areas where managed care enrollment is high. Medicare's policies, therefore, may penalize managed care plans in counties where they have already helped to slow the growth in fee-for-service spending.

The risk-based, managed care program also has been criticized for failing to make adequate risk adjustments in plan payment amounts. Medicare uses a limited number of demographic variables to adjust payments for enrollee characteristics (age, sex, Medicaid status, and institutional status), but these measures are poor predictors of actual expenditures. Better measures are being investigated that incorporate utilization data for hospital and ambulatory care, prescription drug use, and other factors directly related to health care use and spending.

HCFA is reviewing ways to improve the payment methods for Medicare's risk-based, managed care contracts. The Commission recommends that HCFA continue these efforts to strengthen this component of the Medicare program.

Providing more equitable payments could encourage greater plan participation, thereby giving more beneficiaries the option of enrolling in managed care. Further, evaluations of spending under Medicare managed care should be based on longitudinal comparisons of beneficiary experience. Medicare's managed care option could become even more important under many of the health care reform proposals.

Payment Updates

The Commission is mandated by law to report to the Congress each year on an appropriate update to the inpatient hospital payment rates under PPS. ProPAC considers several factors in developing its annual update recommendation: the hospital market basket index (which reflects the prices of resources used by hospitals in providing inpatient care), scientific and technological advances, hospital productivity, case-mix change, and the quality and long-term cost-effectiveness of health care. The Secretary of Health and Human Services is required to consider the Commission's recommendation in developing her update recommendation. The actual update historically has been legislated by the Congress in the budget reconciliation process.

In the Omnibus Budget Reconciliation Act (OBRA) of 1993, the PPS operating update was established for each fiscal year through 1997. For fiscal year 1995, the update for hospitals in large urban areas (areas with populations over one million) and other urban areas is set equal to the change in the hospital market basket index minus 2.5 percentage points. The update for rural hospitals is the amount necessary to bring the rural standardized amount to the same level as the other urban standardized amount. Even though the fiscal year 1995 update has been set by law, the Commission has continued its traditional approach of examining the individual factors that together determine the appropriate update to the PPS payment rates. ProPAC believes this approach results in a payment increase that is sufficient, in the context of the current health care financing system, to maintain Medicare beneficiaries' access to quality care while encouraging hospital efficiency in providing that care.

In addition to the update to the PPS payment rates, the Commission recommends an update for the Federal capital payment rate. ProPAC also recommends an update for rates derived from hospital base-year costs, which may be used in place of the PPS rates for sole community hospitals. Finally, the Commission considers the update for facilities currently excluded from PPS. ProPAC's recommendation for an update to the composite payment rate for dialysis services is also presented.

Recommendation 9: Update Factor for Operating Payments to PPS Hospitals

For fiscal year 1995, the PPS standardized payment amounts should be updated to account for the following:

- The projected increase in the HCFA PPS market basket index, currently estimated at 3.7 percent;
- An adjustment of zero percentage points for the difference between the projected ProPAC and HCFA market baskets;
- A negative adjustment of 1.1 percentage points for substantial error in the fiscal year 1993 market basket forecast;
- A positive adjustment of 0.3 percentage points to reflect the cost-increasing effects of scientific and technological advances;
- A negative adjustment of 0.7 percentage points to encourage hospital productivity improvements; and
- A net adjustment of zero percentage points for case-mix change.

In addition, a positive adjustment of 3.1 percentage points should be made for hospitals in rural areas to complete the phase-out of the differential in standardized amounts between rural and other urban hospitals. ProPAC's recommendation would result in an estimated average update factor of 2.7 percent for fiscal year 1995: an increase of 2.2 percent for urban hospitals and of 5.3 percent for rural hospitals.

This recommendation reflects the Commission's judgment about the appropriate increase in the level of PPS payment rates. Since it is based on current projections of the fiscal year 1995 increase in the market basket index, the effective value of ProPAC's update factor recommendation may be modified as more recent forecasts become available. The components of ProPAC's update factor recommendation are summarized in Table 2–1, and a discussion of each follows.

It should be noted that the increase in average per case payments in each year exceeds the PPS update. This is because increases in the Medicare case-mix index (CMI) result in proportionally higher hospital payments. Future changes in case mix are difficult to predict; however, on the basis of currently available data, ProPAC estimates that the CMI will rise by 0.9 percent in fiscal year 1995. Based on the Commission's recommendation of a 2.7 percent average update, the average increase in per case payments would be about 3.6 percent.

PPS Market Basket Forecast and Forecast Error Correction—The forecasted increase in the market basket index is the expected change in the prices of the resources used during a typical hospital stay. This forecast is the reference point used in updating the PPS payment rates. The current forecast is for a 3.7 percent increase in HCFA's PPS market basket index during fiscal year 1995.

In its March 1990 *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services*, ProPAC proposed modifications to the market basket used by HCFA. Although HCFA adopted most of these modifications, it did not incorporate the key provision that increased the weight of internal hospital wages in the computation of the market basket index. The Commission believes HCFA's market basket as currently constructed does not adequately recognize the unique characteristics of the hospital labor market.

Since the PPS update for fiscal year 1995 is legislated relative to HCFA's market basket, that market basket is used as the basis for ProPAC's update framework. The Commission takes this into account by making an adjustment to allow for the estimated effect of the modifications it has proposed. However, the current fiscal year 1995 forecast is that the increase in ProPAC's and HCFA's market baskets will be the same. The corresponding adjustment, therefore, is zero percentage points.

A forecasted market basket increase of 4.1 percent was used to set payments in fiscal year 1993. The actual market basket increase, however, was only 3.0 percent. The update for fiscal year 1993 thus was set 1.1 percentage points higher than if the actual market basket increase had been known at the time.

The Commission believes a correction for substantial error in market basket forecasts in an important part of its update framework. This correction protects both hospitals and the Federal government by adjusting the base payment rates so that the effects of past forecast errors (both positive and negative) are removed. Therefore, ProPAC's update recommendation also includes a −1.1 percentage point adjustment for fiscal year 1993 market basket forecast error.

TABLE 2–1.—RECOMMENDED UPDATE FACTOR FOR PPS HOSPITAL OPERATING PAYMENTS, FISCAL YEAR 1994

Components of the Update		
Components applied to all hospitals:		
Fiscal year 1995 HCFA PPS market basket forecast[a]	.....	3.7%
Adjustment for difference between HCFA and ProPAC market baskets[a]	.....	0.0
Correction for fiscal year 1993 forecast error	.....	−1.1
Allowance for scientific and technological advances	.....	0.3
Adjustment for productivity	.....	−0.7
Adjustments for case-mix change (fiscal year 1994):		
Total DRG case-mix index change	−0.9	.....
Real across-DRG case-mix change	0.7	.....
Within-DRG case-complexity change	0.2	.....
Net adjustment for case-mix change	.....	0.0
Additional adjustments to the standardized amounts:		
Adjustment for large urban areas[b]	0.0	.....
Adjustment for other urban areas[c]	0.0	.....
Adjustment for rural areas	3.1	.....
Total Update Factor		
Overall average	.....	2.7
Large urban areas	2.2	.....
Other urban areas	2.2	.....
Rural areas	5.3	.....

[a] Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1993. The market basket forecast is subject to change as more current data becomes available.
[b] Large urban areas = metropolitan areas with populations of one million or more.
[c] Other urban areas = metropolitan areas with populations of less than one million.

Adjustment for Scientific and Technological Advances—The allowance for scientific and technological advances is a future-oriented policy target. It provides additional funds for hospitals to adopt quality-enhancing health care advances, even when they increase costs. To develop an informed judgment about the appropriate level of this allowance, ProPAC annually examines emerging, cost-increasing technologies and scientific developments. (See Appendix A for more information on the technologies contributing to the increase.) The Commission believes 0.3 percent is an appropriate level for the operating scientific and technological advances allowance for fiscal year 1995.

Adjustment for Productivity Improvement—The productivity adjustment is also a future-oriented policy target. The Commission believes it is reasonable to expect hospitals to achieve productivity improvements during fiscal year 1995 that are comparable to those achieved in other sectors of the economy. The recommended adjustment of −0.7 percentage points is based on ProPAC's determination that hospital productivity should increase by 1.4 percent and that the savings from such productivity improvement should be shared equally by hospitals and the Medicare program. The Commission thinks it is appropriate for the costs of scientific and technological advances to be financed in part by expected productivity gains, to provide an incentive for hospitals to strive for productivity improvement as they adopt new technologies. (See Appendix A for more information on trends in hospital productivity.)

Adjustments for Case-Mix Change—The fiscal year 1995 PPS update should be adjusted to account for the net effect of case-mix change during fiscal year 1994. The net adjustment in this year's update is zero percentage points and reflects the following:

- A 0.9 percentage point reduction for the estimated change in the CMI,
- A positive allowance of 0.7 percentage points for real case-mix change across diagnosis-related groups (DRGs), and
- A positive allowance of 0.2 percentage points for within-DRG case-complexity change.

Adjusting for these factors allows payments to increase due to real changes in the resources required to treat an average Medicare patient. At the same time, it removes the effect of changes in medical record documentation and coding practices that are unrelated to patient resource requirements. (See Appendix A for a more detailed discussion of case-mix change.)

Differential Adjustments to the Standardized Amounts—ProPAC supports the provisions of OBRA 1990 and OBRA 1993 that eliminate the difference between the standardized payment amounts for rural and other urban areas in fiscal year 1995. This year's update would complete a process begun in 1991 that has provided higher updates in each year to rural hospitals. The Commission estimates that the differential would be eliminated if the rural update were 3.1 percentage points higher than the urban update for fiscal year 1995.

Since the beginning of PPS, the ratio of Medicare payments to costs has been higher for urban hospitals than for rural institutions. This is primarily the result of two factors. First, urban hospitals have benefited more from the PPS payment adjustments—particularly the effects of CMI change and the IME and DSH adjustments. In addition, rural hospitals have had large declines in inpatient volume, raising fixed costs per case. However, as indicated in ProPAC's October 1991 report to the Congress, *Rural Hospitals Under Medicare's Prospective Payment System*, several recent policy changes have improved the relative performance of rural hospitals under PPS. This trend promises to continue. The Commission will monitor and analyze the further effects of these policies as additional data become available.

Recommendation 10: Update Factor for Capital Payments to PPS Hospitals

For fiscal year 1995, the Commission recommends that a formula-based approach be used to update capital

payment rates. The capital update should include the following:

- The projected increase in a capital market basket index that measures one-year changes in a fixed basket of capital goods hospitals purchase, currently estimated at 3.4 percent;
- An adjustment of zero percentage points to correct for past forecast errors;
- An adjustment of zero percentage points to reflect changes in financing costs;
- A positive adjustment of 0.9 percentage points for scientific and technological advances;
- A negative adjustment of 0.7 percentage points to encourage hospital productivity; and
- A net adjustment for zero percentage points for case-mix change.

The Commission's recommendations would result in a 3.6 percent increase in the Federal capital payment rate for both urban and rural hospitals.

ProPAC believes the capital update should be for future capital purchases. It is designed to provide Medicare capital payments reflective of future capital replacement prices. It would provide updates appropriate to maintain hospital capital stock adequate to provide efficient and effective care to Medicare beneficiaries.

The components of the update recommendation are summarized in Table 2–2; a discussion of each of these components follows. (See Appendix A for more information on the capital update.)

Capital Market Basket—ProPAC's capital update recommendation reflects projected increases in a market basket index designed to measure changes in the prices of capital assets hospitals purchase. This index, developed by the Commission, provides a measure of the increase in capital input prices analogous to that used to update PPS operating payments. (See Recommendation 9.) It also measures annual change in the price of a fixed mix of capital goods.

The recommended market basket includes three price components: building and fixed equipment, movable equipment, and other capital-related costs such as insurance. The market basket weights reflect hospitals' patterns of capital acquisition. In the absence of accurate and current information on actual capital purchases, the Commission believes that shares of depreciation expense, adjusted for other capital-related costs, are the best available measures of future purchases. Therefore these shares, combined with annual outlays for capital-related costs, are used as weights in the market basket.

TABLE 2–2.—RECOMMENDED UPDATE FACTOR FOR CAPITAL PAYMENTS, FISCAL YEAR 1995

Components of the Update	
Fiscal year 1995 capital market basket[a]	3.4%
Correction for fiscal year 1993 forecast error	[b]
Financing policy adjustment	0.0
Allowance for scientific and technological advances	0.9
Adjustment for productivity improvement	−0.7
Adjustment for case-mix change[c]	0.0
Total capital update	3.6

[a] Market basket estimate developed by ProPAC using forecasted data supplied by the Health Care Financing Administration, Office of the Actuary, January 1994. The market basket forecast is subject to change as more current data become available.

[b] Not applicable.

[c] Case-mix change components = total DRG CMI change, real across-DRG case-mix change, and within-DRG case-complexity change.

Although updates should apply to the full Medicare capital payment rate, which reflects historical levels of depreciation and interest, interest rate changes should be handled separately from the market basket. The Commission's financing policy adjustment addresses the issue of interest rate change in the update framework.

The capital market basket proposed by the Secretary uses a complex structure of weighted average changes in economywide price proxies and measures of interest expense. Its value is largely determined by historical values of its components. In ProPAC's view, a straightforward market basket that reflects the change in the price of hospital capital purchases and other capital-related costs in the coming fiscal year is more appropriate. The recommended market basket would provide Medicare capital payments reflective of future capital purchase prices.

ProPAC studied a range of alternative capital price measures. In its March 1993 *Report and Recommendations to the Congress*, the Commission recommended using two price proxies especially relevant to hospital industry capital purchases: for hospital building and fixed equipment capital costs, the Boeckh building cost index subindex for apartments and office buildings (institutional construction); and for movable equipment capital costs, the Marshall and Swift hospital equipment index. Changes in other capital-related costs would be measured by the consumer price index for residential rent. Components would be weighted as discussed above. The market basket would be used to prepare single-year projections of price change.

As of January 1994, the projected increase in ProPAC's market basket index for fiscal year 1995 is 3.4 percent. This forecast may change as more up-to-date data become available and methodologies for estimating the components of the market basket are refined.

Forecast Error Correction—The Commission believes the correction of past market basket index forecast errors should be part of the update framework. This correction protects both hospitals and the Federal government by adjusting the payment rates so that the effects of past forecast errors are not perpetuated. Because a capital market basket has not yet been used to increase capital payment rates, a correction factor is not needed this year.

Financing Policy Adjustment—The Commission's capital update frame work includes a financing policy adjustment to account for the effects of changes in interest rates on hospital capital costs. In ProPAC's view, interest rate fluctuations should not be reflected in the market basket. If they were, such changes might lead to volatility in updates, overcompensation of hospitals in some circumstances, and undue risk for facilities at other times. Instead, ProPAC recommends an explicit adjustment to the capital update factor to account for significant changes in interest rates.

The financing policy adjustment reflects interest rate changes that might otherwise create a significant financial burden for hospitals, as well as those that would produce substantial reductions in capital costs. It would raise payments to compensate hospitals faced with disruptive effects of extreme interest rate increases and allow the Medicare program to share in some of the savings resulting from lower interest rates.

Though relatively high compared with short-term rates and in light of expected inflation, long-term interest rates are anticipated to remain stable through fiscal year 1995. The Commission believes it is not appropriate to adjust capital payments for forecasted changes in interest rates at this time.

Scientific and Technological Advances—ProPAC recognizes that future hospital capital investments may include more costly, quality-enhancing medical technology. The capital update framework adjusts payments to allow for scientific and technological advances. (See Recommendation 9.) The Commission recommends a 0.9

percentage point adjustment for the capital component of scientific and technological advances.

Productivity Improvement—ProPAC recognizes the need to adapt the capital stock of hospitals to a health care environment with less demand for inpatient services through its productivity adjustment. This adjustment serves as a target for improvement in productivity due to more efficient use of plant and equipment and purchase of cost-decreasing technologies. The Commission recommends an adjustment of −0.7 percentage points to encourage more efficient use of existing plant and equipment and the purchase of cost-decreasing technologies. (See Recommendation 9.)

Case-Mix Change—Medicare uses the same DRG definitions and relative weights for both operating payments and capital payments. As a result, capital payments, respond to changes in the CMI in the same way as do PPS operating payments. Thus the adjustment to capital payment rates for CMI change is identical to that made to operating payment rates. (See Recommendation 9.) The net adjustment for case-mix change is zero percentage points.

Recommendation 11: Single Operating and Capital Update Factor

The Commission recommends that when the transition to fully prospective capital payments is complete, a single update factor be used for adjusting PPS operating and capital payment rates. Based on ProPAC's recommended updates to the operating and capital payment rates, the total increase to a fully prospective combined payment rate would be 2.8 percent for fiscal year 1995.

The Commission believes there ultimately should be one payment for hospital inpatient operating and capital expenses and a single annual update to that payment. ProPAC recognizes that a combined capital and operating update factor cannot be used until the transition to a fully prospective capital payment system is complete. This is because the update applies only to the prospective portion of capital payment rates. Further, the operating payment update is currently set by law, while the Secretary has authority to establish capital prospective payment updates through annual rulemaking. The Medicare program, however, should move to a single update approach for inpatient operating and capital payment rates as soon as possible. Despite the separate payment methods, hospitals do not distinguish between their operating and capital payments. Operating payments may be used to defray capital shortfalls and vice versa. Separate update factors for operating and capital expenses do not reflect the way hospitals actually use their revenues or make investment decisions.

ProPAC therefore recommends the development and use of an update framework that includes capital and operating components for fiscal year 1995. Like the operating update use by ProPAC, the combined update approach should incorporate operating and capital market baskets to measure changes in prices, as well as adjust for productivity, scientific and technological advances, and case-mix change. This would ensure that updates to both operating and capital base payment rates reflect increases in the costs of the goods and services that hospitals require to produce inpatient hospital care efficiently. Ultimately, operating and capital components should be included in a single market basket and set of adjustments.

A combined fully prospective update would yield an average payment rate increase of 2.8 percent under the Commission's recommendation. The total payment rate increase, however, would be about 3.7 percent, because of expected increases in the CMI (see Table 2–3).

Recommendation 12: Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates

The Commission believes payments based on hospital-specific base-year costs for sole community hospitals should be updated by the average update given to all hospitals.

The recommendation would result in an update to the hospital-specific rates of 2.7 percent for fiscal year 1995, consistent with the Commission's recommendation on the PPS update. Since the update is based on current projections of the fiscal year 1995 increase in the market basket index, its effective value may be modified as more recent forecasts become available.

OBRA 1989 provides that certain hospitals be paid on the basis of the PPS rate, their own 1982 base-year costs updated to the current year, or their updated 1987 base-year costs, whichever would yield the largest payment. Sole community hospitals, which meet certain criteria based on distance from other hospitals or market share, qualify for this special treatment. Provisions affecting small rural Medicare-dependent hospitals, which were defined as rural hospitals with fewer than 50 beds and at least a 60 percent Medicare share of total discharges or inpatient days, expired with cost reporting periods ending on or after April 1, 1993. However, OBRA 1993 restored this provision for cost reporting periods ending before October 1, 1994. For fiscal year 1995. Medicare-dependent hospitals will no longer be paid on the basis of hospital-specific rates and will be treated like other rural hospitals.

TABLE 2–3.—ESTIMATED FISCAL YEAR 1995 AVERAGE INCREASE IN PER CASE PAYMENTS UNDER FULLY PROSPECTIVE RATES—PERCENT

Operating update factor	2.7
Capital update factor	3.6
Total average update	2.8
Estimated case-mix index change (fiscal year 1995)	0.9
Total average increases in PPS payments*	3.7

*The total average increase in PPS payments reflects the multiplicative effects of the total average update and case-mix index change.

Current law requires that the hospital-specific rates for these hospitals be updated at a rate equal to the expected average update for all PPS hospitals. ProPAC concurs with this provision. Sole community hospitals are accorded special treatment under PPS because they may face higher historical costs due to their special circumstances. Nevertheless, these hospitals should be able to control their cost increases as other hospitals do. Last year, the Commission recommended that the update for rural areas be applied to the hospital-specific rate, on the grounds that other rural hospitals are the appropriate comparison group for these hospitals. However, this year's PPS update for rural hospitals (including sole community hospitals) is substantially higher than the average for all hospitals. The Commission believes the average increase for all hospitals provides a reasonable update for the hospital-specific rates available to these facilities.

Recommendation 13: Update Factor for PPS-Excluded Hospitals and Distinct-Part Units

For fiscal year 1995, the largest rates for PPS-excluded hospitals and distinct-part units should be updated by 2.7 percent. This recommendation accounts for the following:

- The projected increase in the HCFA PPS-excluded hospital market basket, currently estimated at 3.7 percent.
- An adjustment of zero percentage points for the difference between the

projected ProPAC and HCFA market baskets;

- A negative adjustment of 1.0 percentage points for substantial error in the fiscal year 1993 market basket forecast; and
- An adjustment of zero percentage points for scientific and technological advances.

When PPS was established, it was clear that prospective payment based on DRGs could not be applied universally and that certain providers would need to be excluded. At this time, five types of specialty hospitals (psychiatric, rehabilitation, long-term, children's, and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. These providers are excluded primarily because DRGs fail to accurately predict the resource costs for the patients they treat.

PPS-excluded hospitals and distinct-part units are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of its current Medicare-allowable inpatient operating costs per discharge, or a target amount. The target amount is based on the provider's allowable costs per discharge in a base year, trended to the current year by an annual update factor. Medicare's share of allowable capital costs is paid in its entirety.

Under TEFRA, a facility with inpatient operating costs per discharge that are less than its target rate receives its costs plus either 50 percent of the difference between its cost per discharge and the target or 5 percent of the target amount, whichever is less. A facility with inpatient operating costs per discharge above its target rate receives the target amount plus half the difference between that amount and its cost per discharge, but no more than 110 percent of the target. Further, the Secretary is required to provide for an adjustment to a facility's payment when events beyond the facility's control distort its cost increase for a cost reporting period.

Although the Congress legislates the update to the TEFRA target amounts, ProPAC and the Secretary of Health and Human Services are required to recommend an annual update factor. For fiscal years 1994 through 1997, each facility will receive an update ranging from the projected increase in the market basket to the market basket increase minus 1.0 percentage points. The Commission recommends an average update to the target rate equal to the market basket increase minus 1.0 percentage points for fiscal year 1995 (see Table 2–4).

Market Basket—The update recommendation is determined primarily by the projected increase in the PPS-excluded market basket index, which measures the price of inputs used by these facilities in treating Medicare patients. The current HCFA market basket increase forecast for fiscal year 1995 is 3.7 percent. There is no difference between the HCFA and ProPAC market basket forecasts for 1995, so no adjustment to reflect this difference is necessary.

Forecast Error Correction.—ProPAC believes the update should be corrected for substantial past market basket forecast errors. Because projections must rely on available data, they cannot accurately anticipate all future economic conditions that may affect input prices. Updates based on market basket forecasts, therefore, may result in overpayments or underpayments to PPS-excluded facilities, which should not be carried forward to subsequent payment years. The market basket projection used to update TEFRA target amounts in fiscal year 1993 was 4.2 percent. The actual market basket increase, however, was only 3.2 percent. Therefore, ProPAC's update recommendation includes a −1.0 percentage point adjustment for fiscal year 1993 market basket forecast error.

TABLE 2–4.—RECOMMENDED UPDATE FACTOR FOR PPS-EXCLUDED HOSPITALS, FISCAL YEAR 1995—PERCENT

Components of the Update	
Fiscal year 1995 HCFA PPS-excluded market basket forecast*	3.7
Adjustment for difference between HCFA and ProPAC market baskets	0.0
Correction for fiscal year 1993 forecast error	−1.0
Allowance for scientific and technological advances	0.0
Total update	2.7

*Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1993. The market basket forecast is subject to change as more current data become available.

Scientific and Technological Advances—ProPAC also believes the update should include an allowance for scientific and technological advances for PPS-excluded hospitals and distinct-part units. This allowance is intended to encourage providers to adopt quality-enhancing technologies, even when they increase costs. It reflects the Commission's judgment about the expected growth in the cost of providing inpatient services resulting from scientific and technological advances.

To reach an informed judgment on the appropriate allowance, ProPAC examined emerging technologies used in PPS-excluded facilities to estimate their operating costs and predict their increased use in fiscal year 1995. (See Appendix A for a full discussion of ProPAC's methodology.) To be included in the estimate, a technology must be emerging (that is, diffused beyond minimal use but not fully diffused), quality-enhancing, and cost-increasing. The contractor identified two scientific advances that met these criteria: the drugs sertraline hydrochloride and ondanestron hydrochloride. The total increase in operating costs due to these advances is estimated to be $140,000, or 0.002 percent of Medicare payments to PPS-excluded facilities in fiscal year 1995. Therefore, the Commission is recommending no allowance for scientific and technological advances.

Unlike the update for PPS hospitals, the update for excluded facilities does not include a productivity adjustment. The productivity adjustment to the PPS update is based on the principle that Medicare should share in the savings generated by productivity improvements. However, Medicare automatically shares in the savings under TEFRA because part of any productivity increase is factored into reduced Medicare payments. ProPAC believes a further reduction in payments for gains in productivity is not appropriate.

Revising the Payment Method—In October 1992, the Commission submitted an interim report on payment reform for PPS-excluded providers. The findings suggested that in aggregate, TEFRA payments to PPS-excluded facilities appeared adequate for most provider types. Notable exceptions were psychiatric hospitals and distinct-part units, and long-term hospitals. However, substantial variation in the proportion of facilities with costs exceeding their target rate was found across and within all provider types. Further, the Commission could not make definitive conclusions regarding the adequacy of the TEFRA payment system due to the lack of information on the amount of exceptions payments made to PPS-excluded providers.

Specialty hospitals and distinct-part units were excluded from PPS primarily because the DRG patient classification system does not adequately group patients in these facilities according to resource use. However, considerable effort has been put into developing a

patient classification system for rehabilitation hospitals and distinct-part units based on patient functional status. The Commission supports such efforts in hope that a prospective payment system for specialty facilities can be developed.

Although at this time prospective payment for these facilities is not feasible, modifications to the current TEFRA payment method may be possible. Each type of PPS-excluded provider has unique patient characteristics and cost experiences, yet for payment purposes all types are treated similarly. TEFRA does not recognize varying factors that affect costs, such as changes in case mix and treatment patterns, and all providers receive the same basic update to the target rate. A more complete understanding of the factors that differentiate these facilities may help to identify appropriate revisions to the current TEFRA payment system and update formula.

ProPAC encourages the Secretary to examine further the factors contributing to cost increases among these facilities. The Commission will continue to evaluate the appropriateness of the TEFRA system for PPS-excluded providers, and will respond to the Secretary's proposal for payment reform when it becomes available.

Recommendation 14: Update to the Composite Rate for Dialysis Services

The fiscal year 1995 update recommendations for the composite rate for dialysis services accounts for the following:

- The projected increase in the market basket for dialysis services in fiscal year 1995, estimated at 4.3 percent;
- A positive adjustment of 0.7 percentage points to reflect the additional costs associated with scientific and technological advances;
- A negative adjustment of 1.0 percentage points to encourage productivity improvements; and
- A negative discretionary adjustment of 4.0 percentage points to reflect the relationship between payments and estimated fiscal year 1994 costs.
- This results in a net update recommendation of zero percent.

In 1972, the Congress extended Medicare coverage to almost all U.S. residents with end-stage renal disease. These beneficiaries are entitled to all Medicare-covered services, including dialysis treatments or transplant services to replace lost kidney function. Since 1983, payment for outpatient dialysis services has been based on a composite rate. The composite rate is a prospective payment intended to cover the costs of services typically furnished during a dialysis treatment. Derived from data from 1977 through 1979, it represents a weighted average cost per treatment for dialysis provided in facilities and at home according to the proportion of beneficiaries treated in each site. This method was intended to promote the less expensive home treatment alternative by paying the same amount for care provided in either site. The level of the composite rate has remained essentially unchanged since it was developed.

OBRA 1990 mandated that ProPAC recommend an annual update to dialysis payments. In developing its recommendation, the Commission first estimated how much payments should increase between fiscal years 1994 and 1995 using a methodology similar to that employed in the update recommendation for PPS hospital payments. Then it evaluated the appropriateness of the base payment rate to which the update factor would be applied. (See Appendix A for more information on the background analyses.)

Market Basket—The market basket index measures changes in the price of inputs dialysis facilities use to produce dialysis treatments. It is based on a set of input components that reflect all the goods and services dialysis providers purchase. Using 1992 dialysis facility cost report data, four types of inputs were identified: capital, labor, other direct costs, and overhead. Each component has a weight that represents its cost share, or proportion of total expenses. The price change for each component is measured by a proxy. The price proxies were adapted from those Medicare uses for the PPS, home health agency, and skilled nursing facility market baskets. The Commission estimates that the prices of inputs used in a dialysis treatment will rise 4.3 percent between fiscal years 1994 and 1995.

Scientific and Technological Advances—The scientific and technological advances allowance is intended to encourage dialysis facilities to adopt new technologies that improve the quality of patient care, even when they increase costs. It is an estimate of the combined operating and capital costs of new and emerging dialysis-related technologies, and their expected increase in use for the coming fiscal year. To reach an informed judgment on the appropriate allowance, ProPAC examined a set of the most important new cost-increasing innovations in the dialysis industry. On the basis of this analysis, the Commission concluded that Medicare payments should rise by 0.7 percent to cover the costs of new technologies in fiscal year 1995.

Productivity Improvement—The productivity adjustment is intended to give dialysis facilities a financial incentive for continued improvements in productivity through the more efficient use of resources. It is an estimate of the productivity gains that can be expected for the coming year. The Commission considered a range of options to reach an appropriate adjustment. ProPAC's historical productivity study and recent trends in the cost per dialysis treatment suggest a higher estimate may be appropriate. Concerns that further reductions in the length of dialysis sessions may adversely affect quality of care support a lower adjustment. ProPAC concluded that a modest productivity target of 2.0 percent arrives at the proper balance. The savings from productivity gains should be shared equally by the industry and Medicare, resulting in a productivity adjustment of −1.0 percentage points.

Discretionary Adjustment—ProPAC's analysis indicates that in aggregate, the estimated cost per dialysis treatment in fiscal year 1994 is about 5 percent below the median wage-adjusted composite rate. This varies by type of facility. The estimated cost per treatment for independent facilities is about 13 percent below the payment rate. Costs are about 16 percent above payments for hospital-based facilities. Determining the true difference between payments and costs was complicated by data deficiencies. Nonetheless, the Commission believes it is important to recognize this difference in its update recommendation through an adjustment to the base composite rate.

The latest cost data probably are overstated substantially because they have not been audited, although the magnitude of this effect is not known. Inconsistent cost reporting practices and cost allocation methods raise additional concerns about data comparison and reliability across facilities. Further, government regulations implemented in 1992 have likely increased facility costs, but the exact amount is not known. In the Commission's judgment, a discretionary adjustment of −4.0 percentage points balances the need to account for the difference between 1994 estimated costs and payments with uncertainties regarding the current level of costs.

ProPAC appreciates HCFA's continued efforts in compiling the database of unaudited dialysis facility cost reports and in auditing a sample of fiscal year 1991 cost reports. These data

are important in developing annual update recommendations. The Commission supports HCFA's actions to improve the quality of the cost data by adding edits to the Hospital Cost Report Information System, revising the cost report schedules and instructions, and working with facilities and fiscal intermediaries to ensure that cost reports are filed correctly and completely. These measures will enhance the accuracy and reliability of the data, which is essential for decision making.

ProPAC will continue to evaluate payments to dialysis facilities. Its analysis will focus on the difference between payments and costs and how this relationship varies across providers. Additionally, ProPAC will take a closer look at the disparity between reported and audited costs to better assess the adequacy of payments. Because accurate and reliable data are crucial to this undertaking, the Commission urges HCFA to continue its measures to improve data quality and to regularly audit a representative sample of independent and hospital-based dialysis facility cost reports.

Other Payment Policies

PPS adjusts hospital payments in several ways to account for factors that may legitimately affect hospital costs, such as the level of teaching activity, wage rates, and patient mix.

As part of its mandate, the Commission examines the distribution of PPS payments across hospitals and makes recommendations concerning the various adjustments to the payment system. ProPAC considers adjustments that are made both at a hospital level and at a case level. In this year's report, the Commission recommends improvements in the PPS hospital wage index, outlier payment policy, and the indirect medical education adjustment.

ProPAC is also responsible for making recommendations on Medicare payment for facility services provided in settings other than the inpatient hospital. These payments have grown rapidly throughout the 1980s and have become an increasingly important part of the Commission's agenda. In this report, ProPAC's recommendations concern payment to skilled nursing facilities and hospital outpatient facilities.

Recommendation 15: Improvements in Hospital Wage Data

The Secretary should develop and implement improved methods for collecting data on employee compensation and paid hours of employment for hospital workers by occupational category. Once these data become available, the Secretary should implement an adjustment to the hospital wage index under PPS. This adjustment would correct the wage index for the inappropriate effects of including geographic differences in the mix of occupations employed.

The PPS wage index is intended to measure geographic differences in the unit prices of labor inputs hospitals purchase to provide inpatient services. Currently, hospitals report only total compensation and total paid hours for all employees, regardless of occupation. Consequently, the average hourly wage calculated for each labor market area measures the average labor cost per hour for hospitals in the area, reflecting both unit prices for labor and the occupational mix of employees.

The Commission believes the wage index should adjust payments for relative differences in local labor prices, rather than in costs. While local market prices for labor presumably are determined by forces beyond the control of an individual hospital, the quantity and skill mix of labor purchased clearly result from management decisions. Differences among hospitals in mission, services offered, and patient population served may lead to variations in the volume and mix of labor required to produce needed inpatient services. The resulting differences in operating cost per discharge, however, are accounted for by other hospital-specific adjustments in PPS, such as the case-mix index, and by the indirect medical education and disproportionate share adjustments.

Hospitals located in large cities tend to employ a substantially more expensive mix of labor than hospitals located in rural areas. Consequently the current wage index values for large urban areas tend to be too high, while those for rural areas tend to be too low. This results in overpayment for some hospitals and underpayment for others.

Previous ProPAC studies of 1988 occupation-specific compensation data reported by California hospitals suggest that an adjustment for occupational mix would increase the current wage index values for rural hospitals and decrease those for hospitals located in large urban areas. In 1992, the Commission again used the California data to examine the effect of occupational mix adjustment on wage indexes based on hospital-specific labor market areas. The results from this study were consistent with ProPAC's earlier findings. Adjustment for occupational mix may be particularly important for hospitals located in areas where there are few other hospitals.

Differences in occupational mix are an important factor affecting the accuracy of the wage index and equity of payment under PPS. To address this problem, the Commission previously has recommended collecting compensation and employee hours data by occupational category. However, the Secretary has rejected this recommendation on several grounds, including the burden that would be imposed on the hospital industry and lingering doubts about the likely accuracy of occupation-specific data. The Commission believes accurate occupation-specific data can and should be obtained to correct the continuing bias in the wage index. Further, the burden of collecting such data could be minimized by adapting methods currently used by the Bureau of Labor Statistics to collect occupation-specific data for the employment cost index.

A second set of issues relates to the timeliness and accuracy of the wage data. Accurate and timely data are essential to improve equity of payments among hospitals under PPS. These issues are important because the wage index directly affects the distribution of about 70 percent of all payments under PPS, or some $42 billion per year.

Under current law, the Secretary is required to update the wage index annually, beginning in fiscal year 1994. The wage data collected on hospitals' annual cost reports for this purpose, however, will continue to lag by three to four years because of the length of the cost reporting cycle, intermediary auditing, and data submission to HCFA. In addition, the wage data many hospitals submitted on their fiscal year 1990 cost reports were initially inaccurate or substantially incomplete. HCFA's experience collecting wage data by mail survey, with or without occupation-specific data, has been equally poor.

ProPAC believes the implementation of a new wage index based on hospital-specific market areas may help to improve the accuracy of the wage data. (See Recommendation 16.) With a nearest neighbor approach, a hospital's own data would generally have more influence on its wage index than is now the case. Therefore, hospital administrators may be more strongly motivated to ensure the quality of the information they submit.

Adjustment of the wage index for occupational mix would substantially improve payment equity among hospitals under the current PPS labor market definitions. It would be equally desirable for a wage index based on nearest neighbor labor market areas. In this case, ProPAC believes an

occupational-mix adjustment would reduce variation in wage index values among nearby hospitals and would help the wage index more accurately reflect the labor price levels hospitals face.

Recommendation 16: Improvements in the PPS Hospital Wage Index

The Secretary should substantially revise the hospital wage index under PPS for fiscal year 1995. The revised wage index should be calculated using hospital-specific labor market definitions based on hospital geographic proximity measured by the air-mile distances between nearby hospitals. The Congress should repeal the current statutory provisions relating to geographic reclassification for the wage index.

The Commission believes the wage index would be substantially more accurate if it were calculated using hospital-specific labor market areas based on geographic proximity rather than on political boundaries, as is now the case. Under this approach, a labor market area would be defined for each hospital (the target hospital), including only hospitals located in its immediate vicinity. Consequently, each hospital's "nearest neighbor" wage index would reflect its own wage rate averaged with those paid by other nearby hospitals.

This approach has strong intuitive appeal. Hospitals located near each other represent potential alternative sources of employment for health care workers living in the area. Therefore, in almost all instances, the average wage rate paid by all nearby hospitals should provide a reasonably accurate measure of the amount the target hospital must pay to compete for labor.

ProPAC's analysis suggests that hospital-specific labor market areas offer important advantages compared with the present definitions. The current market areas have fixed borders defined by the county and state boundaries of metropolitan statistical areas and statewide rural areas. Hospitals located near each other but on opposite sides of such borders often have widely different wage indexes and PPS payment rates, even though they face similar local market conditions. By contrast, nearest neighbor labor markets for nearby hospitals overlap substantially, including many of the same hospitals. This tends to reduce the likelihood of large differences in their wage index values.

A second advantage is that nearest neighbor labor market areas generally are much smaller than the current labor market areas. Consequently, they more effectively capture geographic differences in market wage levels.

Under current policy, hospitals located in the same labor market area have the same wage index, which is based on the average wage for the area. Excluding the effects of geographic reclassification, about 65 percent of all PPS hospitals incur a large loss or a large gain because their hourly wage rates differ from the labor market average by more than 5 percent. Because many labor market areas are large, however, local hospital wage levels often vary substantially within them. As a result, a significant portion of the losses and gains currently experienced by individual hospitals are attributable to their location in a part of the market area where local wage rates are higher or lower than the labor market average. Although many of these hospitals pay wage rates that are consistent with those of other nearby hospitals, they are inappropriately penalized or rewarded because the local wage level differs from the labor market average. This results in inequitable payment.

Under a nearest neighbor approach, each hospital's wage index would be based on the level of wage rates paid by hospitals located nearby. Consequently, many of the hospitals that now face large losses or gains would find these discrepancies reduced or eliminated. Other hospitals are inappropriately sheltered by the current system. Many of these hospitals would find their small losses or gains substantially altered, reflecting the level of wages in their immediate area.

Implementation of a nearest neighbor wage index in fiscal year 1995 would result in a substantial redistribution of PPS payments among hospitals. However, these changes would make payments more accurate and equitable.

ProPAC has examined a number of alternatives for determining the most appropriate size of nearest neighbor labor market areas. Increases in the size of the market areas tend to have two different effects. On the one hand, the wage index values for nearby hospitals are less likely to be substantially different. Consequently, hospitals located near each other are less apt to be paid significantly different PPS payment rates. This occurs because each hospital's wage index is based on wage data for a larger number of hospitals.

On the other hand, larger market areas include hospitals that are located farther from the target hospital. Consequently, wage rates within each area tend to vary more. This suggests that some of the more distant hospitals may face labor market conditions that differ from those in the immediate vicinity of the target hospital. Therefore, using larger market areas may yield wage index values that are less accurate indicators of the labor market conditions faced by the target hospital.

Finding a balance between these conflicting outcomes is complicated by the fact that hospital circumstances vary widely. About 30 percent of all PPS hospitals are located in relatively high density areas, with seven or more other PPS hospitals located within a radius of 20 miles. At the other end of the spectrum, 46 percent of all PPS hospitals are located in low density areas, with fewer than three other hospitals located within 20 miles.

For hospitals in areas where there are many other hospitals nearby, hospital-specific labor market areas could include the nearest 15 hospitals within a 20-mile radius. This would keep the variability in wage rates at a low level, while limiting the frequency of large differences in wage indexes among nearby hospitals. For hospitals located in areas with few hospitals nearby, hospital-specific markets should include at least three other hospitals. In many instances, this would require going beyond 20 miles. To avoid incorporating hospitals facing substantially different labor market conditions, however, the maximum distance should be 30 to 35 miles.

In short, a labor market area could be defined for each hospital by including the nearest 15 hospitals within a 20-mile radius, but going up to a maximum of 30 to 35 miles to find at least three other hospitals. Although any of these criteria could be modified, minor changes probably would not make the wage index less accurate. A wage index based on labor market definitions similar to those outlined above would, in ProPAC's view, be far more accurate than the current one.

Implementation of this approach would impose both one-time and ongoing administrative burdens on HCFA. For example, HCFA would need to verify the latitude and longitude coordinates for each PPS hospital. Methods and procedures would need to be developed for incorporating new hospitals into the wage index, and for dealing with multi-campus hospitals.

In addition, HCFA would need to devise methods and administrative processes for addressing requests for exceptions. The Commission's research shows that hospital-specific labor market areas defined using air-mile distances generally correspond closely with those defined using road miles. Differences will occur, however, because of the presence of major transportation barriers such as a river or mountainous terrain. An exceptions process may be needed where a road-

mile definition would produce a substantially different wage index.

ProPAC recognizes that adoption of a new wage index based on nearest neighbor labor markets will have a significant effect on PPS payments for many hospitals. This effect is due partly to changes in the labor market definitions, and partly to eliminating geographic reclassification for the wage index. The Commission believes strongly that continued reclassification of the wage index would not be needed once a nearest neighbor wage index is implemented.

Hospitals whose wage index values are reduced by the adoption of a nearest neighbor wage index would receive lower payments because of this change. ProPAC believes, however, that such changes in hospital wage index values generally would reflect improvements in accuracy and fairness. Hospitals whose wage indexes decline would be primarily those previously sheltered by their inclusion in an appropriately large labor market area or those that received an in appropriately high wage index because of geographic reclassification.

Recommendation 17: Nursing Facility Wage Index

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

Medicare payments to nursing facilities are adjusted by the hospital wage index to reflect geographic differences in labor costs. Yet the geographic differentials in the cost of labor for hospital employees differ from those for employees of nursing facilities. This may be because there are state variations in regulations affecting staffing of nursing facilities that differ from those of hospitals. Further, through their Medicaid programs and certification and oversight roles, states have a major impact on the costs and structure of nursing facilities. Some of this variation is being reduced through provisions in OBRA 1987 that mandated stepped-up Federal oversight of nursing facilities.

Another potential reason why the geographic differentials in hospital wages do not adequately reflect variation in nursing facility wages may be skill mix differences. Compared with hospitals, nursing facilities employ more aides. The relative differences in the salaries of aides and nurses may not be the same across geographic areas. These differences in the employee mix and relative wages are not reflected by the hospital wage index.

An accurate wage index is necessary to account for geographic differences in wages. As with the hospital wage index, the method used to collect wage and hour data for nursing facilities should be prospective. Further, the Commission suggests the Secretary phase in the use of the nursing facility wage index to allow facilities to adjust.

ProPAC recognizes that collecting nursing facility wage data and developing an index may take several years. The Commission investigated an interim approach of separate cost limits for each Census division to account for geographic cost differences. (See Appendix A for a more complete discussion.) This technique substantially changed the distribution of payments compared with the way payments were allocated under the current hospital wage index or a simulated nursing facility wage index. It inappropriately adjusted for cost variation caused by differences in state Medicaid payment policies and rates and other state certification requirements. The Commission thus rejects the interim measure, recommending instead that efforts focus on the development of a nursing facility wage index.

Recommendation 18: Improving Outlier Payment Policy

The Commission believes the outlier payment provisions of the Omnibus Budget Reconciliation Act of 1993 will improve the current policy for identifying outlier cases and determining outlier payments under PPS. However, the following changes also should be implemented for fiscal year 1995:

- The estimated cost of the case and the outlier payment amount should no longer be adjusted to reflect the hospital's indirect medical education and disproportionate share status.
- The marginal cost factor for cost outliers should be increased to 80 percent.
- These changes would further increase the effectiveness of outlier payment in protecting against the risk of large losses on some cases. They would also improve the distribution of outlier payments across hospitals, including hospitals that receive a large number of transfer cases.

The DRGs used to determine PPS payment are designed to group cases with similar resource requirements. The hospital's payment for each case is based on the nationwide average cost of patients in the DRG. The hospital is at risk for the difference between the cost of the case and the payment it receives. However, costs for individual cases in any DRG may vary widely, due to patient-specific or treatment-specific factors that are not incorporated in the current classification system. Even an efficient hospital, therefore, may have some cases with much higher than average resource requirements. These cases represent large financial losses to the hospitals that threat them.

In general, most hospitals should be able to offset losses from more costly cases with gains from less costly ones. However, this averaging principle does not adequately protect hospitals with a small number of admissions, because they may be unable to offset the losses associated with an occasional very costly case. It also fails to protect certain hospitals that regularly care for a greater than average share of costly patients.

To recognize this, additional payment is provided to hospitals for cases that are exceptionally resource intensive. Outlier payment is also intended to protect against incentives that may adversely affect certain types of patients or cases that are perceived to be associated with a greater likelihood of financial loss.

Definition of Outlier Cases—Currently, hospitals receive additional payment for cases that have exceptionally long stays (day outliers) or high costs (cost outliers). Cases that qualify as both day and cost outliers are paid according to the formula that yields the highest payment. Over time, there has been increased emphasis on cost as a criterion for identifying outlier cases and determining outlier payments. The estimated proportion of outlier payments based on the day outlier formula has fallen from 85 percent in fiscal year 1984 to 32 percent in fiscal year 1994.

The Commission consistently has supported the increased emphasis on cost outliers relative to day outliers because the cost criterion better identifies the cases associated with the largest losses to the hospital. In its March 1993 *Report and Recommendations to the Congress*, ProPAC recommended eliminating day outlier payments over a three-year period. In OBRA 1993, the Congress required that payments for day outlier cases be phased out beginning in fiscal year 1995 and ending in fiscal year 1998.

As the emphasis on cost outliers grows, however, it becomes more important to measure case-level costs accurately. Because costs are not reported for individual cases, the only way to identify cost outlier cases is to

adjust reported charges. The Commission intends to analyze alternative methods for estimating case-level costs, their relative accuracy, and their implications for the distribution of outlier payments.

Outlier Thresholds—A case does not qualify for outlier payment unless it exceeds the day or cost outlier threshold. One problem with the current threshold is that the loss incurred before outlier payments begin is not the same for every DRG, because DRGs have different payment amounts. Further, the loss is not the same for every hospital, because the cost of each case is adjusted by the hospital's IME and DSH payment adjustments.

A threshold based on a fixed loss—that is, one that is set so that the loss incurred before outlier payments begin is equivalent for every case and hospital—would be more effective in reducing the impact of large losses associated with individual cases. In its March 1993 *Report and Recommendations to the Congress*, the Commission recommended that the cost outlier threshold for each case at each hospital should be a fixed amount (adjusted for differences in area wages and cost of living) above the DRG payment rate for the case. In OBRA 1993, the Congress enacted this change, to begin in fiscal year 1995.

Another issue is whether estimated costs and outlier payments should be adjusted to reflect the hospital's teaching and disproportionate share status. Currently, the estimated cost for each case is reduced by the hospital's IME and DSH payment adjustments. For example, a case costing $50,000 at a teaching or disproportionate share hospital is considered less costly for the purposes of outlier payment than one costing $50,000 at a non-teaching, non-disproportionate share hospital. The amount by which the estimated cost exceeds the outlier threshold (which determines the outlier payment amount) thus is smaller for the case treated at the teaching or disproportionate share hospital. The resulting outlier payment amount is then increased by the hospital's IME and DSH adjustments, but this generally is not enough to offset the loss in outlier payments resulting from the reduced cost estimate for the case.

ProPAC's analysis indicates that these adjustments result in substantial underpayment for outlier cases treated by teaching and disproportionate share hospitals. The IME and DSH adjustments should apply to the base payment amount that hospitals receive for every case. Outlier payments, on the other hand, are intended to defray the loss incurred beyond some threshold in treating exceptionally expensive cases. Teaching or disproportionate share hospitals should not have to bear greater losses before outlier payments begin than do otherwise similar hospitals. Moreover, outlier payments should be based on the loss incurred on the case rather than the hospital's teaching or disproportionate share status.

Marginal Cost Factors—Once a case exceeds the relevant outlier threshold, the payment rate depends on the marginal cost factor. For example, hospitals are paid 75 percent of the estimated cost beyond the threshold for cost outliers and therefore must bear 25 percent of the additional estimated cost beyond the threshold. This is intended to provide an incentive to continue to control the costs of outlier cases. In addition, it is believed that the additional payment for outlier cases should be less than the estimated cost beyond the threshold because of a potential bias in the way cost is estimated.

The changes discussed above would improve the effectiveness of outlier payment policy in identifying and directing payment to the most costly cases. Outlier payments no longer would be made for cases on which the hospital incurs only small losses or even gains. Given these changes, the Commission believes it would be appropriate to compensate hospitals for a higher percentage of the losses beyond the cost outlier threshold. The marginal cost factor for cost outliers therefore should be raised to 80 percent.

Outlier Payment Pool—The outlier pool is expressed in terms of the percentage of total PPS payments (excluding the IME and DSH adjustments) that is set aside for outlier payments. By law, it must be between 5.0 percent and 6.0 percent; it currently is set at 5.1 percent.

Last year, ProPAC recommended that the outlier payment pool should be increased to 6.0 percent of total PPS payments. Upon further examination, however, the Commission has determined that the reduction in DRG payment rates required to fund a larger outlier pool would offset the benefit from reduced losses that hospitals would have to incur before outlier payments begin (see the discussion below). The Commission will continue to examine the implications of changing the size of the outlier pool in the context of recent and proposed changes in outlier payment policy.

Financing Outlier Payments—Outlier payments are financed by across-the-board reductions in the DRG payment amounts for urban and rural hospitals—5.5 percent and 2.3 percent, respectively, in fiscal year 1994. These reductions reflect the difference in the anticipated percentages of outlier payments for the two groups. In fiscal year 1995, with the elimination of the differential between the standardized payment amounts for rural and other urban areas, these reductions will be equal for all hospitals.

Recent ProPAC analyses indicate that outlier cases and payments are concentrated among groups of hospitals and DRGs. These findings suggest that financing outlier payments by an equal reduction in the basic DRG rate paid for each case results in overpayment for DRGs with a high percentage of outlier payments and underpayment for DRGs with a low percentage of outlier payments.

Financing outlier payments by reducing the payment rates for cases in each DRG, based on the anticipated percentage of outlier payments in that DRG, holds promise in improving the effectiveness of outlier payments and overall payment equity. Last year, ProPAC recommended this change. The Commission is concerned, however, about the potential redistribution of payments that would result. ProPAC intends to continue its work on this issue, specifically in analyzing the impact on payments across hospitals and types of cases.

Transfer Cases and High-Transfer Hospitals—ProPAC has also examined the impact of the outlier payment changes enacted in OBRA 1993 and the additional changes proposed by the Commission. The results indicate that while the OBRA 1993 changes generally target a higher proportion of outlier payments to the most expensive cases, they actually reduce estimated payments to transfer cases and the hospitals that most frequently receive them.

This reduction is due largely to the application of the IME and DSH payment adjustments in estimating outlier costs and calculating outlier payments. As discussed earlier, the application of these adjustments results in substantial underpayment for outlier cases at teaching and disproportionate share hospitals. Because many of the hospitals that receive the most transfer cases are teaching hospitals, and because a high proportion of transfer cases are outliers, the effect on these cases and hospitals is particularly adverse.

The implementation of the additional changes recommended by the Commission would substantially increase payments for transfer cases and hospitals that receive a large number of

these cases, by targeting more outlier payments to the cases associated with the largest losses. ProPAC's analysis of these issues will be described in more detail in its technical report, *Outlier Payment Policy* (June 1994).

Recommendation 19: Level of the Indirect Medical Education Adjustment to PPS Operating Payments

The Commission recommends that the indirect medical education adjustment to PPS operating payments be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1995. This reduction should be implemented with the anticipated decrease in indirect medical education payments returned to all hospitals through a proportionate increase in the standardized payment amounts. The Commission also recommends continuation of the indirect medical education adjustment to PPS payments until an alternative system of compensating appropriately for the higher costs of patient care in teaching institutions is fully operational.

The IME adjustment is intended to recognize the higher costs teaching hospitals incur in treating Medicare patients. These higher costs have been attributed to caring for patients with more severe or complex illnesses, providing a broader scope of services and more services per patient, and using a costlier mix of staff.

ProPAC annually estimates the relationship between teaching intensity and standardized Medicare operating costs per discharge. The standardization controls for differences in costs that are accounted for by other PPS payment factors. These include geographic differences in the PPS base payment amounts, the local area wage index, the hospital's Medicare case-mix index, and outlier payments for extremely long or costly cases. The most recent analysis was based on cost data from the eighth year of PPS and payment rules for fiscal year 1994. The results indicate that, on average, a 10 percent difference in teaching intensity is associated with a 5.2 percent difference in Medicare operating costs per discharge.

The estimated relationship between costs and teaching intensity is affected by other aspects of the payment system. For example, the differential in rural and other urban standardized payment amounts will be eliminated in fiscal year 1995. If the elimination of this differential were effective in fiscal year 1994, the IME estimate would rise to 5.3 percent. Implementation of improvements in the PPS hospital wage index and outlier payment policy would increase Medicare payments to teaching hospitals. (See Recommendations 16 and 18.) These changes also would require that the IME adjustment be reduced to reflect more accurately the relationship between costs and teaching intensity.

The Commission recognizes that since PPS began, the Medicare program has more than adequately compensated teaching hospitals for the costs of treating medicare patients. The current 7.7 percent IME operating payment adjustment is substantially higher than the empirical estimate of 5.2 percent indicated by the most recent analysis. Moreover, PPS operating margins consistently have been higher for teaching hospitals than for nonteaching hospitals. PPS margins have been especially high for major teaching hospitals (that is, those with the highest levels of teaching intensity).

However, the Commission is concerned that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care might be impaired by a substantial immediate reduction of Federal support. ProPAC believes the Medicare program's responsibility to its enrollees is broader than merely paying for services for beneficiaries. This responsibility includes maintaining access to the quality of care and types of services available at teaching hospitals, which might be affected adversely by a sharp decline in IME payments.

Given these considerations, the Commission believes a gradual reduction of the IME adjustment is a prudent course of action. ProPAC's recommendation would reduce the adjustment by approximately one-third of the difference between the current adjustment and the Commission's estimate of 5.2 percent. The Commission will continue to examine the financial status of teaching hospitals to avoid any deleterious effects on access to quality care for Medicare enrollees. This approach recognizes as an ultimate objective the use of the IME adjustment to compensate appropriately for differences in Medicare costs that are attributable to differences in teaching intensity.

The Health Security Act would eliminate the IME adjustment to PPS payments beginning in fiscal year 1996. Instead, Medicare and all other payers would contribute to an Academic Health Center Account, from which the Secretary would distribute payments to teaching institutions. Medicare's proposed $2.1 billion contribution to this account in 1996 is based, in part, on estimated IME expenditures using a 3.0 percent IME payment adjustment.

The 3.0 percent factor is consistent with previous estimates—using HCFA's methodology—of the relationship between teaching intensity and Medicare inpatient operating cost per case. This consistency, however, is an artifact of HCFA's analytic approach, which offsets the disproportionate share hospital payment adjustment against each hospital's Medicare costs per discharge. ProPAC does not offset costs of DSH payments, because the Commission has determined that DSH payments generally do not reflect differences in costs.

The Health Security Act would reduce the DSH adjustment, because it would also reduce the number of uninsured and underinsured patients. A smaller DSH adjustment would raise HCFA's estimate of the relationship between teaching intensity and Medicare inpatient costs per case almost to the level of ProPAC's estimates. This change would not affect ProPAC's estimates. Thus, a 3.0 percent adjustment is likely to be substantially lower than either HCFA's or ProPAC's estimate of the empirical relationship between teaching intensity and Medicare inpatient costs per case.

ProPAC is concerned that the level of funding of the Academic Health Care Account and the formula for distributing these funds are not based on objective analysis of the costs incurred by teaching hospitals in carrying out their functions. (See Recommendation 3.) Therefore, the Commission believes Medicare can best carry out its responsibilities to maintain access to quality care for Medicare beneficiaries and other patients by retaining the IME adjustment to PPS payments until an alternative system of compensating appropriately for the higher costs of patient care in teaching institutions is fully operational.

Changes in the IME adjustment should be considered in the context of its interactions with other components of the payment system and its effects on PPS payments, as well as hospitals' overall financial status. The impact on the quality of care and access to that care should also be considered. In general, any change in Medicare payment policy must be considered in terms of its effect on the health care system as a whole.

In the coming year, ProPAC will continue to examine the level and structure of the IME adjustment, as well as other factors that affect hospitals' payments, costs, and financial condition. The distribution of PPS and total margins and the other effects of possible changes in the IME adjustment will be studied. The Commission will

also examine the potential effects on teaching hospitals of proposals in the Health Security Act. (See Recommendation 3.) A description of ProPAC's most recent analyses is available in the Commission's technical report, *Indirect Medical Education and Disproportionate Share Payment Adjustments to Hospitals (March 1994).*

Recommendation 20: Prospective Payment Method for Outpatient Services

The Commission believes a prospective payment system for hospital outpatient services should be implemented. Outpatient payment reform should result in consistent policies across all sites and providers. Payment should be based on a prospective price per unit of service until other methods can be developed that would appropriately control the volume of services. The payment rate should be adjusted to reflect justifiable cost differences across settings.

The Commission supports congressional intent to establish prospective payment methods for hospital outpatient services. These methods will create incentives for controlling costs by offering providers the opportunity for a profit as well as the risk of financial loss. Such incentives are enhanced further as more services are bundled within the rate. The current payment method for hospital-provided outpatient services contributes to both cost and charge inflation. Because payments incorporate at least a portion of facility-specific costs or charges, hospitals that reduce their costs receive less in payments. Thus, there is little financial incentive to deliver care more efficiently.

The Commission believes the method and unit of payment should be comparable across settings. This consistency is necessary because the ambulatory services offered by hospitals are also furnished in other sites, such as free-standing surgery centers and physician offices. Moreover, most ambulatory care is provided outside of hospital settings. Additionally, the various payment methods and units that Medicare employs for ambulatory services encourage choosing the site of service on the basis of financial rather than clinical considerations. Finally, the lack of payment comparability across sites inhibits efforts to control overall health care expenditures.

Although the same method and unit should be used to determine payment to all providers of ambulatory services, the payment rate may vary for different providers and across treatment sites. There are many reasons why costs may differ among similar providers (such as teaching and non-teaching hospitals) and across treatment sites (such as hospitals and physician offices). The Commission believes it is desirable to recognize in the payment system those factors that represent a benefit to society and are beyond the control of the provider, such as the costs associated with medical education. Further, these costs should be shared more broadly across the health care system to avoid financial discrimination against teaching facilities.

Medicare should establish a prospective payment rate per unit of service based on methods currently used in other settings. Such a system would go a long way toward improving the financial incentives to providers by rewarding efficiencies in service provision and penalizing inefficiencies. ProPAC recognizes that such a system should be only an interim measure, however, because it does not control the growth in volume of services. The Commission therefore recommends that an outpatient prospective payment system be implemented as soon as possible to incorporate volume control measures. The payment should move from a fee for an individual service to a larger payment unit containing more services. Such a bundled approach, along with the integration of hospital-provided outpatient services into the physician volume performance standards, is necessary to control outpatient expenditures.

ProPAC will submit additional recommendations to the Congress as part of its analysis of the pending report from the Secretary on outpatient payment. Problems with the current payment method, however, should not be ignored until a new system for outpatient services is fully implemented. Features of the current system that encourage cost and charge inflation and increase beneficiary liability should be changed immediately.

Recommendation 21: Revision of the Payment Formula for Outpatient Services

Until prospective payment systems can be implemented for hospital outpatient services, the blend formula used to calculate hospital payments for ambulatory surgery center-approved procedures, radiology services, and diagnostic services should be revised. The formula should subtract beneficiary copayment after the total payment has been calculated. The resulting reduction in Medicare program payments to hospitals should be used to partially offset increases in program expenditures due to reducing beneficiary liability.

The total Medicare payment for certain ambulatory surgery, radiology, and other diagnostic services is based on the lesser of costs, charges, or a blended amount. The beneficiary's copayment is 20 percent of charges. Medicare's share is intended to be the total payment amount minus the beneficiary copayment. For facilities paid the blended amount, however, program payments are not reduced by the full amount of the copayment. Thus, total payments to hospitals for outpatient services are higher than the Congress intended.

The formula that determines the blended amount combines two parts: the first is the hospital-specific portion of payment based on the lesser of costs or charges minus 20 percent of charges; the second is the prospective portion based on 80 percent of the applicable prospective rate. For ambulatory surgery, the prospective rate is the payment for the relevant procedure category used in paying free-standing ambulatory surgery centers (ASCs). For radiology and diagnostic services, it is a portion of the payment in the physician fee schedule that is intended to represent the technical expense of providing that service.

The second part of the formula, calculated at 80 percent of the prospective rate, inappropriately assumes that 20 percent of the prospective rate equals 20 percent of charges (the copayment). In fact, charges are usually much higher than the prospective rate. Because the full contribution of beneficiary cost sharing is not captured. Medicare's share of hospital payments is overstated. To correct the formula, the copayment should be subtracted after the calculation of the total amount. For ambulatory surgery, the current and the corrected payment calculations are illustrated in Figure 2–1.

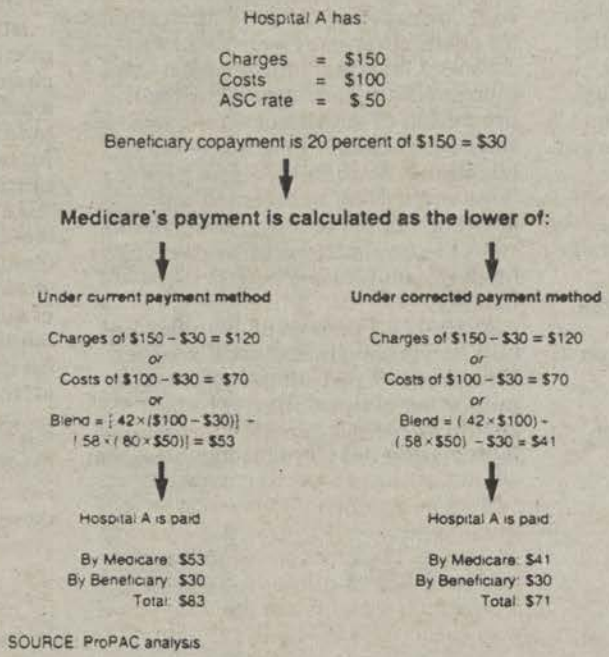
The Commission believes the current blend formula results in payments to hospitals that are higher than the Congress intended. Additionally, this quirk in the formula provides a strong incentive for hospitals to increase charges, which increases beneficiary liability and total payments to the hospital.

Correcting the formula would substantially reduce hospital payments. The Commission recommends this reduction in program expenditures should be used to partially offset the increase in program expenditures for outpatient services that results from setting the beneficiary copayment at 20 percent of payments rather than at 20

percent of charges. (See Recommendation 22.).

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Figure 2-1. Current and Corrected Payment Formulas for Hospital Outpatient Services



SOURCE: ProPAC analysis

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Recommendation 22: Beneficiary Liability for Hospital Outpatient Services

Beneficiary coinsurance for hospital outpatient services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, beneficiary copayment would need to be estimated because it is not known at the time of service delivery.

Medicare payment to hospitals for most outpatient services is based at least partly on costs or charges. Payment for these hospital outpatient services is not prospective. Therefore, it is known until the annual Medicare Cost Report is settled. Consequently, beneficiary liability is set at 20 percent of charges, rather than at 20 percent of payments as it is for the same services in other settings. Because hospital charges generally are higher than the costs of Medicare payments for outpatient services, beneficiaries are responsible for substantially more than 20 percent of costs or payments. In addition, for most providers charges have grown more rapidly than payments, resulting in disproportionate increases in beneficiary cost sharing.

HCFA estimated that, in fiscal year 1993, beneficiaries were responsible for 33 percent of the facility portion of hospital outpatient spending. This is considerably more than if the services had been provided in other ambulatory settings. This difference in cost sharing unfairly penalizes beneficiaries who receive care in hospital outpatient departments. Further, it provides incentives for beneficiaries to choose a site of care on the basis of financial considerations rather than the appropriateness of the setting.

ProPAC recommends reducing beneficiary liability for hospital outpatient services to 20 percent of payments. The Commission recognizes that until prospective payment is implemented for outpatient services, payment for a service will not be known at the time of delivery. Beneficiary liability based on payments, therefore, must be estimated. This could be done in several ways. Copayments could equal a lower percentage of charges, for example. Alternatively, the interim payment to charge ratio, which HCFA furnishes to all hospitals, could be used to determine the coinsurance amount for each service.

The Commission believes it would be ideal to address beneficiary coinsurance in conjunction with the implementation of a prospective payment system for hospital outpatient services. (See Recommendation 20.) It is not clear, however, when such a system will be in place. Reducing the coinsurance requirement thus should not be delayed until implementation of prospective payment. This change is necessary to reduce the significant burden on Medicare beneficiaries who receive outpatient services in a hospital.

ProPAC understands that reducing beneficiary coinsurance will substantially increase Medicare outlays and reduce hospital payments. The Commission therefore recommends phasing in the change in beneficiary liability over a five-year period.

Recommendation 23: Limit the Length of Outpatient Observation Stays

The Commission recommends limiting the length of hospital outpatient observation stays. Further, these changes should be coordinated with Peer Review Organizations so that

appropriate short stay admissions are not denied. ProPAC supports HCFA's effort in this regard.

Observation services are furnished by a hospital on an outpatient basis and include the use of a bed and periodic monitoring by a hospital's nursing staff. To be reimbursed by Medicare, these services must be reasonable and necessary to evaluate a patient's condition or determine the need for an admission. Medicare requires that the services are ordered by a physician. Observation stays are intended to last fewer than 24 hours, but there are no limits on how long an individual might stay under observation.

When Medicare's prospective payment system was implemented, Peer Review Organizations examined short inpatient admissions to prevent hospitals from receiving the full DRG payment for unnecessary stays. Outpatient observation stays, paid on a cost basis, allowed Medicare reimbursement for services to beneficiaries who did not need to be admitted as inpatients.

Before 1989, Medicare's policy specified that if an observation stay lasted more than 23 hours, the stay would be deemed an inpatient admission. Thus, the hospital would receive the relevant DRG payment, and the stay would be subject to PRO review. This policy was never published in the **Federal Register**, however, so implementation and administration were inconsistent. After 1989, the limits for observation stays were removed.

ProPAC analysis indicates that even though observation stays are a small proportion of outpatient services, these stays—particularly long ones—are increasing. Because Medicare pays for these services on a cost basis, the growing number of longer observation stays has implications for higher Medicare outlays and beneficiary liability.

In 1991, 2.3 percent of all outpatient bills had observation stay charges, an increase of 77 percent over 1989. The proportion of these bills with stays lasting more than two days increased from 7.1 percent in 1989 to 11.1 percent in 1991. The average change for all observation stays was $3,212 in 1991. The implications for beneficiary liability are substantial because copayments are currently set at 20 percent of charges. Compared with the $628 deductible for a hospital admission in 1991, the beneficiary copayment for an observation stay lasting two or more days averaged $765.

HCFA is planning to limit the length of multiple-day observation stays. The change would require hospitals to admit a patient who has been under observation in an outpatient department for two consecutive midnights. The hospital would receive payment under the appropriate DRG, and the stay would be subject to PRO review. These changes might increase the number of short inpatient stays: HCFA plans to coordinate with the PROs to ensure that appropriate short admissions are not disallowed. The Commission supports all these efforts.

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federal register

Friday
May 27, 1994

Part IV

Department of the Interior

Office of Surface Mining Reclamation and Enforcement

30 CFR Parts 779, 780, et al.
Surface Coal Mining and Reclamation Operations; Permanent Regulatory Program; Land Use Information; Final Rule

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Parts 779, 780, 783, and 784

RIN 1029–AB57

Surface Coal Mining and Reclamation Operations; Permanent Regulatory Program; Land Use Information

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Final rule.

SUMMARY: The Office of Surface Mining Reclamation and Enforcement (OSM) of the United States Department of the Interior (DOI) is amending its regulations governing the information that must be submitted in a permit application concerning premining and postmining land use. The regulations are being amended for the purpose of eliminating duplicative and/or unnecessary reporting requirements in order to simplify and reduce the reporting burden for permit applicants.

EFFECTIVE DATE: June 27, 1994.

FOR FURTHER INFORMATION CONTACT: Archana Kohli, 1951 Constitution Avenue, suite 640 NC, Washington, DC 20240; Telephone: (202) 343–3871 commercial or FTS.

SUPPLEMENTARY INFORMATION:

I. Background
II. Discussion of Comments and Final Rule
III. Procedural Matters

I. Background

On March 13, 1979, OSM promulgated permanent program rules (44 FR 14902) as required by section 501(b) of the Surface Mining Control and Reclamation Act of 1977 (SMCRA or the Act), 30 U.S.C. 1201 *et seq.* In these rules, 30 CFR part 779 establishes the minimum permit application requirements for information on existing environmental resources that may be impacted by the location and conduct of proposed surface mining activities. (Part 783 for underground mining) (44 FR 15026, March 13, 1979).

Thirty CFR part 780 establishes the minimum permit application requirements for surface mining operation and reclamation plans. (Part 784 for underground mining) (44 FR 15047, March 13, 1979).

The information requirements of parts, 779, 780, 783, and 784 accord with the prescriptions of sections 507, 508, 515, and 516 of the Act in two ways: First, the permit application submitted pursuant to these parts must contain sufficient information to meet the public disclosure requirements of the Act. Second, the permit application must also contain sufficient information for the regulatory authority to be able to find in writing, on the basis of that information and information otherwise available, whether the proposed operation should be permitted.

The level of detail and scope of information required in the permit application will vary depending on the needs of the regulatory authority to fulfill its responsibility to make sound approval decisions based on the findings prescribed under section 510(b) or SMCRA and 30 CFR 773.15(c). The information required in a permit application is, in the main, intended to assist the regulatory authority in determining whether the applicant can comply with the performance standards for surface and underground mining and whether reclamation of these areas is feasible.

The information requirements of parts 779, 780, 783, and 784 impose a significant reporting burden on permit applicants to obtain, analyze, and present information to both the regulatory authority and the public when seeking to permit a surface coal mining operation. Under the Paperwork Reduction Reauthorization Act of 1986, OSM is responsible for ensuring that its rules do not impose any unnecessary reporting burden on the permit applicant (44 U.S.C. 3507(a)(1)(B)). In 1987, OSM established a work group to review its regulatory program and permitting rules. One purpose of the review was to determine whether changes to the information requirements of the permitting rules could be made to reduce the reporting burden on the permit applicant without compromising the implementation of the purposes and provisions of the Act.

After reviewing the work group's recommendations regarding rule changes, OSM identified two changes to its regulations governing surface and underground mining activities which are the subject of this rulemaking. While OSM recognizes its obligation under the Paperwork Reduction Reauthorization Act of 1986 to ensure that public reporting burden be minimized, the Office also recognizes the need to maintain a stable regulatory program implementing the Act. On this basis, the balance of the work group's recommended rule changes were rejected because OSM felt the insignificant reduction in reporting burden which they would afford did not justify the potential disruption to the regulatory program which would be caused by such changes.

On January 8, 1993 (57 FR 3458), OSM proposed a rulemaking based on two of these recommendations. The public comment period closed on March 9, 1993. For surface mining activities, this final rulemaking consolidates the land use information requirements of sections 30 CFR 779.22 and 30 CFR 780.23 into final 30 CFR 780.23 and deletes the slope measurement requirements of 30 CFR 779.25(a)(11). For the counterpart regulations governing underground mining activities, this rulemaking consolidates the land use information requirmeents of 30 CFR 783.22 and 30 CFR 784.15 into final 30 CFR 784.15 and deletes the slope measurement requirements of 30 CFR 783.25 (a)(11).

Because the cited regulations governing underground activities are identical to counterpart regulations governing surface mining activities, the discussion of changes or deletions to 30 CFR 779.22, 779.25(a)(11) and 780.23 will also apply to 30 CFR 783.22, 783.25(a)(11) and 784.15.

A. Land Use Information Rules

Section 30 CFR 779.22 identified the premining land use information required in a permit application.

Section 779.22(a) required that the application contain a statement of the condition, capability, and productivity of the land within the proposed permit area. Section 779.22(a)(1) required that the application contain a map and a narrative that describes the use of the proposed permit area at the time of filing and the premining land use if its use was changed within five years before the date of application. The map was used to compare premining land uses with proposed postmining land uses. Section 779.22(a)(1) implemented section 508(a)(2)(A) of the Act.

Section 779.22(a)(2) required that the permit application include a narrative of the capability and productivity of the land to support a number of uses which can be used in analyzing the land use description contained in section 779.22(a)(1). Environmental information from § 779.22(a)(2) together with land use information from § 779.22(a)(1) provided a foundation for the reclamation plan required by former section 30 CFR 780.23 (Reclamation plan: Postmining land uses). Section 779.22(a)(2) and its two subsections, (i) and (ii), implemented sections 508 (a)(2)(B) and (C) of the Act.

Section 779.22(b) required a description of premining land use conditions for previously mined areas. These regulations provided that an application for a previously mined area identify the type of mining method

used, the coal seams or other mineral strata mined, the extent of coal or minerals removed, the approximate dates of past mining, and the uses of the land preceding mining. According to the 1979 Preamble, this information, if available, was intended to be used by the operator and the regulatory authority to assure that the mining operation will be conducted in a manner which mitigates the environmental damage caused by the previous mining activities (44 FR 15041, March 13, 1979). The 779.22(b)(5) informational requirements as to the uses of land preceding prior mining implemented sections 508(a)(2)(A) and 515(b)(2) of the Act. The balance of § 779.22(b) is not specifically required by the Act.

Section 779.22(c) required that the application describe the proposed mining area's existing land uses and their classifications under local law. Information from this section was used by the regulatory authority to evaluate the proposed postmining land uses and to assess the compatibility of the proposed land use with the existing land use policies and plans. The information required by this section was essentially the same information required by former § 780.23(a)(4) and (b). Section 779.22(c) implemented Section 508(a)(3) of the Act.

Section 30 CFR 780.23 established the criteria used to approve a postmining land use analysis and plan. Section 780.23 implemented Section 508(a) (3) and (4) of the Act.

Section 780.23(a) required that the applicant's reclamation plan describe the proposed postmining land use. Included must be a discussion of the utility and capacity of the reclaimed land to support a variety of alternative uses which must conform to the existing land use policies and plans. Section 780.23(a) implemented Section 508(a)(3) of the Act.

Section 780.23(a)(1) required a description of the proposed postmining land use and the method in which the proposed postmining land use is attained. Section 780.23(a)(1) implemented section 508(a)(4) of the Act.

Section 780.23(a)(2) required specific management plans when range and grazing is proposed as a postmining land use. Range or grazing management plans are not specifically required by the Act.

Section 780.23(a)(3) required information needed to support approval for an alternative postmining land use when requested under § 816.133. Section 780.23(a)(3) implemented section 508(a)(3) of the Act.

Section 780.23(a)(4) required that consideration be given to making proposed mining activities consistent with the existing surface owner plans and applicable State and local land use plans and programs. Section 780.23(a)(4) implemented section 508(a)(3) of the Act.

Section 780.23(b) provided that the reclamation plan include a copy of the comments of the proposed land use by the legal or equitable owner of record of the surface of the proposed permit area and the applicable State and local government agency. Section 780.23(b) implemented section 508(a)(3) of the Act.

B. Slope Measurement

Section 30 CFR 779.25 (Cross sections, maps, and plans) required slope measurements against which new mining effects can be compared. Section 779.25(a)(11) required the applicant to include the existing slopes of the proposed mine site. The 1979 preamble indicates that slope can be derived from either a topographic map or from field calculations (44 FR 15045, March 13, 1979). These slope measurements were to be used by the regulatory authority to evaluate the applicant's ability to achieve approximate original contour. There is no specific requirement in the Act to provide preexisting slope measurements.

II. Discussion of Comments and Final Rule

OSM received letters on the proposed rule from eight commenters representing industry, State regulatory authorities, Federal and State agencies, and individual citizens. OSM has reviewed each comment carefully and has considered the commenters' suggestions and remarks in writing this final rule.

The final rulemaking simplifies the current regulations by promulgating a single new rule, 30 CFR 780.23 (Land use information), to replace the two former land use information rules. Final § 780.23 combines sections from former 780.23 (Reclamation plan: Postmining land uses) and former 779.22 (Land use information). This rulemaking deletes former § 779.22 in its entirety. Paragraphs from former § 779.22 needed to implement prescriptions of the Act have been relocated to final 780.23. The final rule also deletes 30 CFR 779.25(a)(11) (Cross sections, maps, and plans) in its entirety.

A. Land Use Information

Listed below is an outline of the informational requirements that are incorporated into final 30 CFR 780.23 (Reclamation plan: Land use information). This rule is identical to proposed 30 CFR 780.23 except as indicated below.

1. Final section 780.23(a) requires that the applicant provide a statement of the condition, capability, and the productivity of the land within the proposed permit area. Section 780.23(a) is identical to former § 779.22(a). No comments were received addressing the redesignation of this section. Section 780.23(a) implements section 508(a)(2) of the Act.

2. Final § 780.23(a)(1) requires a map and supporting narrative describing the uses of the land at the time of the filing of the application. The description must also include any changes to the land use which occurred during the past five years, except in a case where the application is for lands which were previously mined, in which case the description must include the use of the land prior to any mining to the extent such information is available. Final section 780.23(a)(1) incorporates the provisions of former § 779.22 (a)(1) and (b)(5). Proposed section 780.23(a)(1) was identical to former § 779.22(a)(1) except that it would have deleted the five-year limit on the historical land use description. As proposed, § 780.23(a)(1) would have also subsumed the reporting requirements of § 779.22(b)(5).

Several commenters felt that the proposed deletion of the five-year limit on the historical land use description would have added to the reporting burden on the applicant and that the information collected would often be unnecessary. One commenter supported the proposed change and believed that there was sufficient enabling language for the regulatory agency's requirement of a historical land use description. OSM has reconsidered the proposal and agrees with the concerns of the commenters opposing the deletion of the five-year time frame in that it may add an unnecessary reporting burden on the applicant.

Section 515(b)(2) of the Act requires that the operation restore the land affected to a condition capable of supporting the uses which it was capable of supporting prior to any mining and section 508(a)(2)(A) requires the reclamation plan to include a statement on the condition of the land to be covered by the permit prior to any mining, including the uses existing at the time of the application and, if the land has a history of previous mining, the uses which preceded any mining. Accordingly, final § 780.23(a)(1) will retain the five-year limit on the historical land use description of former § 779.22(a)(1) and will include for

previously mined areas the land use reporting provisions of former § 779.22(b)(5) which are required to implement sections 508(a)(2)(A) and 515(b)(2) of the Act.

3. Final § 780.23(a)(2) requires that the applicant provide a narrative of the land capability and productivity, which analyzes the land use description in conjunction with other environmental resource information. Final § 780.23(a)(2) is identical to former § 779.22(a)(2). No comments were received addressing this redesignation. Section 780.23(a)(2)(i) implements section 508(a)(2)(B) of the Act and § 780.23(a)(2)(ii) implements section 508(a)(2)(C) of the Act.

4. Final section 780.23(b) requires that the applicant provide a statement on the utility and capacity of the reclaimed land to support a variety of alternative uses. Final § 780.23(b) is identical to former § 780.23(a). No comments were received addressing this redesignation. Section 780.23(b) implements section 508(a)(3) of the Act.

5. Final § 780.23(b)(1) requires that the applicant discuss how the proposed postmining land use will be achieved. Final § 780.23(b)(1) is identical to former § 780.23(a)(1). No comments were received addressing this redesignation. Section 780.23(b)(1) implements sections 508(a)(4) of the Act.

6. Final § 780.23(b)(2) requires that the applicant include a detailed description of proposed postmining land uses that are different from the premining land uses. Final § 780.23(b)(2) is identical to former section 780.23(a)(3). No comments were received addressing this redesignation. Section 780.23(b)(2) implements sections 508(a)(2)(A) and 508(a)(3) of the Act.

7. Final § 780.23(b)(3) requires that the applicant describe the consideration which has been given to making all of the proposed surface mining activities consistent with surface owner plans and applicable State and local land use plans and programs. These provisions are identical to those of former § 780.23(a)(4) and the first sentence of proposed § 780.23(c) and have been redesignated as § 780.23(b)(3) to enhance the organizational clarity of the final rule. Section 780.23(b)(3) implements section 508(a)(8) of the Act.

8. Final § 780.23(c) requires that the applicant describe comments by the legal or equitable owner of record of the surface of the proposed permit area and the State and local government agencies which would have to initiate, implement, approve, or authorize the proposed use of the land following reclamation. Final § 780.23(c) is identical to former § 780.23(b). Section 780.23(c) implements section 508(a)(3) of the Act.

One comment was received alleging the impracticality of such a requirement and the lack of flexibility which it affords the operator in obtaining comments. However, OSM is retaining this requirement as it implements specific statutory prescriptions.

B. Deletion of Land Use Information Requirements

Listed below is an outline of the informational requirements that were deleted from former rules during the formulation of final 30 CFR 780.23 (Reclamation plan: Land use information). This rule is identical to proposed 30 CFR 780.23 except as indicated below.

1. This rulemaking deletes section 30 CFR 779.22(b). This section required that if specific information about mining activities at previously mined areas is available, such information must be included in the permit application. As will be discussed below, if the information required under this section is even available, it is either provided elsewhere by the applicant in his permit application or is available from former program permitting records and is, therefore, more accessible to the regulatory authority than to the applicant.

Two commenters agreed with OSM's proposed deletion of § 779.22(b) in its entirety. They felt that much of the information required under this provision will already be contained in the application through other applicable provisions.

a. Former § 779.22(b)(1) required a description of the type of mining method used at any previously mined area. To the extent that the applicant is able to submit the required cross sections, maps, and plans of prior mining operations within and adjacent to the permit area under existing 30 CFR 779.25(a) (5) and (8), the regulatory authority can determine from this information the type of mining methods which were used. OSM agrees with the one comment received regarding the deletion of 779.22(b)(1) that the information provided by this section has historically been of minimal benefit.

b. Former §§ 779.22(b) (2) and (3) required a description of the coal seams or other mineral strata mined and the extent of coal or other minerals removed from the previously mined area. This information can easily be calculated by the regulatory authority from other information required to be submitted by the applicant under 30 CFR 779.25(a) (3), (4), (8), and 30 CFR 780.11(a). OSM agrees with the one comment received regarding the deletion of 779.22(b) (2) and (3) that the information provided by these sections has historically been of minimal benefit.

c. Former § 779.22(b)(4) required a statement of the approximate dates of previous mining activities. In its 1979 rules, OSM did not require the precise dates of these activities because of the acknowledged difficulty of obtaining such information with any degree of accuracy (44 FR 15041, March 13, 1979). In practice, information as to the approximate dates of previous mining activities has proven to be generally unnecessary. The only time that the approximate dates of previous mining activities might be necessary is when the applicant intends to reclaim in accordance with the requirements of 30 CFR 816.106. Under those circumstances, the applicant is required by the authority, that of 30 CFR 773.15(c) and (c)(12), to affirmatively include in the permit application information as to the cessation dates of previous activities. The regulatory authority must then find in writing that the site of the proposed operation is a "previously mined area" as defined in 30 CFR 701.5. Accordingly, the continuance of § 779.22(b) serves no useful regulatory purpose.

One commenter opposed this deletion claiming that the information of 779.22(b)(4) is necessary when judging the success at 30 CFR 816.116(5). As this section is nonexistent, the apparent intended reference is 30 CFR 816.116(b)(5). OSM rejects this comment as there is no clear relationship between the approximate date of premining operations required under 779.22(b)(4) and establishment of the baseline level of vegetative cover before redisturbance required by 816.115(b)(5). As it is, there is more than sufficient information required under the other permit application provisions of 30 CFR parts 779 and 780 for the regulatory authority to fulfill its responsibilities under § 816.116(b)(5).

d. Former § 779.22(b)(5) required a statement of the premining land use for lands previously affected by mining to the extent such information is available. Final § 780.23(a)(1) will include this requirement among its provisions. One commenter supported the proposed deletion of 779.22(b)(5) on the basis that the scope of information required by that section served little useful purpose. Another commenter contended that because the same historical land use information required by 779.22(b)(5) would also be required by proposed 780.23(a)(1), the stated purpose of the

rulemaking of eliminating or reducing paperwork would not really be accomplished. In partial response to this comment and as discussed above, OSM decided not to finalize the expanded reporting requirement of proposed 780.23(a)(1) but instead retain that section's existing, less burdensome requirements. This necessitated the inclusion of former § 779.22(b)(5) in final § 780.23(a)(1) in order to ensure that §§ 515(b)(2) and 508(a)(2)(A) of the Act are implemented and that the land use of previously mined land is described. This description helps to ensure the restoration of the land affected by mining will be to the same or higher or better land use than existed prior to any mining as required by the Act. The permit applicant's historical land use reporting burden continues to be reduced as the consolidation of requirements into final § 780.23(a)(1) eliminates duplicative reporting requirements.

2. This rulemaking deletes 30 CFR 779.22(c) which required a description of the existing land uses and land use classifications under local law of the proposed permit area and adjacent areas. While OSM considers the information required by this provision to be important land use information, it is essentially the same information required by former §§ 780.23 (a)(4) and (b) redesignated in the final rule as §§ 780.23 (b)(3) and (c). These redesignated sections provide that the application indicate the consideration given to making the surface mining activities consistent with applicable State and local land use plans and programs as well as comments on the proposed use by applicable State and local agencies.

One commenter opposed this deletion alleging that proposed 780.23(c) does not specifically require the same information as was provided to the regulatory authority by former 779.22(c) deleted in this rulemaking. The commenter characterized § 779.22(c) as serving to eliminate any doubt as to the regulatory agency's authority for requiring a description and classification of the land uses under local law. In deleting former § 779.22(c), OSM does not intend to infer that final 780.23(c) does not continue to convey sufficient general authority for the regulatory authority to require all the information previously and specifically required by the deleted section.

3. This rulemaking also deletes former 30 CFR 780.23(a)(2) which required the submission of a detailed management plan where range or grazing was the proposed postmining land use. In 1979, OSM rejected comments to delete this section. At that time, OSM stated its belief that a detailed management plan was necessary to determine the feasibility of a proposed range/grazing postmining land use. (44 FR 15058, March 13, 1979). Since then, OSM has reconsidered the utility of requiring such detailed plans. In concert with this rulemaking, OSM consulted the Bureau of Land Management regarding its current views on the need for a detailed management plan to be included in the permit application for a surface coal mining and reclamation operation. The Bureau indicated that the proposed deletion of the requirement for submitting such plans would not affect its program which also required detailed management plans. OSM understands that for legitimate economic and/or ecological reasons the actual management plan implemented for a reclaimed area may often vary greatly from the detailed plan originally submitted under § 780.23(a)(2). The uncertain benefit which may be derived from the submission of these plans is not felt to justify the burden of their preparation.

One commenter supported the deletion of § 780.23(a)(2) stating that a detailed management plan was unnecessary. Two other commenters disagreed with the deletion but suggested a change in the regulatory language of § 780.23(a)(2) to require a "general" instead of a "detailed" management plan. OSM does not accept that suggestion. Former § 780.23(a)(1) which required an explanation of how the postmining land use is to be achieved has been redesignated as final section 780.23(b)(1) and should allow for the level of reporting detail necessary for the regulatory authority to determine the feasibility of any proposed range land/grazing land use.

B. Vegetation Information

The Proposed Rules discussed the deletion of 30 CFR 779.19 (Vegetation information). This section authorizes a regulatory authority to require a map and a description of the plant communities within the proposed permit area and within any proposed reference area. OSM originally envisioned that this detailed information could be helpful in completing the vegetative land use analysis required by § 779.22 (land use information). (44 FR 15037, March 13, 1979). In revisiting this issue in its proposed rule, OSM justified the deletion of § 779.19 on the grounds that it was felt to be redundant and that other specified permit application provisions provide the regulatory authority with sufficient authority to require the level of detailed information necessary to complete § 779.22(a)'s vegetative land use information requirements.

Numerous comments were received strongly opposing this deletion. The commenters stressed that the information of §§ 779.19 and 779.22 was "complementary and not duplicative." The commenters expressed their view that section 779.19 serves an essential and wider purpose than merely helping to complete § 779.22(a)'s land use information requirements. These commenters further questioned whether the other permit application provisions cited by OSM in its proposed rule actually provide the regulatory authority with sufficient authority to require the detailed information relative to species diversity and ground cover which is needed to properly evaluate an operator's ability to revegetate the disturbed area. In light of the comments opposing the proposed deletion of § 779.19, OSM has determined to retain that section unaffected by this rulemaking.

C. Premining Slope Measurement

This rulemaking deletes section 30 CFR 779.25(a)(11) (Cross sections, maps, and plans) requiring slope measurements. OSM recognizes that premining slope measurements are needed to ensure that restored contours meet approximate original contour (AOC) conditions. The former rule was, however, redundant as it provided no additional information beyond that already available to the regulatory authority under 30 CFR 777.14(a) and OSM's technical information processing system (TIPS). In the 1979 preamble to § 779.25, OSM acknowledged that the required slope measurements could be derived from existing topographic maps or from measurements taken in the field (44 FR 15045, March 13, 1979). Since that time, OSM has found that most permit applicants derive the required measurements from a topographic map rather than from field measurements. Section 777.14(a) requires a permit applicant to submit a topographic map of the permit area which includes U.S. Geological Survey topographic features. Therefore, it makes no difference whether the applicant measures the slope from a topographic map, in fulfillment of the requirements under § 779.25(a)(11), or the regulatory authority measures the slope from the same or similar topographic map submitted under § 777.14(a) so long as the regulatory authority has adequate information on the slope of the proposed permit area to assure that approximate original contour will be

achieved. Subsequent to the 1979 promulgation and issuance of § 779.25(a)(11), OSM has also made available to regulatory authorities the TIPS software and data analysis capabilities which allows both premining slopes and cross sections to be computed.

Several commenters agreed with the proposal to delete § 779.25(a)(11) as they felt that the information is already available to the regulatory authority independent of any submission by the applicant. One commenter opposed the proposal on the basis that it is the operator's responsibility to supply the baseline slope measurement data. However, as discussed above, the operator is already required by § 777.14(a) to supply the appropriate topographic maps of the permit area which represent the baseline information for slope measurement calculations. All regulatory authorities also have access to TIPS systems and have the capability to calculate premining slopes and cross sections from the topographic maps provided. This same commenter alleged that the operator may not be able to demonstrate AOC if the regulatory authority is the only party with the slope data. OSM does not agree. Irrespective of the deletion of § 779.25(a)(11), the permit applicant must demonstrate in the plan, under the requirement of § 816.102, the ability to meet the performance standards for AOC. Thus, the deletion of this section does not relieve the applicant of the responsibility to demonstrate how AOC is achieved in the reclamation plan.

IV. Procedural Matters

Federal Paperwork Reduction Act

The collections of information contained in this rule have been approved by the Office of Management and Budget under 44 U.S.C. 3501 *et seq.* and assigned clearance numbers 1029–0035 and 1029–0038.

Executive Order 12866

This rule has been reviewed under Executive Order 12866.

Regulatory Flexibility Act

The Department of Interior has determined, pursuant to the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, that the final rule will not have a significant economic impact on a substantial number of small entities. The final rule consolidates requirements for premining and postmining land use and thereby eliminates redundancies in the regulations with a resulting reduction in the reporting burden on the public. This should result in a cost savings to the public.

National Environmental Policy Act

OSM has prepared an environmental assessment (EA), and has made a finding that this rule will not significantly affect the quality of the human environment under section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332(2)(C). The EA and finding of no significant impact are on file in the OSM Administrative Record, room 660, 800 North Capitol Street NW., Washington, DC.

Executive Order 12778 on Civil Justice Reform

This rule has been reviewed under the applicable standards of section 2(b)(2) of Executive Order 12778, Civil Justice Reform (56 FR 55195). In general, the requirements of section 2(b)(2) of Executive Order 12778 are covered by the preamble discussion of this rule. Additional remarks follow concerning individual elements of the Executive Order:

A. What is the preemptive effect, if any, to be given to the regulation?

To the extent that the rule would relieve, rather than impose, regulatory requirements, the rule would have no preemptive effect.

B. What is the effect on existing Federal law or regulation, if any, including all provisions repealed or modified?

This rule modifies the implementation of SMCRA as described herein, and is not intended to modify the implementation of any other Federal statute. The preceding discussion of this rule specifies the Federal regulatory provisions that are affected by this rule.

C. Does the rule provide a clear and certain legal standard for affected conduct rather than a general standard, while promoting simplification and burden reduction?

The standards established by this rule are as clear and certain as practicable, given the complexity of the topics covered and the mandates of SMCRA.

D. What is the retroactive effect, if any, to be given to the regulation?

This rule is not intended to have retroactive effect.

E. Are administrative proceedings required before parties may file suit in court? Which proceedings apply? Is the exhaustion of administrative remedies required?

No administrative proceedings are required before parties may file suit in court challenging the provisions of this rule under section 526(a) of SMCRA, 30 U.S.C. 1276(a).

Prior to any judicial challenge to the application of the rule, however, administrative procedures must be exhausted. In situations involving OSM application of the rule, applicable administrative procedures may be found at 43 CFR part 4. In situations involving State regulatory authority application of provisions equivalent to those contained in this rule, applicable administrative procedures are set forth in the particular State program.

F. Does the rule define key terms, either explicitly or by reference to other regulations or statutes that explicitly define those items?

Terms which are important to the understanding of this rule are set forth in 30 CFR 700.5 and 701.5.

G. Does the rule address other important issues affecting clarity and general draftsmanship of regulations set forth by the Attorney General, with the concurrence of the Director of the Office of Management and Budget, that are determined to be in accordance with the purposes of the Executive Order?

The Attorney General and the Director of the Office of Management and Budget have not issued any guidance on this requirement.

Author

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List of Subjects

30 CFR Part 779

Environmental protection, Reporting and recordkeeping requirements, Surface mining.

30 CFR Part 780

Reporting and recordkeeping requirements, Surface mining.

30 CFR Part 783

Environmental protection, Reporting and recordkeeping requirements, Underground mining.

30 CFR Part 784

Reporting and Recordkeeping requirements, Underground mining.

Dated: May 4, 1994.

Bob Armstrong,

Assistant Secretary, Land and Minerals Management.

Accordingly, 30 CFR Parts 779, 780, 783, and 784 are amended as set forth below.

PART 779—SURFACE MINING PERMIT APPLICATIONS—MINIMUM REQUIREMENTS FOR INFORMATION ON ENVIRONMENTAL RESOURCES

1. The authority citation for part 779 continues to read as follows:

Authority: 30 U.S.C. 1201 *et seq.*; sec. 115 of Pub. L. 98–146, (30 U.S.C. 1257), and 16 U.S.C. 470 *et seq.*

§ 779.22 [Removed]

2. Section 779.22 is removed.

§ 779.25 [Amended]

3. In section 779.25, paragraph (a)(11) is removed.

PART 780—SURFACE MINING PERMIT APPLICATIONS—MINIMUM REQUIREMENT FOR RECLAMATION AND OPERATION PLAN

4. The authority citation for part 780 continues to read as follows:

Authority: Pub. L. 95–87, 30 U.S.C. 1201 *et seq.*, as amended; sec. 115 of Pub. L. 98–146, 30 U.S.C. 1257; 16 U.S.C. 470 *et seq.*; and Pub. L. 100–34.

5. Section 780.23 is revised to read as follows:

§ 780.23 Reclamation plan: Land use information.

(a) The plan shall contain a statement of the condition, capability, and productivity of the land within the proposed permit area, including:

(1) A map and supporting narrative of the uses of the land existing at the time of the filing of the application. If the premining use of the land was changed within 5 years before the anticipated date of beginning the proposed operations, the historic use of the land shall also be described. In the case of previously mined land, the use of the land prior to any mining shall also be described to the extent such information is available.

(2) A narrative of land capability and productivity, which analyzes the land-use description under paragraph (a) of this section in conjunction with other environmental resources information. The narrative shall provide analyses of:

(i) The capability of the land before any mining to support a variety of uses, giving consideration to soil and foundation characteristics, topography, vegetative cover, and the hydrology of the proposed permit area; and

(ii) The productivity of the proposed permit area before mining, expressed as average yield of food, fiber, forage, or wood products from such lands obtained under high levels of management. The productivity shall be determined by yield data or estimates for similar sites based on current data from the U.S. Department of Agriculture, State agricultural universities, or appropriate State natural resource or agricultural agencies.

(b) Each plan shall contain a detailed description of the proposed use, following reclamation, of the land within the proposed permit area, including a discussion of the utility and capacity of the reclaimed land to support a variety of alternative uses, and the relationship of the proposed use of existing land use policies and plans. This description shall explain:

(1) How the proposed post mining land use is to be achieved and the necessary support activities which may be needed to achieve the proposed land use; and

(2) Where a land use different from the premining land use is proposed, all materials needed for approval of the alternative use under 30 CFR 816.133.

(3) The consideration which has been given to making all of the proposed surface mining activities consistent with surface owner plans and applicable State and local land use plans and programs.

(c) The description shall be accompanied by a copy of the comments concerning the proposed use by the legal or equitable owner of record of the surface of the proposed permit area and the State and local government agencies which would have to initiate, implement, approve, or authorize the proposed use of the land following reclamation.

PART 783—UNDERGROUND MINING PERMIT APPLICATIONS—MINIMUM REQUIREMENTS FOR INFORMATION ON ENVIRONMENTAL RESOURCES

6. The authority citation for part 783 continues to read as follows:

Authority: 30 U.S.C. 1201 *et seq.*; sec. 115 of Pub. L. 98–146, (30 U.S.C. 1257), and 16 U.S.C. 470 *et seq.*

§ 783.22 [Removed]

7. Section 783.22 is removed.

§ 783.25 [Amended]

8. In section 783.25, paragraph (a)(11) is removed.

PART 784—UNDERGROUND MINING PERMIT APPLICATIONS—MINIMUM REQUIREMENTS FOR RECLAMATION AND OPERATION PLAN

9. The authority citation for part 784 continues to read as follows:

Authority: Pub. L. 95–87, 30 U.S.C. 1201 *et seq.*, as amended; sec. 115 of Pub. L. 98–146, 30 U.S.C. 1257; 16 U.S.C. 470 *et seq.*; and Pub. L. 100–34.

10. Section 784.15 is revised to read as follows:

§ 784.15 Reclamation plan: Land use information.

(a) The plan shall contain a statement of the condition, capability, and productivity of the land within the proposed permit area, including:

(1) A map and supporting narrative of the uses of the land existing at the time of the filing of the application. If the premining use of the land was changed within 5 years before the anticipated date of beginning the proposed operations, the historic use of the land shall also be described. In the case of previously mined land, the use of the land prior to any mining shall also be described to the extent such information is available.

(2) A narrative of land capability and productivity, which analyzes the land-use description under paragraph (a) of this section in conjunction with other environmental resources information. The narrative shall provide analyses of:

(i) The capability of the land before any mining to support a variety of uses, giving consideration to soil and foundation characteristics, topography, vegetative cover, and the hydrology of the proposed permit area; and

(ii) The productivity of the proposed permit area before mining, expressed as average yield of food, fiber, forage, or wood products from such lands obtained under high levels of management. The productivity shall be determined by yield data or estimates for similar sites based on current data from the U.S. Department of Agriculture, State agricultural universities, or appropriate State natural resource or agricultural agencies.

(b) Each plan shall contain a detailed description of the proposed use, following reclamation, of the land within the proposed permit area including a discussion of the utility and capacity of the reclaimed land to support a variety of alternative uses, and the relationship of the proposed use to existing land use policies and plans. This description shall explain:

(1) How the proposed postmining land use is to be achieved and the necessary support activities which may be needed to achieve the proposed land use; and

(2) Where a land use different from the premining land use is proposed, all materials needed for approval of the alternative use under 30 CFR 817.133.

(3) The consideration which has been given to making all of the proposed surface mining activities consistent with surface owner plans and applicable

State and local land use plans and programs.

(c) The description shall be accompanied by a copy of the comments concerning the proposed use by the legal or equitable owner of record of the surface of the proposed permit area and the State and local government agencies which would have to initiate, implement, approve, or authorize the proposed use of the land following reclamation.

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May 27, 1994

Part V

Department of Housing and Urban Development

Funding Availability for the HUD-Administered Small Cities Community Development Block Grant (CDBG) Program, Fiscal Year 1994; Notice

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Community Planning and Development

[Docket No. N–94–3766; FR 3723–N–01]

Funding Availability for the HUD-Administered Small Cities Community Development Block Grant (CDBG) Program—Fiscal Year 1994

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice of Funding Availability (NOFA) for Fiscal Year (FY) 1994.

SUMMARY: This Notice of Funding Availability (NOFA) announces the availability of $50,616,000 in FY 1994 funding for the HUD-administered Small Cities Program in New York State under the Community Development Block Grant (CDBG) Program. The NOFA contains information concerning the deadline for filing grant applications; eligibility of applicants; available amounts; selection criteria; and the application process, including how to apply for funding and how selections will be made.

DATES: Applications are due by July 26, 1994. Application kits may be obtained from and must be submitted to either HUD's New York or Buffalo Office. Applications, if mailed, must be postmarked no later than midnight on July 26, 1994. If an application is hand-delivered to the New York or the Buffalo Office, the application must be delivered to the appropriate office by no later than 4 p.m. on the deadline date. Application kits will be made available by a date that affords applicants no fewer than 30 days to respond to this NOFA. For further information on obtaining and submitting applications, please see Section II of this NOFA.

The above-stated application deadline is firm as to date and hour. In the interest of fairness to all competing applicants, the Department will treat as ineligible for consideration any application that is not received by 4 p.m. on, or postmarked by, July 26, 1994. Applicants should take this procedure into account and make early submission of their materials to avoid any risk of loss of eligibility brought about by unanticipated delays or other delivery-related problems.

FOR FURTHER INFORMATION CONTACT: Stephen Rhodeside, State and Small Cities Division, Office of Community Planning and Development, Department of Housing and Urban Development, room 7184, 451 Seventh Street SW., Washington, DC 20410. Telephone (202) 708–1322 (voice) or (202) 708–2565 (TDD). (These are not toll-free numbers.)

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act Statement

The information collection requirements related to this CDBG program have been approved by the Office of Management and Budget (OMB) and have been assigned OMB approval number 2506–0020.

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I. Purpose and Substantive Description

A. Authority and Background

1. Authority

Title I, Housing and Community Development Act of 1974 (42 U.S.C. 5301–5320); 24 CFR part 570, subpart F.

2. Background

Title I of the Housing and Community Development Act of 1974 authorizes the Community Development Block Grant (CDBG) Program. Section 106 of Title I permits the States to elect to assume the administrative responsibility for the CDBG Program for nonentitled areas within their jurisdiction. Section 106 provides that HUD will administer the CDBG Program for nonentitled areas within any State that does not elect to assume the administrative responsibility for the program. Subpart F of 24 CFR part 570 sets out the requirements for HUD's administration of the CDBG Program in nonentitled areas (Small Cities Program). This NOFA supplements subpart F of 24 CFR part 570, which sets out the requirements applicable to the CDBG Program in nonentitled areas.

In accordance with 24 CFR 570.420(e) and 570.420(h)(3), and with the requirements of section 102 of the Housing and Urban Development Reform Act of 1989 (HUD Reform Act), HUD is issuing this NOFA for New York State's Small Cities Program for Fiscal Year (FY) 1994 to announce the allocation of funds for Single Purpose and Comprehensive grants, and to establish the deadline for filing grant applications. The NOFA explains how HUD will apply the regulatory threshold requirements for funding eligibility, and the selection criteria for rating and scoring applications for Comprehensive grants and for scoring projects in applications for Single Purpose grants.

Section I.A.3 of this NOFA provides a description of certain statutory amendments that apply to the HUD-Administered Small Cities Program, even though conforming regulations have not yet been adopted. The statutory amendments listed in Section I.A.3 require little or no regulatory elaboration. Conforming amendments will be made to 24 CFR part 570, subpart F in future rulemaking. Other information about the Small Cities Program will be provided in the application kit, which will be made available to applicants by HUD's New York and Buffalo Offices.

3. Statutory Changes

Both the National Affordable Housing Act (Pub. L. 101–625, approved November 28, 1990) (NAHA) and the Housing and Community Development Act of 1992 (Pub. L. 102–550, approved October 28, 1992) (the 1992 Act) amended Title I of the Housing and Community Development Act of 1974 (the HCD Act). Various amendments made by the two recent statutes are applicable, as described below, to the funds made available under this NOFA.

a. *Principal Benefit Certification.* NAHA amended section 101(c) of the HCD Act to require that at least 70 percent of the CDBG assistance provided over a specified period must be used for activities that principally benefit low- and moderate-income persons. Applicants must certify that CDBG assistance will be used as required by the amended section 101(c). The principal benefit certification has been revised to incorporate this change from 60 percent to 70 percent.

b. *Program Income.* In determining the applicability of CDBG requirements to the use of program income, section 804 of the 1992 Act removes any consideration of whether the grantee is still participating in the CDBG program. This means that program income generated from projects funded in FY 1993 and thereafter will always be subject to all of the CDBG requirements.

c. *Microenterprise and Small Business Development.* Section 807(c) of the 1992 Act defines a "small business" as one that meets the criteria set forth in section 3(a) of the Small Business Act (15 U.S.C. 632(a)), and defines a "microenterprise" as a commercial enterprise having five or fewer employees, one or more of whom own the enterprise.

Additionally, section 807(c) of the 1992 Act provides that in the provision of assistance under § 570.203(b) to for-profit microenterprises and small businesses, HUD will not consider the use of CDBG funds for training, technical assistance, and other support costs provided to such entities to be planning or administrative costs.

(Section 807(c) also directs HUD not to consider CDBG funds as being used for a planning or administrative activity when the funds are used to pay costs to develop the capacity of the grantee (or a subrecipient) to provide training, technical assistance or other support services to small businesses or microenterprises. Consequently—since these activities are not to be considered as planning or administrative activities—they *are* subject to compliance with the national objective requirements.)

d. *Lump Sum Drawdowns.* The use of lump sum drawdowns for residential rehabilitation has been re-authorized for CDBG funds appropriated after Fiscal Year 1992.

e. *Eligible Activities*—(1) *Changes Affecting Existing Categories—(a) Assistance to For-Profit Businesses.* Section 806(b) of the 1992 Act amends section 105(a) of the HCD Act so that CDBG assistance provided to for-profit businesses is not limited to activities for which no other forms of assistance are available, or to activities that could not be accomplished, but for that assistance.

(b) *Direct Homeownership Assistance.* NAHA amended section 105(a) of the HCD Act to provide that CDBG funds can be used to provide direct assistance to facilitate and expand homeownership among persons of low- and moderate-income. Under this provision, CDBG funds may be used to: subsidize interest rates and mortgage principal amounts for low- and moderate-income homebuyers; finance the acquisition by low- and moderate-income homebuyers of housing that is occupied by the homebuyers; acquire guarantees for mortgage financing obtained by low- and moderate-income homebuyers from private lenders (except that assistance under Title I of the HCD Act may not be used by recipients or subrecipients to guarantee mortgage financing directly); provide up to 50 percent of the downpayment required from low- and moderate-income buyers; and pay reasonable closing costs normally associated with the purchase of a home incurred by a low- and moderate-income homebuyer. While this provision was set to expire on October 1, 1993, it has been extended to October 1, 1994 by section 807(b) of the 1992 Act. Under the terms of this provision, the locality must commit funds to a specific homeowner prior to October 1, 1994. It is extremely likely that this provision will be extended until October 1, 1995. Applications will be rated assuming that the extension will be granted.

(c) *Code Enforcement.* Section 807(e) of the 1992 Act adds "private improvements or services" undertaken in an area to the list of activities that may be considered, together with code enforcement, in determining whether CDBG funds may be used to pay for the code enforcement in an area.

(d) *Loans to Subrecipients.* Section 807(d) of the 1992 Act amends section 105(a)(14) of the HCD Act to authorize the use of CDBG assistance for activities

in the form of loans—both interim and long-term—as well as grants.

(e) *Public Service Cap.* NAHA amended section 105(a)(8) of the HCD Act by placing the 15 percent cap for public services on each State's total nonentitlement CDBG allocation, plus 15 percent of program income anticipated to be received in the fiscal year. (Previously, the 15 percent cap for public services was applied to each recipient's grant.) As a result of this provision, HUD may award a grant to a recipient for public service activities with 100 percent of the funds spent for public service activities. However, any application requesting funds for public service activities must be ratable under one of the existing Single Purpose or the Comprehensive grant categories. HUD will apply the 15 percent statewide cap to public service activities by funding public service activities in the highest-rated applications until the cap is reached.

(f) *Neighborhood-Based Nonprofit Organizations.* Section 807(f) of the 1992 Act amends section 105(a)(15) of the HCD Act to add nonprofit organizations serving the development needs of communities in nonentitlement areas as entities eligible to carry out CDBG activities.

(2) *New Categories of Eligible Activities—(a) Nonprofit Capacity Building.* Section 807(a)(4) makes eligible the provision of technical assistance to public or nonprofit entities to increase the capacity of these entities to carry out eligible neighborhood revitalization or economic development activities. Section 807(a)(4) makes clear, however, that the use of funds for technical assistance is *not* to be considered as a planning or administrative cost of the program. Before the amendment, the use of CDBG funds for nonprofit capacity building was an eligible activity only under § 570.205, and therefore was subject to the cap on planning and administration set out at § 570.200(g). While nonprofit capacity building is now eligible under the new provision and is not subject to a percentage limitation, it should be noted that any such use of funds under the new authority must be shown to meet one of the national objectives. (This may be difficult in some cases, since all activities carried out by the nonprofit using the added capacity will need to be considered for that purpose.)

(b) *Institutions of Higher Education.* Section 807(a)(4) of the 1992 Act makes it possible for a grantee to provide CDBG funds to institutions of higher education to carry out activities otherwise eligible for CDBG assistance, provided that it can be determined that the institution has demonstrated a capability to carry out such activities.

(c) *Acquisition by Tax Foreclosure.* Section 807(a)(4) of the 1992 Act makes eligible the use of CDBG funds to make essential repairs and to pay operating expenses necessary to maintain the habitability of housing units acquired through tax foreclosure proceedings in order to prevent abandonment and deterioration of housing in primarily low- and moderate-income neighborhoods.

(d) *Microenterprises.* Section 807(a)(4) of the 1992 Act establishes a new category of eligibility under which CDBG funds may be used to provide assistance to public and private organizations, agencies, and other entities (including nonprofit and for-profit entities) to enable these entities to facilitate economic development by:

- Providing credit (including providing direct loans and loan guarantees, establishing revolving loan funds, and facilitating peer lending programs) for the establishment, stabilization, and expansion of microenterprises;
- Providing technical assistance, advice, and business support services (including assistance, advice, and support relating to developing business plans, securing funding, conducting marketing, and otherwise engaging in microenterprise activities) to owners of microenterprises and persons developing microenterprises; and
- Providing general support (such as peer support programs and counseling) to the owners of microenterprises and to persons developing microenterprises.

(e) *Housing Services.* Section 807(a)(4) of the 1992 Act establishes a new category of eligibility for "housing services". Housing services include housing counseling, energy auditing, preparation of work specifications, loan processing, inspections, tenant selection, management of tenant-based rental assistance, and other services related to assisting owners, tenants, contractors, and other entities, participating or seeking to participate in housing activities authorized under the CDBG program or the HOME program. Activities that are carried out under this provision are to be subject to the 20 percent limitation on administrative expenses.

It is important to note that these activities are currently eligible in the CDBG program when carried out in conjunction with rehabilitation (see 24 CFR 570.202(b)(9)), and therefore not subject to the administrative cap on expenditures.

(f) *Lead-Based Paint Hazards.* Section 1012 of the 1992 Act amends section 105(a) by stating that CDBG funds may be used for lead-based paint hazard evaluation and reduction, as defined in section 1004 of the Residential Lead-Based Paint Hazard Reduction Act of 1992 (42 U.S.C. 4851). It should be noted that § 570.202(a)(iv) currently authorizes inspection and abatement of lead-based paint in conjunction with CDBG-assisted rehabilitation. Additionally, § 570.205 authorizes evaluation of lead-based paint hazards within the jurisdiction generally. Until the regulations are modified to incorporate this new provision, grantees may use the new authority to fund lead-based paint inspection of houses whether or not rehabilitation of the houses will be CDBG-funded. The new authority may also be used to fund large scale evaluation of lead based-paint hazards in the community (assuming that it is an approved activity in the Small Cities application), outside of the 20 percent limitation on planning and administration cost, if the grantee can demonstrate that the evaluation addresses a CDBG national objective.

(3) *Changes concerning national objectives—(a) Low/mod jobs presumption.* Section 806(e) of the 1992 Act amends section 105(c) of the HCD Act by adding a new paragraph (4) which states that, for purposes of determining whether an activity involves the employment of persons the majority of whom are low- and moderate-income persons, a person may be presumed to be a low- and moderate-income person in either of the following circumstances:

- If the employee resides in, or the assisted activity through which he or she is employed, is located in a census tract that meets the Federal enterprise zone eligibility criteria; or
- The employee resides in a census tract where not less than 70 percent of the residents are low- and moderate-income persons.

The provision of new paragraph (4) concerning the percentage of low- and moderate-income persons residing in a census tract was effective upon enactment. However, because existing HUD regulations do not clearly apply enterprise zone criteria to census tracts, the portion of new paragraph (4) concerning census tracts that meet the Federal enterprise zone eligibility criteria will not become effective until regulations are established identifying the specific criteria that must be met.

f. *Housing Strategies.* Any applicant which plans to undertake a housing activity with Fiscal Year 1994 funds

under the HUD-administered Small Cities Program must prepare and submit a comprehensive housing affordability strategy (CHAS) to be eligible to apply for such assistance. In order to receive funding if the Small Cities application is approved, the housing strategy must be approved by HUD. Further, any Small Cities application for which a housing strategy is required must include a certification that the application is consistent with the housing strategy.

Current CHAS regulations were published in the **Federal Register** on September 1, 1992, at 57 FR 40038, as amended, in part, on March 12, 1993 at 58 FR 13686. These regulations are codified in 24 CFR part 91. Applicants under this NOFA are permitted to use an abbreviated housing strategy, as set forth in § 91.25 of the CHAS regulations. Applicants are advised to begin preparation of the abbreviated strategy at the earliest possible time in order to have sufficient time to fulfill the applicable citizen participation requirements, which provide that the strategy must be available to the public for at least thirty days before its submission to HUD.

If possible, applicants should endeavor to submit the abbreviated strategy in advance of the Small Cities application due date. The latest time at which the abbreviated strategy will be accepted by HUD for the HUD-administered Small Cities Program in New York will be the application due date for the Small Cities application. Failure to submit the abbreviated strategy by the due date is not a curable technical deficiency. Questions regarding the housing strategies should be directed to the appropriate HUD field office.

Complete Small Cities applications for which the abbreviated strategy has been submitted but not yet approved will still be rated and ranked with the other applications; if determined to be fundable, those applications will receive a conditional approval subject to approval of the abbreviated strategy. However, such an approval will be rescinded if the abbreviated strategy has not been approved by HUD within 60 days from the date that the conditional approval has been announced. In such event the funding will be awarded to the highest rated fundable applicant that did not receive funding under this competition.

g. *Section 3.* Section 3 of the Housing and Urban Development Act of 1968 was amended substantially by section 915 of the Housing and Community Development Act of 1992, and the issuance of regulations to implement the new requirements was mandated. The following policy was set forth in the statute:

"It is * * * the purpose of this section to ensure that the employment and other economic opportunities generated by Federal financial assistance for housing and community development programs shall, to the greatest extent feasible, be directed toward low- and very low-income persons * * * "

HUD published a proposed rule October 8, 1993 (24 CFR part 135) with a public comment period extended to December 8, 1993. Upon publication of the interim rule, requirements (including reporting requirements) relative to section 3 (for the purpose of determining the effectiveness of section 3) will be applicable to the HUD-administered Small Cities Program. At the time of publication of the interim rule, HUD will provide further information and instructions to applicants concerning the requirements of section 3.

4. Accountability in the Provision of HUD Assistance: Documentation and Public Access Requirements; Applicant/Recipient Disclosures. HUD has promulgated a final rule to implement section 102 of the Department of Housing and Urban Development Reform Act of 1989 (HUD Reform Act). The final rule is codified at 24 CFR part 12. Section 102 contains a number of provisions that are designed to ensure greater accountability and integrity in the provision of certain types of assistance administered by HUD. (See also Section II.D. of this NOFA.) On January 16, 1992, HUD published at 57 FR 1942, additional information that gave the public (including applicants for, and recipients of, HUD assistance) further information on the implementation of section 102. The documentation, public access, and applicant and recipient disclosure requirements of section 102 are applicable to assistance awarded under this NOFA as follows:

a. *HUD responsibilities*—(1) *Documentation and public access.* HUD will ensure that documentation and other information regarding each application submitted pursuant to this NOFA are sufficient to indicate the basis upon which assistance was provided or denied. This material, including any letters of support, will be made available for public inspection for a five-year period beginning not less than 30 days after the award of the assistance. Material will be made available in accordance with the Freedom of Information Act (5 U.S.C. 552) and HUD's implementing regulations at 24 CFR part 15. In addition, HUD will include the recipients of assistance pursuant to this NOFA in its quarterly **Federal Register** notice of all recipients of HUD assistance awarded on a competitive basis. (See 24 CFR 12.14(a) and 12.16(b), and the notice published in the **Federal Register** on January 16, 1992 (57 FR 1942), for further information on these requirements.)

(2) *Disclosures.* HUD will make available to the public for five years all applicant disclosure reports (HUD Form 2880) submitted in connection with this NOFA. Update reports (also Form 2880) will be made available along with the applicant disclosure reports, but in no case for a period of less than three years. All reports—both applicant disclosures and updates—will be made available in accordance with the Freedom of Information Act (5 U.S.C. 552) and HUD's implementing regulations at 24 CFR part 15. (See 24 CFR subpart C, and the notice published in the **Federal Register** on January 16, 1992 (57 FR 1942), for further information on these disclosure requirements.)

b. *Units of General Local Government Responsibilities.* Units of general local government awarded assistance under this NOFA are subject to the provisions of either paragraph b(1), or paragraph (b)(2) and (b)(3). For units of local government awarded assistance under this NOFA which in turn make the assistance available on a non-competitive basis for a specific project or activity to a subrecipient, paragraph b(1) applies. For units of local government awarded assistance under this NOFA, which in turn make the assistance available on a competitive basis for a specific project or activity to a subrecipient, paragraphs b(2) and (3) apply.

(1) *Disclosures.* The units of general local government receiving assistance under this NOFA must make all applicant disclosure reports available to the public for three years. Required update reports must be made available along with the applicant disclosure reports, but in no case for a period less than three years. Each unit of general local government may use HUD Form 2880 to collect the disclosures, or may develop its own form. (See 24 CFR 12 subpart C, and the notice published in the **Federal Register** on January 16, 1992 (57 FR 1942) for further information on these disclosure requirements.)

(2) *Documentation and Public Access.* The recipient unit of general local government must ensure that documentation and other information regarding each application submitted to the recipient by a subrecipient applican*

are adequate to indicate the basis upon which assistance was provided or denied. The unit of general local government must make this material, including any letters of support, available for public inspection for a five-year period beginning not less than 30 days after the award of the assistance. Unit of general local government recipients must also notify the public of the subrecipients of the assistance. Each recipient will develop documentation, public access, and notification procedures for its programs. (See 24 CFR 12.14(b) and 12.16(c), and the notice published in the **Federal Register** on January 16, 1992 (57 FR 1942) for more information on these documentation and public access requirements.)

(3) *Disclosures.* Units of general local government receiving assistance under this NOFA must make all applicant disclosure reports available to the public for five years. Required update reports must be made available along with the applicant disclosure reports, but in no case for a period less than three years. Each unit of general local government may use HUD Form 2880 to collect the disclosures, or may develop its own form. (See 24 CFR subpart C, and the notice published in the **Federal Register** on January 16, 1992 (57 FR 1942) for further information on these disclosure requirements.)

B. Allocation Amounts

1. Total Available Funding and Allocation

The nonentitlement CDBG funds for New York State for FY 1994 total $50,616,000 and will be allocated as follows:

a. *Buffalo Office.* $44,438,000 is allocated for distribution to eligible units of general local government within the jurisdiction of HUD's Buffalo Office. Maximum grant amounts for units of general local government under the jurisdiction of the Buffalo Office will be $400,000 for Single Purpose grant applications and $900,000 for Comprehensive grant applications, except that counties may apply for up to $600,000 in Single Purpose funds. The maximum amount for Single Purpose grant applications made jointly by units of general local government will be $600,000.

b. *New York Office.* $6,178,000 is allocated for distribution to eligible units of general local government within the jurisdiction of HUD's New York Office. Maximum grant amounts for communities under the jurisdiction of the New York Office will be $400,000 for Single Purpose grants and $750,000 for Comprehensive grants, except that counties may apply for up to $600,000 in Single Purpose funds. The maximum amount for Single Purpose grant applications made jointly by units of general local government will be $600,000.

2. Distribution of Funds Between Single Purpose and Comprehensive Grants

Generally, 85 percent of the funds allocated separately to the New York and Buffalo offices shall be for Single Purpose grants with the remaining 15 percent to be reserved for Comprehensive grants. However, in order to assure a competitive distribution of funds, each HUD office has the option to revise the division of funds between Single Purpose and Comprehensive grants to as low as 75 percent for Single Purpose and up to 25 percent for Comprehensive grants. Applicants requesting more that $600,000 in Comprehensive funding will be expected to provide clear and convincing evidence that the proposed activities will effectively address and correct conditions affecting large segments of the low- and moderate-income community, and that the grantee has the capability to expend the funds in a timely fashion. If this is not provided, the field office may reduce the grant amount.

3. Imminent Threats

The criteria for grants to alleviate or remove imminent threats to health or safety that require an immediate solution are described at § 570.432. All imminent threat projects must meet the national objective of benefitting low- and moderate-income persons. For FY 1994, $6,665,700 is being set aside in the Buffalo Office, and $926,700 is being set aside in the New York Office for imminent threat projects. These funds will be available in each office until the office completes the rating and ranking process for funds distributed under this NOFA.

C. Eligibility

1. Eligible Applicants

Eligible applicants are units of general local government in New York State, excluding: metropolitan cities, urban counties, units of government which are participating in urban counties or metropolitan cities even if only part of the participating unit of government is located in the urban county or metropolitan city, and Indian tribes eligible for assistance under section 106 of the HCD Act. Applications may be submitted individually or jointly.

2. Previous Grantees

Eligible applicants, which previously have been awarded Small Cities Program CDBG grants, are also subject to an evaluation of capacity and performance. Numerical thresholds for drawdown of funds have been established to assist HUD in evaluating a grantee's progress in implementing its program activities. (These standards apply to all CDBG Program grants received by the community.) An additional threshold relates to the submission of annual Performance Assessment Reports (PARs) which are due annually for each grant which a local government has received. Failure to submit a PAR is not a curable technical deficiency. Applicants generally will be determined to have performed adequately in the area(s) where the thresholds are met. Where a threshold has not been met, HUD will evaluate the documentation of any mitigating factors, particularly with respect to actions taken by the applicant to accelerate the implementation of its program activities.

3. Eligible Activities and National Objectives

Eligible activities under the Small Cities CDBG Program are those identified in subpart C of 24 CFR part 570. Each activity must meet one of the national objectives (i.e. benefit to low- and moderate-income persons, elimination of slums or blighting conditions, or meeting imminent threats to the health and safety of the community), and each grant must meet the requirements for compliance with the primary objective of principally benefitting low- and moderate-income persons, as required under the provisions of § 570.200(a) (2) and (3) and § 570.208, which supersede § 570.420(h)(2). As described in Section I.A.3.a. of this NOFA, the principal benefit requirement was increased by NAHA from 60 to 70 percent. The method of calculating the use of these funds for compliance with the 70 percent overall benefit requirement is set forth in § 570.200(a)(3) (i) through (v).

4. Environmental Review Requirement

The HUD environmental review procedures contained in 24 CFR part 58 apply to this program. Under part 58, grantees assume all of the responsibilities for environmental review, decision-making and action pursuant to the National Environmental Policy Act of 1969 and the other provisions of law specified by the Secretary in 24 CFR part 58 that would

apply to the Secretary were he to undertake such projects as Federal projects.

D. Types of Grants

1. Comprehensive Grants

a. *General.* Comprehensive grants are available to fund projects which meet the following criteria:

(1) Address a substantial portion of the identified community development needs within a defined area or areas;

(2) Involve two or more activities related to each other that will be carried out in a coordinated manner;

(3) Have a beneficial impact within a reasonable period of time.

HUD may make an exception to the requirement that all activities must be carried out in a defined area or areas if the applicant can demonstrate that the comprehensive strategy is a reasonable means of addressing identified needs.

If an application for a Comprehensive grant does not meet the requirements of the Comprehensive Grant Program, HUD will rate the proposal as a Single Purpose grant.

b. *Funding requirements.* The total amount of funds requested for a Comprehensive grant must be within the established ceilings. Grant ceilings for each of the administering offices are indicated in Section I.B.1 of this NOFA. Grant funds requested must be sufficient, either by themselves or in combination with funds from other sources, to complete the project within a reasonable amount of time. If other sources of funds are to be used with respect to a project, the source of those funds must be identified and the level of commitment indicated.

2. Single Purpose Grants

a. *General.* Single Purpose grants are designed to address and resolve a specific community development need. A Single Purpose grant may consist of more than one project. A project may consist of one activity or a set of activities. Each project must address community development needs in one of the following problem areas:

—Housing
—Public Facilities
—Economic Development

Each project will be rated against all other projects addressing the same problem area, according to the criteria outlined below. It should be noted that each project within an application will be given a separate impact rating, if each one is clearly designated by the applicant as a separate and distinct project (i.e. separate Needs Description, Community Development Activities, Impact Description and Program Schedule forms have been filled out, indicating project names). In some cases, it may be to the applicant's advantage to designate separate projects for activities that can "stand on their own" in terms of meeting the described need, especially where a particular project would tend to weaken the impact rating of the other activities, if they were rated as a whole, as has been the case with some economic development and housing projects. If, however, the projects tend to meet impact criteria to the same extent, or the weaker element is only a small portion of the overall project, there is no discernable benefit in designating separate projects.

b. *Funding requirements.* The total amount of funds requested for a Single Purpose grant must be within the established ceilings. Grant ceilings are discussed in Section I.B.1. of this NOFA. Grant funds requested must be sufficient, either by themselves or in conjunction with funds from other sources, to complete the project within a reasonable period of time. If other sources of funds are to be used with respect to a project, the source of those funds must be identified and the level of commitment indicated.

c. *Projects with multiple activities.* If a project consists of more than one activity, the activity that directly addresses the need must represent at least a majority of the funds requested. Other activities must be incidental to, and in support of the principal activity.

d. *Applications with multiple projects.* If an application contains more than one project, each project will be rated separately for program impact. Applicants should note that regardless of the number of projects, the total grant amount cannot exceed the appropriate grant ceilings identified in Section I.B.1. of this NOFA.

3. Final Selection

The total points received by a project for all of the selection factors are added, and the project is ranked against all other projects from all applications, regardless of the problem areas in which the projects were rated. The highest ranked projects will be funded to the extent funds are available. Applicants will receive a single grant in the amount of the project or projects applied for which were ranked high enough to be funded. In the case of ties at the funding line, HUD will use the following criteria in order to break ties:

—The project receiving the highest program impact rating will be funded;
—If tied projects have the same program impact rating, the project having the highest combined score on the needs factors will be funded;
—If tied projects have the same program impact ratings and equal needs factor scores, the project having the highest score on the percent of persons in poverty needs factor will be funded; and
—If tied projects have the same program impact ratings, equal needs factor scores, and an equal percent of persons in poverty needs factor score, the application having the most outstanding performance in fair housing and equal opportunity will be funded.

As soon as possible after the rating and ranking process has been completed, HUD will notify all applicants regarding their rating scores and funding status. Thereafter, applicants may contact HUD to discuss scores or any aspects of the selection process.

E. Selection Criteria/Ranking Factors

1. General

Complete applications received from eligible applicants by the application due date are rated and scored by HUD. Regardless of the type of grant sought (Single Purpose or Comprehensive), applications are rated and scored against four factors. These four factors are discussed in more detail in subsection 3 of this Section E. Previous grantees of Small Cities Program CDBG grants also undergo a performance evaluation. The criteria for determining adequacy of performance are discussed in subsection 2 of this Section E.

2. Performance Evaluation

As noted in Section C of this NOFA, previous grantees of Small Cities Program CDBG grants are subject to an evaluation of performance and capacity to undertake the proposed program. For purposes of making performance evaluations, HUD will use any information available as of the application due date. Performance also will be evaluated using information which may be available already to HUD, including previously submitted performance reports, site visit reports, audits, monitoring reports and annual in-house reviews. Grantees may be requested to submit additional information, if generally available facts raise a question as to capacity to undertake the proposed program. No grants will be made to an applicant that does not have the capacity to undertake the proposed program. A performance determination will be made by evaluation of the following areas:

a. *Community Development Activities.* The following thresholds for performance in expending CDBG funds have been established for FY 1994 and pertain to all Single Purpose and Comprehensive Grants:

FY 1989 and earlier—Grants must be closed out
FY 1990—Grant funds 100% expended
FY 1991—Grant funds 75% expended
FY 1992—Grant funds 30% expended
FY 1993—Recipients must be on target with respect to the latest Small Cities Program Schedule received by HUD.

Note: These standards will be used as benchmarks in judging program performance, but will not be the sole basis for determining whether the applicant is ineligible for a grant due to a lack of capacity to carry out the proposed project or program. Any applicant that fails to meet the percentages specified above may wish to provide updated data to HUD, either in conjunction with the application submission or under separate cover, but in no case will data received by HUD after the application due date be accepted.

b. *Compliance with applicable laws and regulations.* An applicant will be considered to have performed inadequately if the applicant:

(1) Has not substantially complied with the laws, regulations, and Executive Orders applicable to the CDBG Program, including applicable civil rights laws as may be evidenced by: an outstanding finding of civil rights noncompliance, unless the applicant demonstrates that it is operating in compliance with a HUD-approved compliance agreement designed to correct the area(s) of noncompliance; an adjudication of a civil rights violation in a civil action brought against it by a private individual, unless the applicant demonstrates that it is operating in compliance with a court order designed to correct the area(s) of noncompliance; a deferral of Federal funding based upon civil rights violations; a pending civil rights suit brought against it by the Department of Justice; or an unresolved charge of discrimination issued against it by the Secretary under section 810(g) of the Fair Housing Act, as implemented by 24 CFR 103.400;

(2) Has not resolved or attempted to resolve findings made as a result of HUD monitoring; or

(3) Has not resolved or attempted to resolve audit findings.

An applicant will be ineligible for a grant where the inadequate performance in compliance with applicable laws and regulations evidences a lack of capacity to carry out the proposed project or program. An application also will not be accepted from a unit of general local government which has an outstanding audit finding or monetary obligation for any HUD program. Additionally, applications will not be accepted from any entity which proposes an activity in a unit of general local government that has an outstanding audit finding or monetary obligation for any HUD program. The Director of the Community Planning and Development Division of the HUD field office may provide waivers to this prohibition, but in no instance will a waiver be provided where funds are due HUD, unless a satisfactory arrangement for repayment of the debt has been made.

c. *Performance assessment reports.* Under 24 CFR 570.507, Small Cities CDBG grantees are required to submit Performance Assessment Reports (PARs) annually on the date when the grant was originally executed. For an application for FY 1994 funds to be considered for funding, the applicant must be current in its submission of Performance Assessment Reports. Failure to submit a PAR is not a curable technical deficiency under Section V of this NOFA.

3. Four Factor Rating

As noted in subsections 1 and 3 of this Section E, all applications are rated and scored against four factors. These four factors are:

—Need based on absolute number of persons in poverty;
—Need based on the percent of persons in poverty;
—Program Impact; and
—Outstanding performance in fair housing and equal opportunity.

A maximum of 615 points is possible under this system with the maximum points for each factor being:

	Points
Need—absolute number of persons in poverty	75
Need—percent of persons in poverty	75
Program Impact	400
Outstanding performance—FHEO:	
Provision of fair housing choice	20
Fair Housing Programs	20
Minority contracting	15
Equal opportunity employment	10
Total	615

Each of the four factors is outlined below. All points for each factor are rounded to the nearest whole number. Applicants should note that there is a distinct difference in the methods used to evaluate Program Impact for Single Purpose grants versus Program Impact for Comprehensive grants. These differences are more fully discussed below.

a. *Need—Absolute number of persons in poverty.* HUD uses 1990 census data to determine the absolute number of persons in poverty residing within the applicant unit of general local government. Comprehensive and Single Purpose grant applicants are grouped and rated separately for this factor. Applicants which are county governments are rated separately from all other applicants. Applicants in each group are compared in terms of the number of persons whose incomes are below the poverty level. Individual scores are obtained by dividing each applicant's absolute number of persons in poverty by the greatest number of persons in poverty of any applicant and multiplying by 75.

b. *Need—Percent of persons in poverty.* HUD uses 1990 census data to determine the percent of persons in poverty residing within the applicant unit of general local government. Comprehensive and Single Purpose grant applicants are grouped and rated separately for this factor. Applicants in each group are compared in terms of the percentage of their population below the poverty level. Individual scores are obtained by dividing each applicant's percentage of persons in poverty by the highest percentage of persons in poverty of any applicant and multiplying by 75.

c. *Program Impact—General.* In evaluating program impact, HUD will consider:

—Extent and seriousness of the identified needs;
—Results to be achieved;
—Number of beneficiaries, given the type of program;
—Nature of the benefit;
—Additional actions that may be necessary to fully resolve the need;
—Previous coordinated actions taken by the applicant to address the need;
—Environmental considerations;
—Whether displacement will be involved and what steps will be taken to minimize displacement and to mitigate its adverse effects or related hardships; and
—Where appropriate, housing site selection standards.

Assessments are done on a comparative basis and, as a result, it is important that each applicant present information in a detailed and uniform manner.

In addressing Program Impact criteria, applicants should adhere to the following general guidelines for quantification. Where appropriate, absolute and percentage figures should be used to describe the extent of community development needs and the impact of the proposed program. This

includes, but is not limited to, appropriate units of measure (e.g., number of housing units or structures, linear feet of pipe, pounds per square inch, etc.), and costs per unit of measure. These quantification guidelines apply to the description of need, the nature of proposed activities and the extent to which the proposed program will address the identified need.

Appropriate documentation should be provided to support the degree of need described in the application. Basically, the sources for all statements and conclusions relating to community needs should be included in the application or incorporated by reference. Examples of appropriate documentation include planning studies, letters from public agencies, newspaper articles, photographs and survey data.

Generally, the most effective documentation is that which specifically addresses the subject matter and has a high degree of credibility. Applicants which intend to conduct surveys to obtain data are advised to contact the appropriate HUD office prior to conducting the survey for a determination as to whether the survey methodology is statistically acceptable.

There are a number of program design factors related to feasibility which can alter significantly the award of impact points. Accordingly, it is imperative that applicants provide adequate documentation in addressing these factors. Common feasibility issues include site control, availability of other funding sources, validity of cost estimates, and status of financial commitments as well as evidence of the status of regulatory agency review and approval.

Past productivity and administrative performance of prior grantees will be taken into consideration when reviewing the overall feasibility of the program. Overall program design, administration and guidelines are other feasibility issues that should be articulated and presented in the application, since they are critical in assessing the effectiveness and impact of the proposed program.

(1) *Program Impact—Single Purpose Grants.* Each project will be rated against other projects addressing the same problem area, so that, for example, housing projects only will be compared with other housing projects, according to the criteria outlined below. It should be noted that each project within an application will be given a separate impact rating, if each one is clearly designated by the applicant as a separate and distinct project (i.e. separate Needs Descriptions, Community Development Activities, and Impact Description and Program Schedule forms have been filled out, indicating separate project names).

In some cases, it may be to the applicant's advantage to designate separate projects for activities that can "stand on their own" in terms of meeting the described need, especially where a particular project would tend to weaken the impact rating of the other activities, if they were all related as a whole, as has been the case with some economic development projects. If, however, the projects tend to meet the impact criteria to the same extent, or the weaker element is only a small portion of the overall program, there is no discernable benefit in designating separate projects.

Applicants should bear in mind that the impact of the proposed project will be judged by persons who may not be familiar with the particular community. Accordingly, individual projects will be rated according to how well the application demonstrates in specific, measurable terms, the extent to which the impact criteria are met. General statements of need and impact alone will not be sufficient to obtain a favorable rating.

(a) *Program Impact—Single Purpose—Housing.* There are three distinct types of Single Purpose Housing projects: Housing Rehabilitation, Creation of New Housing and Direct Homeownership Assistance. Separate rating criteria are provided for each type of project.

(i) *Housing Rehabilitation—Needs.* Each application should provide information on the total number of units in the project area, the number that are substandard, and the number of substandard units occupied by low- and moderate-income households. The purpose of this information is to establish the relative severity of housing conditions within the designated project area compared to other housing rehabilitation applications. The application also should describe the date and methodology of any surveys used to obtain the information, including an explicit and detailed definition of "substandard".

Surveys of housing conditions. Surveys of housing conditions serve several purposes in evaluating applications for housing rehabilitation activities. These include establishing the seriousness of need for such assistance in the project area, providing a basis for estimating overall budgetary needs, and providing an indication of the marketability of the project.

Project design and feasibility. The application should describe the project in sufficient detail to allow the reviewer to assess its feasibility and its probable impact on the conditions described. It also should describe project requirements in such a way that regulatory and policy concerns will be addressed.

In reviewing applications from grantees with prior housing rehabilitation projects, reasonableness of cost-per-unit, stated in the application, will be compared against the grantee's actual past performance. All applications should provide documentation to justify the cost-per-unit estimates, particularly grantees where past performance does not support the estimates in the applications.

It should be noted that HUD encourages communities to design projects supplementing CDBG rehabilitation funds with private funds wherever feasible and appropriate, especially in the case of rental units and housing not occupied by lower income persons. In such cases, the CDBG subsidy should be as low as possible, while retaining sufficient incentive to attract local participants. On the other hand, projects designed for low income homeowners should not require private contributions at a level that puts the project out of reach of potential participants.

Where the creation of new units is proposed through conversion, the application should document the need for additional units based on vacancy rates, waiting lists, and other pertinent information. The proposed project clearly must support, or result in, additional units for low- and moderate-income persons. The units may result from the rehabilitation of currently vacant structures, conversion of non-residential structure for residential use, or new construction projects for which the proposed project will provide non-construction assistance.

Where the proposed project involves the use of Federally assisted housing, the applicant must identify and document the current commitment status of the Federal assistance. Lack of a firm financial commitment for assistance may adversely affect project impact. Applicants should address issues of site control and marketability, in addition to addressing feasibility from the standpoint of market financing.

The impact of the proposed project will be based on the degree of need, the number of units to be created, overall feasibility and the nature and cost of the proposed activities.

For projects consisting of more than one activity, the activity that directly addresses the need must represent at

least the majority of funds requested. Other activities must be incidental to and in support of the principal activity. For example, public improvements included in a rehabilitation project that addresses housing need must: be a relatively small amount in terms of funds requested; clearly be in support of the housing objective; and demonstrate a positive and direct link to the national objective.

For incidental activities claiming benefit to low- and moderate-income persons on an area basis, the application must document that at least 51 percent of the residents of the service area meet the low- and moderate-income requirement. Funds should not be requested for activities that are not incidental to, and in support of the principal activity.

Scoring. Individual projects often vary in the extent to which they meet the criteria outlined above. Accordingly, it is difficult to define precisely those combinations of characteristics which constitute, for example, "maximum" versus "substantial" impact. Not all projects receiving a particular rating will match all the criteria point-by-point, in the same manner. The objective for non-target area projects, in as much as they are sparsely populated, only should be to assist low- and moderate-income persons. Accordingly, the following standard will be used for rating housing rehabilitation projects:

Maximum (400 Points)

1. Severe need is shown in the project area, in terms of the proportion of units that are substandard and the extent of disrepair in the units.

2. The project would bring all, or almost all, of the units in the project area up to standard.

3. There are no feasibility questions, such as availability of other resources, marketability, or appropriateness of project design, which would hinder the timely completion of the project as proposed.

4. Benefits a large number of persons when compared to other housing projects.

5. Significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Substantial (300 Points)

1. Serious need is shown.

2. Project would bring most of the units in the area up to standard.

3. There are no major feasibility questions.

4. Benefits a substantial number of persons.

5. Substantially supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Moderate (200 Points)

1. Serious need is shown, but is not as well documented as in other applications.

2. Project would bring units up to standard, but not to the same extent as other applications.

3. There may be some minor feasibility questions.

4. Benefits a significant number of persons.

5. Moderately supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Minimal (100 Points)

1. Some need is evident, but it is not serious compared to other applications, or is not well documented.

2. Project may bring most units up to standard, but not to same extent as in other applications.

3. There are serious feasibility questions.

4. Benefits a small number of persons.

5. Minimally supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Insignificant (0 Points)

1. Very little need has been demonstrated.

2. Project would not rehabilitate most units.

3. There are serious feasibility questions.

4. Benefits a very small number of persons.

5. Does not support the strategic plan of a designated Empowerment Zone or Enterprise Community.

(ii) *Creation of new housing.* CDBG funds may be used to support the construction of new housing units, and, in certain circumstances, to finance the actual cost of constructing new units. New construction may be carried out by an eligible non-profit entity pursuant to 24 CFR 570.204, or as last resort housing. Support of new construction could include activities such as the acquisition and/or clearance of land, the provision of infrastructure, or the payment of certain planning costs.

Where the creation of new units is proposed, the application should document the need for additional units based on vacancy rates, waiting lists, and other pertinent information. The proposed project clearly must support, or result in, additional units for low- and moderate-income persons. The units may result from new construction projects for which the proposed project will provide non-construction assistance.

Where the proposed project involves the use of Federally assisted housing, the applicant must identify and document the current commitment status of the Federal assistance. Lack of a firm financial commitment for assistance may adversely affect project impact. Applicants should address issues of site control and marketability, in addition to addressing feasibility from the standpoint of market financing.

The impact of the proposed project will be based on the degree of need, the number of units to be created, overall feasibility and the nature and cost of the proposed activities.

Scoring. Individual projects often vary in the extent to which they meet the criteria outlined above. Accordingly, it is difficult to define precisely those combinations of characteristics which constitute, for example, "maximum" versus "substantial" impact. Not all projects receiving a particular rating will match all the criteria point-by-point, in the same manner. Accordingly, the following standard will be used for rating projects supporting new housing construction:

Maximum (400 Points)

1. Severe need for new housing affordable to low- and moderate-income persons is shown in the project area.

2. Project would create a large number of new housing units affordable to low- and moderate-income persons.

3. There are no feasibility questions, such as availability of other resources, marketability, or appropriateness of project design, which would hinder the timely completion of the project as proposed.

4. Benefits a large number of persons when compared to other new housing projects.

5. Project would affirmatively further fair housing choice by resulting in the spatial deconcentration of minorities throughout the community, or would provide spatial deconcentration of low- and moderate-income households if there are no areas of minority concentration.

6. Significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Substantial (300 Points)

1. Serious need for new units affordable to low- and moderate-income persons is shown.

2. Project would create a substantial number of new housing units.

3. There are no major feasibility questions.

4. Benefits a substantial number of persons.

5. Project would affirmatively further fair housing choice through significant

efforts toward the spatial deconcentration of minorities throughout the community, or would provide significant efforts toward spatial deconcentration of low- and moderate-income households if there are no areas of minority concentration.

6. Substantially supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Moderate (200 Points)

1. Serious need is shown, but is not as well documented as in other applications.

2. Project would create new units but not a substantial number.

3. There may be some minor feasibility questions.

4. Benefits a significant number of persons.

5. Project would have some effect of affirmatively furthering fair housing choice by encouraging spatial deconcentration of minorities throughout the community, or would encourage spatial deconcentration of low- and moderate-income households if there are no areas of minority concentration.

6. Moderately supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Minimal (100 Points)

1. Some need is evident, but it is not serious compared to other applications, or is not well documented.

2. Project will create a few new units but not as many as in other applications.

3. There are serious feasibility questions.

4. Benefits a small number of persons.

5. Project would minimally affirmatively further fair housing choice by encouraging spatial deconcentration of minorities throughout the community, or would encourage spatial deconcentration of low- and moderate-income households if there are no areas of minority concentration.

6. Minimally supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Insignificant (0 Points)

1. Very little need has been demonstrated.

2. Project would not provide for new units.

3. There are serious feasibility questions.

4. Benefits a very small number of persons.

5. Project would have no effect of affirmatively furthering fair housing choice through the spatial deconcentration of minorities throughout the community, or would not encourage spatial deconcentration of low- and moderate-income households if there are no areas of minority concentration.

6. Does not support the strategic plan of a designated Empowerment Zone or Enterprise Community.

(iii) *Direct homeownership assistance.* Homeownership activities are defined as activities which would promote homeownership within the applicant jurisdiction, focusing particularly on aiding low- and moderate-income persons in becoming homeowners. While declining to identify any particular type of proposed project as superior, HUD is identifying several criteria which must be addressed within the project design, in order for the application to receive the maximum project impact.

Applications must include a well developed description of homeownership needs in the applicant jurisdiction, focusing particularly on the needs of low- and moderate-income persons. The description also should include, if applicable, any alternative approaches which have been considered in meeting homeownership needs. Project feasibility must be addressed as part of the application.

The application must demonstrate that the proposed project would make effective use of all available funds. This would include any local, State or other Federal funds which would be utilized by the proposed project. If other such funds are included as part of the proposed project, the applicant must demonstrate that such funds are committed and truly available for the project.

Any efforts which would affirmatively further fair housing, by promoting homeownership among minorities as well as homeownership throughout the community, must be outlined in the application.

The application must explain how the project would benefit low- and moderate-income homebuyers, particularly focusing on first-time and minority homebuyers. The application also should address any homeownership counseling services, including counseling pertaining to Federal, State, and local fair housing laws and requirements, which would be provided to persons selected to participate in the proposed project. Finally, the application should describe how the project would utilize public/private partnerships to promote homeownership, particularly in the sense that private sector financing would be accessible, as necessary, to project participants to complement available public sector funds, including CDBG money.

HUD will review each application which meets the threshold against the following criteria:

Maximum (400 Points)

1. Project design is appropriate to meet demonstrated homeownership need and alternative approaches to meeting the need are shown to have been considered. Additionally, there are no feasibility questions regarding the implementation and execution of the proposed project according to the schedule.

2. The application documents serious homeownership needs in the community and the proposed project would make effective use of available funds.

3. The proposed project would affirmatively further fair housing by including initiatives to reach out to potential minority homeowners and by promoting homeownership opportunities throughout the community.

4. The proposed project would target first-time homebuyers.

5. The proposed project would provide homeownership counseling to project participants.

6. The proposed project would complement other Federal, State or local programs which promote homeownership.

7. The proposed project would utilize public/private partnerships in attempting to promote homeownership, particularly in regard to participation by local financial institutions.

8. Significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Substantial (300 Points)

1. Project design demonstrates a workable approach to homeownership assistance needs, and there are no major feasibility questions regarding implementation of the proposed project.

2. Substantial homeownership needs are documented by the application, and the proposed project would make effective use of available funds.

3. The proposed project would affirmatively further fair housing by promoting homeownership opportunities throughout the community.

4. The proposed project would encourage homeownership among first-time homebuyers.

5. The proposed project would encourage local financial institutions to lend to assisted homebuyers.

6. Substantially supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Moderate (200 Points)

1. The proposed project has potential to meet homeownership needs in the community, and there are minor feasibility questions regarding implementation.

2. Homeownership needs in the community are documented, but not as well as in other applications.

3. The proposed project would include efforts to affirmatively further fair housing through homeownership.

4. The proposed project would educate and inform citizens of homeownership assistance available through the project.

5. The proposed project would not include private sector involvement.

6. Moderately supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Minimal (100 Points)

1. There are serious feasibility questions regarding the implementation and execution of the proposed project.

2. The proposed project would have little impact upon homeownership needs in the community.

3. The proposed project would contribute minimally to fair housing in the community.

4. The proposed project would marginally aid first-time homebuyers versus all homebuyers.

5. Minimally supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Insignificant (0 Points)

1. The proposed project has major feasibility questions which would inhibit its implementation and execution.

2. The proposed project does not address identified homeownership needs in the community.

3. The proposed project would not actively affirmatively further fair housing.

4. The proposed project would be of little benefit to first time homebuyers.

5. Does not support the strategic plan of a designated Empowerment Zone or Enterprise Community.

(b) *Program impact—single purpose—public facilities affecting public health and safety.* In the case of public facility projects, documentation of the problem by outside, third-party sources is of primary importance. In the case of water and sewer projects, documentation from public agencies is particularly helpful, especially where such agencies have pinpointed the exact cause of the problem and have recommended courses of action which would eliminate the problem. Such supporting documentation should be as up-to-date as possible: the older the supporting material, the more doubt arises that the need is current and immediate. Applicants also should be sure to indicate how the project would address public health and safety needs and conditions. Quantification also is essential in describing needs. Documentation from those affected should be included.

In order to show that the project is likely to impact upon the problem, the following items should be covered:

(1) Total project costs. Total project costs should be documented by qualified third party estimates, and be as recent as possible.

(2) Source of other funds. To the extent that CDBG funds will not cover all costs, the source of other funds should be identified and committed. If local funds are to be used, the applicant should show both the willingness and the ability to provide the funds.

(3) How the project will solve the problem. The applicant should demonstrate that the project will completely solve the problem and, if applicable, the applicant should address whether the proposal would be satisfactory to other State/local agencies which have jurisdiction over the problem.

(4) Cost effectiveness of the proposal. The applicant should address whether the proposal is the most cost effective and efficient among the possible alternatives considered.

(5) Reasonableness of service area. The applicant should address whether the service area claimed for the project is reasonable, in view of the nature of the proposed project, and if not, the applicant should address what effect a more realistic appraisal would have on overall benefit to low- and moderate-income persons.

(6) Project impact on public health and safety; and

(7) Other applicable feasibility issues have been addressed.

Individual projects often vary in the extent to which they meet the criteria outlined above. Therefore, it is difficult to define precisely those combinations of characteristics which constitute, for example, "maximum" versus "substantial" impact. Not all applications receiving a particular rating will match point-for-point all the criteria in the same way. The following standards will be applied:

Maximum (400 Points)

1. Need is serious, current and requires prompt attention.

2. Program would resolve the problem completely, either through funds requested or with the support of other resources already committed.

3. No other obstacles to timely and effective implementation of the program exist.

4. Benefits a large number of persons when compared to other public facility projects.

5. Demonstrates that the applicant has considered and, as appropriate, will use alternative cost effective methods or material in the execution of the project.

6. Public health and safety concerns are fully resolved by the project.

7. Project would significantly address serious deficiencies in accessibility for disabled persons and/or provide a substantial increase in the number of public facilities accessible to disabled persons.

8. Significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Substantial (300 Points)

1. Serious need is shown.

2. Program would resolve the problem completely.

3. There are no major feasibility questions.

4. Benefits a substantial number of persons.

5. There is evidence that efforts have been made to minimize project costs through use of alternative methods and materials, as appropriate.

6. Public health and safety concerns are substantially resolved by the project.

7. Project would substantially address serious deficiencies in accessibility for disabled persons and/or provide a significant increase in the number of public facilities accessible to disabled persons.

8. Substantially supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Moderate (200 Points)

1. Serious need is shown, but is not as serious or well documented as other applications.

2. Program may not meet the need as completely as in some other applications.

3. There may be some questions relative to feasibility.

4. Benefits a significant number of persons.

5. There is evidence that efforts have been made to minimize project costs.

6. Public health and safety concerns are partially met by the project.

7. Project would somewhat address serious deficiencies in accessibility for disabled persons and/or provide some increase in the number of public facilities accessible to disabled persons.

8. Moderately supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Minimal (100 Points)

1. Some need is evident, but is not serious.
2. Only a portion of the need would be met or the problem would not be resolved completely.
3. There are serious feasibility questions.
4. Benefits only a small number of persons.
5. There is little evidence that efforts have been made to minimize costs.
6. Public health and safety concerns are minimally addressed by the project.
7. Project would minimally address serious deficiencies in accessibility for disabled persons and/or provide a minimal increase in the number of public facilities accessible to disabled persons.
8. Minimally supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Insignificant (0 Points)

1. No clear need has been demonstrated.
2. Program is not appropriate to meeting described needs, or there is serious doubt that there would be much impact on needs.
3. There are major feasibility questions.
4. Benefits a very small number of people.
5. There is no evidence that efforts have been made to minimize project costs.
6. Public health and safety needs are not addressed by the project.
7. Project would not address serious deficiencies in accessibility for disabled persons and/or would not provide an increase in the number of public facilities accessible to disabled persons.
8. Project does not support the strategic plan of a designated Empowerment Zone or Enterprise Community.

(c) *Program impact—single purpose—economic development projects.* As discussed earlier in this section of the NOFA, each individual Single Purpose project will receive a separate impact rating. Applicants whose proposed economic development program will include multiple proposals should determine the most appropriate form of submission. This determination will require a choice as to either the incorporation of all proposals into a single project or the submission of separate projects for each proposal (each transaction will be considered a separate project). The single project format presents an "all or nothing" situation. In determining the appropriate submission format, applicants should consider the ability of a transaction to rate well on its own, based on the magnitude of employment impact, size of the financial transaction and the other factors discussed in this section.

The submission of proposals as separate projects must be clearly designated by the applicant with individual Needs Descriptions, Community Development Activities, Impact Descriptions and Program Schedule forms, including an appropriate name for each project on HUD Form 4124.1.

Section 807(c)(3) of the 1992 Act provides that it is the sense of Congress that each grantee should devote one percent of its grant for the purpose of providing assistance under section 105(a)(23) of the HCD Act to facilitate economic development through commercial microenterprises. A microenterprise is defined as a commercial enterprise with five or fewer employees, one or more of whom owns the enterprise. This should be considered in developing an economic development application.

It is noted that in accordance with section 806 of the 1992 Act, the Department will soon publish a proposed rule relating to evaluation and selection of Economic Development activities by grantees. It is strongly suggested that you read the proposed rule as it reflects the Department's latest proposed policy on the evaluation of Economic Development Projects.

In addition to the standard submission requirements, to receive maximum points, Small Cities applicants must submit information that demonstrates that CDBG funds are needed for the proposed project or activity. HUD will evaluate this material as part of its Eligibility Review prior to considering an application for funding in the FY 1994 competition. The following is a discussion of some of the factors HUD will consider in assessing projects in these key areas:

(i) *The appropriate determination.* HUD requires that economic development activities undertaken with CDBG funds be appropriate to carry out an economic development project. Applicants should attempt to demonstrate that each economic development project has a reasonable likelihood of success.

Applicants must document the financial analysis of the project's need for assistance, as well as public benefit factors that were considered in making its determination that assistance is appropriate. The applicant is expected to provide clear documentation on how the decision was reached.

The written documentation of the financial analysis of the project's need should use the following steps:

1. *Reasonableness of Proposed Costs.*—The applicant must review each project cost element and determine that the cost is reasonable and consistent with third-party, fair-market prices for that cost element. The general principle is that the level of CDBG assistance cannot be adequately determined if the project costs are understated or inflated.

2. *Commitment of Other Sources of Funds.* The applicant shall review all projected sources of funds necessary to complete the project and shall verify that all sources (in particular private debt and equity financing) have been firmly committed to the extent practicable, and are available to be invested in the project. Verification means ascertaining that: the source of funds is committed; that the terms and conditions of the committed funds are known; and the source has the capacity to deliver.

3. *No Substitution of CDBG Funds for Private Sources of Funds.* The applicant shall financially underwrite the project and ensure to the extent possible that CDBG funds are not being substituted for available private debt financing or equity capital. The analysis must be tailored to the type of project being assisted (i.e. real estate, user project, capital equipment, working capital, etc.). Real estate projects require different financial analysis than working capital or machinery and equipment projects. Applicants should ensure that both a significant equity commitment by the for-profit business exists, and that the level of certainty of the end use of the property or project is sufficient to ensure the achievement of national objectives within a reasonable period of time.

4. *Establishment of CDBG Financing Terms.* The amount of CDBG assistance provided to a for-profit business ideally should be limited to the amount, with appropriate repayment terms, sufficient to go forward without substituting CDBG funds for available private debt or cash equity. The applicant should structure its repayment terms so that the business is allowed a reasonable rate of return on invested equity, considering the level of risk of the project. It should be remembered that equity funds generally should bear the greatest risk of all funds invested in a project.

5. *Assessing Public Benefit.* The extent of public benefit expected to be derived from the economic development project must be assessed. While no

standards have been promulgated in a final rule, the assessment of public benefit should consider such factors as the number and type of jobs to be created or retained, in relation to the needs of low- and moderate-income persons who are likely to be employed, the extent to which a business provides essential services to low- and moderate-income neighborhoods, and increases to the tax base including property, sales and income taxes in the area. These factors are not all inclusive.

(ii) *CDBG assistance must minimize business and job displacement.* Each applicant will evaluate the potential of each economic development project for causing displacement of existing businesses and lost jobs in the neighborhood where the project is proposed to be located. When the grantee concludes that the potential exists to cause displacement, given the size, scope or nature of the business, then the grantee must, to the extent practicable, take steps to minimize such displacement. The project file must document the grantee's review conclusions and, if applicable, the steps the grantee will take to minimize displacement.

(iii) *Section 105(a)(17) requirements.* Section 105 (a)(17) of the HCD Act requires that an activity assisted under that section achieve one of the following criteria:

(1) Creates or retains jobs for low- and moderate-income persons (note that a project which meets the national objective of principally benefitting low- and moderate-income persons by creating or retaining jobs, 51 percent of which are for low- and moderate-income persons, will be deemed to have met this criterion without any additional documentation);

(2) Prevents or eliminates slums or blight (note that a project which meets the national objective of aiding in the prevention or elimination of slums or blight on an area basis will be deemed to have met this criterion without any additional documentation);

(3) Meets an urgent need (note that a project which meets the national objective of meeting community development needs having a particular urgency will be deemed to have met this criterion without any additional documentation);

(4) Creates or retains businesses owned by community residents;

(5) Assists businesses that provide goods or services needed by and affordable to low- and moderate-income residents;

(6) Provides technical assistance to promote any of the activities under (1) through (5) of this subsection.

(iv) *National objectives.* As previously stated in this NOFA, all CDBG-assisted activities must address one of the three broad national objectives. Since economic development projects usually result in new employment or the retention of existing jobs, these activities most likely would be categorized as principally benefitting low- and moderate-income persons in this manner. Such projects will be considered to benefit low- and moderate-income persons where the criteria of 24 CFR 570.208(a)(4) are met. HUD will consider an activity to qualify under this provision where the activity involves jobs at least 51 percent of which are taken by or made available to such persons, or retained by such persons. The extent to which the proposed project will directly address employment opportunities for low- and moderate-income persons in the applicant jurisdiction will be a primary factor in HUD's assessment of the proposed program.

In determining whether the person is a low- and moderate-income person for these activities, it is the person's family income at the time the CDBG assistance is provided that is determinative. When making judgments concerning whether an individual qualifies as a low- and moderate-income person, both family size and the income of the entire family must be considered. This consideration is necessary because a low- and moderate-income person is defined as a member of a low- and moderate-income family. The 1992 Act amends the HCD Act by stating that a person may be presumed to be a low- and moderate-income person if the employee resides in a census tract where not less than 70 percent of the residents are low- and moderate-income persons. HUD will also accept a written certification by a person of his or her family income and size to establish low- and moderate-income status. The certification may simply state that the person's family income is below that required to be low- and moderate-income in that area. The form for such certification must include a statement that the information is subject to verification. The application must contain adequate documentation to explain fully, and to support, the process that will be used to ensure that project(s) comply with the low- and moderate-income employment requirements. The documentation must be sufficient to show that the process has been developed and that program participants have agreed to adhere to that process.

(v) *Application requirements.* To the extent feasible, the material listed below should be submitted for economic development projects. The material should be submitted for each proposed activity (e.g., each loan will be considered a separate activity), whether the proposed activity is presented as a separate project or as part of a project involving multiple activities. Since economic development projects are rated against each other, the more completely these submission requirements are met, the greater the potential exists for enhancing the impact score of the project.

1. A letter from each appropriate developmental entity which includes at least the following information:

a. A detailed physical description of the project with a schedule of events and maps or drawings as appropriate.

b. The estimated costs for the project, including any working capital requirements.

c. A discussion of all financing sources, including the need for CDBG, the terms of the CDBG assistance, and the proposed lien structure. The amount, source and nature of any equity investment(s) must also be provided as well as a commitment to invest the equity.

d. A discussion of employment impact which includes a schedule of newly created positions. The schedule should identify the number, salary and skill level of each permanent position to be created. If jobs are made available to low- and moderate-income persons, the applicant must also demonstrate and document how persons from low- and moderate-income households will be accorded first consideration for employment opportunities.

e. A discussion of all appropriate feasibility issues including, but not limited to: site control, zoning, public approvals and permits, impact fees, corporate authorizations, infrastructure, environment and relocation.

f. An analysis and summary of market and other data which supports the anticipated success of the project.

2. A development budget showing all costs for the project, including professional fees and working capital.

3. Documentation to support project costs. Documentation generally should be from a third party source and be consistent with the following guidelines:

a. Acquisition costs should be supported by an appraisal.

b. Construction/renovation costs should be certified by an architect, engineer or contractor. Use of Federal Prevailing Wage Rates should be cited where applicable.

c. Machinery and equipment costs should be supported by vendor quotes.

d. Soft costs (e.g., legal, accounting, title insurance) need be substantiated only where such costs are anticipated to be abnormally high.

4. Letters from all financing sources discussing (at a minimum) the amount and terms of the proposed financing, and the current status of the application for funding.

5. Historical financial data of the development entity, preferably for the last three years. This information may be submitted under separate cover with confidentiality requested. It is recognized that historical financial data may be unavailable or inappropriate for some projects (e.g., start-up companies and real estate transactions).

6. A two-to-five year cash flow pro forma with accompanying notes citing basic assumptions.

7. The applicant's assessment of the project's consistency with the CDBG program eligibility appropriate standards and with the national objectives requirements.

(vi) *Review criteria.* In evaluating and rating economic development projects, HUD will analyze the following factors:

1. *Employment:* The extent to which the proposed project will directly address employment opportunities for low- and moderate-income persons in the applicant's jurisdiction will be a primary factor in HUD's assessment of program impact. Applicants are reminded that for an activity to be consistent with the statutory objective of low- and moderate-income benefit, as a result of the creation or retention of jobs, at least 51 percent of created or retained employment opportunities must be held by, or made available to, persons from low- and moderate-income families. Applicants must fully document and describe employment benefits. In addition, applicants should address the following issues:

a. All employment data must be expressed in terms of full-time equivalents (FTEs). Only permanent jobs may be counted, and applicants must take into account such factors as seasonal and part-time employment. A seasonal job may be considered permanent if the season is long enough to be considered the person's principal occupation; permanent part-time jobs must be converted to the full-time equivalent.

b. The amount of CDBG assistance required to produce each full-time equivalent job will affect the impact assessment by HUD. Lower CDBG costs per job are preferable to higher CDBG costs per job. Such assessments of impact will be done on a comparative basis among all projects submitted, rather than by comparison to a given standard.

c. The use of CDBG funds to assist a business with transferring to a different community will generally be considered as having *no* employment impact. Exceptions to this rule may include an expansion to the business as a result of, or concurrent with, the transfer; or if the business can demonstrate that it is infeasible to continue operations at the current site. If the applicant proposes to assist in a transfer of operations based on an exception to the general rule, HUD should be contacted early in the planning process to discuss the viability of such a proposal. Failure to do so could result in the application receiving 0 impact points.

d. Applicants are encouraged to use CDBG funds for projects that provide as many jobs as possible for individuals that are currently receiving public assistance. Providing employment to recipients of public assistance will help break the cycle of dependency and empower low income citizens to take control of their lives.

2. *Feasibility.* A high-impact rating will not be given to projects that are likely to encounter feasibility issues which would hinder the timely completion of the project. Such issues include, but are not limited to: site control, zoning, public approvals and permits, infrastructure, environment, and relocation. Applicants should address these and any other applicable issues and provide documentation where appropriate.

Applicants also must demonstrate the reasonable likelihood of the project's success, from both a financial and employment standpoint. An analysis or market data, which indicates an inordinate risk in the undertaking of the project, will affect the overall rating of program impact.

3. *Leverage.* Leverage is defined as the amount of private debt and equity to be invested as a direct result of the CDBG-funded activity. Projects which fully conform with those requirements by providing the maximum feasible level of private investment will be considered as having appropriate leverage. The extent of firm commitments for private financing will be reviewed as well as the amount of equity investment. The project will be reviewed to determine whether CDBG funds are replacing private sources of funds. In order to receive maximum impact CDBG funds may not replace private financing, CDBG assistance must be limited to the amount necessary to fund the project without replacing CDBG funds for private funds, and equity funds should bear the greatest risk in the project.

4. *Taxes.* While not a primary factor in the evaluation of impact, projects which will augment the applicant's tax base may have a positive effect on the rating of program impact. It is recognized, however, that good projects do not always result in increased tax revenues due to their nature.

5. *Repayment.* Where CDBG repayments are to be made in some manner to the applicant, the proposed use of those repayments for economic development purposes will be considered.

6. *Cost Reasonableness.* In order to receive a rating greater than the minimal, the costs must be reasonable, i.e. not inflated.

7. *Base Closures.* The Department recognizes that communities facing the loss of a military base may need a well-planned economic development project to help alleviate the effect of the base closure. Well planned projects that will help successfully alleviate the economic impact of base closures will tend to have a high impact and rate well in the competition.

8. *Empowerment Zones/Enterprise Communities.* The Department is supportive of using funds from this NOFA to support projects in designated Empowerment Zones and Enterprise Communities. A project that significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community will receive a maximum impact score provided that the other factors for maximum impact are met.

(vii) *Scoring.* Individual projects often vary in the extent to which they meet the criteria outlined above. It is, therefore, difficult to precisely define those combinations of characteristics which constitute, for example, "maximum" versus "substantial" impact. Not all applications receiving a "maximum" rating will match all the criteria, point by point, in the same manner. The following standards will be applied:

Maximum (400 Points)

1. The analysis of market and other risk data provides reasonable assurance that the project will be successful.

2. The project will have a direct and positive impact on employment opportunities for persons from low- and moderate-income households, and the extent of that impact compares favorably with that of other applicants.

3. All appropriate feasibility issues have been addressed (including the submission of firm private financing commitments) and there is reasonable assurance that the project will be completed in a timely manner.

4. The Public Benefits (e.g., loan repayments, increases to the tax base including property, sales and income taxes to the area, other development likely to be stimulated by the activity) to be derived from the project are considerable relative to other proposals.

5. The infusion of CDBG funds will leverage a substantial investment of private and other dollars.

6. The project costs are reasonable (i.e. not inflated).

7. CDBG funds will not replace private financing, CDBG assistance will be limited to the amount necessary to fund the project without replacing CDBG funds for private funds, and equity funds will bear the greatest risk in the project.

8. Project significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Substantial (300 Points)

The criteria for Maximum (400 Points) is met, with either of the following exceptions:

1. While the project will have a direct and positive impact on employment opportunities for persons from low- and moderate-income households, the extent of that impact is less than that demonstrated by applicants receiving the maximum rating.

2. While there are no major feasibility problems, there are feasibility issues which have not been fully addressed and/or may have a negative effect on timely implementation of the project. However, overall success of the project appears achievable.

In addition:

3. The Public Benefits derived from this project will be greater than that received by the majority of applicants.

4. CDBG funds will leverage more private and/or other public dollars than the majority of projects in the competition.

5. The project costs are reasonable (i.e. not inflated).

6. CDBG funds will not replace private financing, CDBG assistance will be limited to the amount necessary to fund the project without replacing CDBG funds for private funds, and equity funds will bear as great a risk as other project funds.

7. Project significantly supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Moderate (200 Points)

The project presents at least one of the following deficiencies which would affect the appropriateness of CDBG funding:

1. An analysis of the project indicates that the likelihood of the availability of other required financing is questionable.

2. There is a major feasibility issue which is likely to affect completion of the project.

3. The analysis of market and other risk data indicates a likelihood that the project will not create a significant employment impact.

4. The number of employment positions to be created is significantly low and/or the CDBG cost per employment position is significantly high in relation to other applications.

In addition:

5. There will be some Public Benefits resulting from this project.

6. CDBG dollars will leverage a moderate amount of private and/or other public funds relative to other projects.

7. The project costs are reasonable (i.e. not inflated).

8. Project moderately supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Minimal (100 Points)

The project presents at least one of the following serious deficiencies which would affect the appropriateness of CDBG funding:

1. An analysis of the project indicates that other required financing is unlikely to be available.

2. There will be few, if any, Public Benefits resulting from this project.

3. CDBG dollars will leverage little private and/or other public investment in the project.

4. Project minimally supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

Insignificant (0 Points)

The activity presents at least one of the following serious deficiencies which indicates the inappropriateness of CDBG funding:

1. It is clear that the activity cannot be accomplished based on any combination of the following factors:

(1) Major feasibility issues.

(2) Inordinate risk.

(3) Unavailability of required financing.

2. The activity will not have a direct impact on employment opportunities for persons from low- and moderate-income households.

3. The completion of the project will result in no Public Benefits or will be detrimental to the community.

4. No other investment will be triggered by the use of CDBG funds for this activity.

5. Project does not support the strategic plan of a designated Empowerment Zone or Enterprise Community.

(2) *Program impact—comprehensive program grants.* Comprehensive programs must address a substantial portion of the identifiable community development needs of a defined area(s). The extent to which activities are coordinated will be a major consideration in the evaluation of program impact. In defining an appropriate area for comprehensive treatment, applicants should consider the severity of condition within the area and the resources to be provided. The impact is greatest where community development needs will be substantially addressed over a reasonable period of time. Exceptions to the requirement that activities be concentrated within a defined area or areas may be made if the applicant can demonstrate that the proposed program represents a reasonable means of addressing the identified needs.

HUD will assess the impact of the program for each of the four program design criteria selected, based on the factors described below. Applicants must describe fully the extent to which the program will address each criterion selected. HUD will compare all programs which address a particular criterion. The best proposal for that criterion will be the standard by which all others will be judged, although that proposal will not necessarily be awarded a significant impact.

Assignment of Program Impact points for a Comprehensive Grant application is a two-step process. First, the potential of the proposed program of activities to achieve the results intended by each selected criterion when considered in relation to other communities selecting the same criterion is assessed. A numerical value is assigned, based on the following:

The results would have insignificant impact—0 Points
The results would have minimal impact—2 Points
The results would have a moderate impact—4 Points
The results would have a maximum impact—8 points

After each of the four criteria selected by an applicant is rated and a value assigned, the values are summed. A minimum of 12 points will be required at this stage in order for the application to be eligible for further consideration. A score of less than 12 points indicates that the proposed activities would have insufficient impact to warrant funding.

Following this process, the actual points for impact are determined by

dividing each applicant's Program Impact Score by the highest Program Impact Score achieved by any applicant and multiplying the result by 400.

Listed below are the ten design criteria and the standards which HUD has developed to evaluate each criterion. The applicant must select and address four of the criteria. In addition to these standards, the Submission Requirements and Review Criteria for Economic Development Projects under the Single Purpose Program apply in determining the eligibility and rating for economic development proposals that are a part of a Comprehensive Program. It is particularly important that applicants fully address the economic development criteria should Criteria 5 and 6 be selected.

(a) *Criterion 1—Supports Comprehensive Neighborhood Conservation, Stabilization, Revitalization, New Housing Construction or Promotes Homeownership.* The applicant must describe the degree to which the identified needs of a defined area or areas will be addressed in a coordinated manner. In defining an area or areas, applicants should examine carefully the extent of needs and the resources available to address those needs. Where an area has not been defined, the applicant should describe fully the appropriateness of implementing activities on a community-wide basis.

In evaluating the impact of the proposed program, HUD will examine the following factors:

—Nature and severity of neighborhood needs.
—Extent to which needs will be addressed.
—Amount of funds required to implement neighborhood activities.
—Extent to which activities are coordinated to address housing, public facility and economic development needs. Program impact will be the greatest where a substantial portion of the needs within a defined area will be met.
—Extent to which the project promotes fair housing choice in homeownership among protected classes.
—Extent to which the project supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

The strongest consideration for housing rehabilitation programs is given to those applicants which have designed their housing programs by taking into account both structural conditions and appropriate financing mechanisms. The proposed program should be structured in a way to be marketable, given income and structural characteristics of the neighborhood area. The physical needs of residential or mixed use properties must be well stated and documented in terms of substandardness. Applicants will be expected to maximize the leveraging of private funds, encourage the participation of local financial institutions, and develop realistic program guidelines. Private funds available from financial lending sources should be established. If leveraging is infeasible, the applicant must fully document that fact. The most effective housing programs will be those which will address a substantial portion of the identified needs, while maximizing the impact of Federal funds.

For those programs that will support the construction of new residential units, project feasibility will be critical. While the extent of need and number of units to be created will be a primary consideration in evaluating the impact, issues of site control, marketability and assurance of private financing must be addressed, and must be documented.

Homeownership activities will be reviewed in terms of: how effectively the program would meet homeownership needs identified in the community; and the extent to which they would make effective use of available funds.

Public service activities also may be considered in conjunction with other activities under this criterion. Again, any such activities would need to meet demonstrated needs within the community.

The impact of public improvement activities will be assessed primarily on the documented severity of the need and the extent to which the proposed program will address that need. Those needs which directly affect the public safety and welfare will be considered the most severe.

Economic development activities also will be evaluated by the extent to which they will alleviate the identified problems. However, the assessed impact for these activities is often diminished due to feasibility concerns.

In addition to quantifying the extent of the anticipated improvements, applicants must demonstrate that the proposed activities can be carried out—that is, documentation with respect to private participation in such activities must be thorough. Letters of only general interest, by either property owners or other private sector participants, do not necessarily ensure their participation in the program. Some degree of assurance of participation should be presented.

Review Criteria and Submission requirements for Housing described under the Single Purpose Program apply in evaluating and rating housing proposals that are a part of a Comprehensive Program.

(b) *Criterion 2—Provides Housing Choice within the Community either Outside Areas with Concentrations of Minorities and Low- and Moderate-Income Persons or in a Neighborhood which is Experiencing Revitalization and Substantial Displacement as a Result of Private Reinvestment, by Enabling Low- and Moderate-Income Persons to Remain in their Neighborhood.* If a proposed program provides housing choice within the community outside areas with concentrations of minorities and low- and moderate-income persons, the application must document that there are existing areas which do, in fact, contain concentrations of low- and moderate-income families and minorities. The proposed program, if implemented, must result in additional housing assistance being provided in areas of non-concentration. Communities with no minorities or minority concentrations may receive impact points where opportunities are provided outside areas of low- and moderate-income concentration. The degree of impact will be based upon the severity of needs, the number of units to be provided, and the nature and cost of the activities.

In a neighborhood which is experiencing revitalization and substantial displacement as a result of private reinvestment, the applicant must provide a detailed description of the revitalization efforts within the neighborhood, the amount of displacement of low- and moderate-income persons, and the manner in which the implementation of the proposed program will enable displacees to remain in the neighborhood. The degree of needs, nature and cost of activities, and percentage of needs to be addressed will be evaluated to determine program impact.

(c) *Criterion 3—Supports the Expansion of Housing for Low- and Moderate-Income Persons by Providing Additional Housing Units Not Previously Available.* The proposed program clearly must support, or result in, additional units for low- and moderate-income persons. The units may result from the rehabilitation of currently vacant structures, conversion of non-residential structures to residential use, or new construction projects for which the proposed program will provide non-construction

or construction assistance. Where the proposed project involves the use of Federally assisted housing, the applicant must identify and document the current commitment status of the Federal assistance. Lack of a firm financial commitment for assistance may adversely affect program impact. Applicants should address the areas of site control and marketability, in addition to addressing feasibility from the standpoint of project financing. Consideration will not be given to proposed programs which will rehabilitate occupied units or displace current occupants. The impact of the proposed programs will be based upon the degree of needs, the number of units to be created, and the nature and cost of the proposed activities.

(d) *Criterion 4—Addresses a Serious Deficiency in a Community's Public Facilities.* Consideration will be given to the extent of deficiencies, and their relative seriousness, of the identified need. The following factors will be considered:

—Documentation of the seriousness of deficiencies. Appropriate documentation should be provided to substantiate the degree of seriousness. Those deficiencies which directly affect the public safety and welfare will be considered most severe.
—The nature and cost of the proposed activities in relation to the percentage of need to be addressed.
—The extent to which the proposed program will address a variety of deficiencies in public facilities within a defined area.
—Coordination with other activities within the defined area.
—The degree to which the application addresses such feasibility issues, including but not limited to, the validity of cost estimates by qualified sources, the availability of other funds, site control, and environmental constraints.
—The number of persons to benefit.
—The extent to which the project addresses serious deficiencies in accessibility requirements and/or expands the number of accessible public facilities.
—Extent to which the project supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

(e) *Criterion 5—Expands or Retains Employment Opportunities.* Consideration will be given to proposed programs that will result in the creation of new jobs or retention of existing employment opportunities. The following factors will be considered:

—The number of jobs to be created or retained in relation to the identified needs. Documentation should be provided to substantiate the number and type (permanent or seasonal, full or part-time) of job claimed. Letters from local development agencies or expected participants which express more than general interest would be appropriate. With respect to job retention, evidence should be provided to demonstrate that without the proposed program, existing jobs would be lost. The applicant also must address the potential impact of job loss on the community.
—The extent to which CDBG funds are used to leverage private commitments. If leveraging is proposed, applicants should analyze the actual amount of additional funds required to make the project financially feasible. In designing a program to assist existing business expansion or retention, or to encourage new business development, applicants must address whether CDBG funds will be used for infrastructure, land assemblage or other financial incentives. These factors may be important considerations for a firm deciding where to locate and whether to expand or reduce the scope of its operation. CDBG funds may be more effectively used as a loan rather than a grant. In this regard, the CDBG funds would generate additional program resources through loan repayments to the community. It is considered especially advantageous if a revolving loan fund is established and repayments continue to be used to expand or retain employment opportunities.
—The relationship of the activity to other projects being implemented within the defined area.
—The number of persons to benefit.
—Particular attention will be given to the extent to which the Review Criteria and Submission Requirements for Economic Development Projects are addressed (see Single Purpose Program Criteria).
—Extent to which the project supports the strategic plan of a designated Empowerment Zone or Enterprise Community.
—Extent to which the project results in the employment of persons on public assistance.

(f) *Criterion 6—Attracts or Retains Businesses which Provide Essential Services.* Consideration will be given to proposed programs which will address the attraction or retention of businesses commonly associated with neighborhood needs (corner grocery stores, dry cleaners, pharmacies, etc.). The applicant must describe clearly the nature and anticipated impact of activities. Documentation in the form of letters from existing or new potential businesses offering a commitment to the program should be included. (Letters of only general interest by property owners do not necessarily ensure their participation in the program, or their willingness to secure debt if private lending is proposed). The following factors will be considered:

—The impact of the proposed program in relation to the identifiable neighborhood needs. The extent of area stability must be documented. In describing the needs of a business district or neighborhood commercial area, such factors as overall structural conditions, business turnovers, and vacancy rates over a period of time should be clearly presented. The formulation of a commercial revitalization program must be based on a thorough assessment of local needs and a realistic program design. An important consideration is whether the proposed program is designed to be marketable given income characteristics, local business condition, etc. The condition of supporting public facilities and improvements and their influence on the business environment must be established. If public improvements are proposed in connection with economic expansion or retention, applicants must address the extent to which the lack of these improvements impact on business.
—Attraction/retention must be fully documented by the applicant. With respect to business retention, evidence should be provided to demonstrate clearly and objectively that without the proposed CDBG Program, existing retail/commercial businesses would curtail their operations. The applicant also must document and address the potential impact of the business loss on the community and/or target area. HUD would accept as examples of clear and objective evidence a notice issued by the business to affected employees, a public announcement by the business, or financial records provided by the business that clearly indicate the need for closing or moving all or portions of the business out of the area.
—The amount of private funds to be leveraged. If leveraging is proposed, applicants should analyze the actual amount of private or public funds needed to make the project financially feasible. In this regard, the establishment of a revolving loan fund, in which repayments would

continue to be used to attract or retain businesses providing essential services, would be considered a positive factor.
—The relationship of the activity to a comprehensive approach to meeting the overall needs of the neighborhood area.
—The impact of the proposed program in utilizing minority, women-owned, and project area businesses.
—Extent to which the project supports the strategic plan of a designated Empowerment Zone or Enterprise Community.
—Extent to which the project results in the employment of persons on public assistance.

(g) *Criterion 7—Removes Slums or Blighting Conditions.* Consideration will be given to proposed programs which will have a direct impact on the removal of slums or blighting conditions. Appropriate areas may include, but are not limited to, deteriorated residential or commercial structures, inappropriate land uses, or blighting conditions, such as repeated flooding and drainage problems or serious deficiencies in public facilities. Applicants should be aware that slum and blight activities can be carried out under the national objective of benefit to low- and moderate-income persons. If an applicant elects to qualify the activity on this basis, the degree of low- and moderate-income benefit must be demonstrated by the applicant.

Where residential or commercial rehabilitation activities are proposed as preventing or eliminating blighting conditions, the application must clearly document the number, type, and condition of deteriorating or deteriorated buildings in the designated target area. Detailed conditions of the physical condition of buildings or structures would be appropriate to establish the extent of substandard and blighting conditions. For rehabilitation of residential structures to be designed as eliminating blight and addressing an area's deterioration, the buildings must be considered substandard under local definition.

When an area is determined to be blighted, there must be a substantial number of deteriorated or dilapidated buildings, or the public improvements throughout the area must be in a state of deterioration. The proposed CDBG program or project must be designed to eliminate or address a substantial portion of the identified blighting conditions or physical decay. CDBG assistance for facilities or structures which are in good repair and show no real signs of deterioration would not score well under this criterion. For instance, minor facade improvements to a commercial building alone would not indicate that a building is in poor condition. However, assistance to a commercial area which consists of deteriorating businesses, storefronts in serious need of rehabilitation, a high vacancy factor, and public improvements, such as parking areas and parking access improvements which are in need of physical upgrading, would have a direct impact on eliminating blighting conditions. Public improvements that are so deteriorated that they constitute a genuine threat to the continued viability of an area by discouraging private investment necessary to maintain properties may also be considered a blighting influence. The following factors will be considered:
—Extent and documented seriousness of conditions/needs. References to engineering studies, surveys or letters from appropriate local agencies should be included.
—Impact of the proposed program in relation to providing long-term permanent solutions to alleviate the identified need. Short-term or superficial improvements will not be considered to have a significant impact.
—Coordination with other projects and activities which will address needs within the defined area.
—Nature of any proposed re-use: degree of commitment for re-use.
—Extent to which the project supports the strategic plan of a designated Empowerment Zone or Enterprise Community.

(h) *Criterion 8—Resolves a Serious Threat to Health or Safety.* The applicant must describe the condition which poses a threat to public health and safety. A serious threat refers to a situation which demands immediate attention. This may be a condition that has just occurred or a condition which, though long standing, has intensified to become an immediate danger.

Applicants should be aware that imminent threat/urgent need activities can be carried out under the national objective of benefit to low- and moderate-income persons. If an applicant elects to qualify the activity on this basis, the degree of low- and moderate-income benefit must be demonstrated by the applicant. Consideration will be given to the following:
—The extent to which a serious threat to health or safety is documented, or of recent origin, or which recently became urgent. Documentation should include the identification of the existing conditions by appropriate agencies.
—The extent to which the serious threat will be resolved.
—The submission of documentation which demonstrates that other financial resources are insufficient or unavailable to resolve such needs.
—The degree to which the application addresses issues such as the validity of cost estimates by qualified sources; the availability of other funds; site control and environmental conditions; or other public body approvals.
—The number of persons to benefit, as well as the number of individuals actually threatened.

Note: This criterion is generally more restrictive than Criterion 4. The existing condition must pose a serious and immediate threat to the health or welfare of the target population.

(i) *Criterion 9—Supports Other Federal or State Programs Being Undertaken in the Community or Deals with the Adverse Impact of Another Recent Federal or State Action. The Other Federal or State Program or Action Must Be of Substantial Size or Impact in the Community in Relation to the Proposed Program.* The application must contain a complete description of the Federal or State Program(s) (excluding other CDBG Programs) which currently are underway, or a complete description of the adverse impact of a recent Federal or State action (e.g. the closing of a military base). A Federal or State program or action not yet initiated will be considered only where the application provides documentation establishing the certainty of, and the approximate commencement date of, the described program or action.

The proposed CDBG Program must demonstrate clearly the magnitude of the effect of the Federal or State Program or action on the community. The degree to which the proposed CDBG Program will support the Federal or State Program, and/or the extent to which the adverse impact of Federal or State action will be mitigated, also must be demonstrated.

In addition to the above, the nature and costs of the proposed activities will be considered in determining the degree of impact.

(j) *Criterion 10—Supports Energy Production or Conservation.* This criterion will be judged, and points will be awarded, based upon the community's ability to demonstrate that the proposed program will support energy production or conservation. Applicants are urged to develop

innovative approaches toward addressing energy needs with Small Cities CDBG funds. Energy considerations can be a factor in most activities proposed by smaller communities. Attention should focus on new methods of producing energy or conserving energy where possible. In developing and evaluating proposals, there are a number of energy aspects to consider. The following factors will be considered:

—Cost efficiency—Relationship of dollar amount to benefits to be derived. The applicant must document estimates of energy costs which are to be saved as a result of the proposed program. The proposed program should make maximum use of non-CDBG resources as well as CDBG funds. Appropriate documentation must be provided to ensure that the proposal is economically feasible.

—The extent to which the proposed program will support other programs currently aimed at addressing energy production or conservation needs of the community. From a management standpoint, proposed projects should be consistent with needs or objectives of any plan for energy management or conservation. Applicants should pursue the availability of other resources from Federal or State energy related programs. The degree of commitment of other resources should be established. State energy offices, private as well as municipally-owned utility companies, and home heating oil companies may be appropriate entities to be involved in the development and planning of proposals.

—The application should address whether the project is based on appropriate technology, materials and methods to maximize energy conservation. Engineering reports or studies would be appropriate evidence to support the overall feasibility of the project. The conversion of existing facilities, where appropriate, rather than proposing new construction may be more economical.

—While housing rehabilitation programs which include weatherization/winterization components will be considered, they generally will not be presumed as addressing a severe need unless unique conditions are specifically identified and cost savings are properly documented.

d. *Fair Housing and Equal Opportunity Evaluation.* Documentation for the 65 points for these items is the responsibility of the applicant. Claims of outstanding performance must be based upon actual accomplishments. Clear, precise documentation will be required. Maps must have a census tract or block numbering area (BNA), and they must be in accordance with the 1990 Census data. Additionally, maps must identify the locations of areas with minorities by census tract or BNA. If there are no minority areas, state so on the map. Only population data from the 1990 Census will be acceptable for purposes of this section.

Please note that a "minority" is a person belonging to, or culturally identified as, a member of any one of the following racial/ethnic categories: Black, Hispanic, Asian or Pacific Islander, and American Indian or Alaskan Native. For the purposes of this section, the separate category—"women" —is not considered a minority.

Counties claiming points under this criterion must use county-wide statistics (excluding entitlement communities). In the case of joint applications, points will be awarded based on the performance of the lead entity only.

The following factors will be used to judge outstanding performance in these areas. Please note that the criteria are the same for Comprehensive and Single Purpose applicants, and that points for outstanding performance may be claimed under each criterion:

(1) *Housing Achievements* (40 points total). (a) 20 Points—Provision of Assisted Housing—Providing assisted housing for low- and moderate-income families, located in a manner which provides housing choice in areas outside of minority, or low- and moderate-income concentrations.

Points will be awarded where both of the following criteria are met:

(i) More than one-third of the housing assistance provided by the applicant in the last five (5) years (excluding Section 8 existing and housing assistance provided in place) has been in Census Tracts (CT) or Block Numbering Areas (BNA) having a percentage of minority population which is less than the minority population in the community as a whole; and

(ii) With regard to the Section 8 Existing Program, a community must show the location (CT or BNA) of its currently occupied family units by race/ethnicity. Points will be awarded if more than one-half of the minority assisted families occupy units in areas which have a lower percentage of minority population than that of the community as a whole.

A community with no minorities must show the extent to which its assisted housing is located outside areas of concentrations of low- and moderate-income persons. In order to receive points under this criterion, applicants should follow the process outlined in (i) and (ii) above, substituting low- and moderate-income persons and families for minority persons or families. Applicants addressing the first criterion must use a map indicating the location of all assisted housing and a narrative which indicates the number of units and the type of assisted housing. The map also must show the general location of low- and moderate-income households and minority households, giving the numbers and percentages for both.

To qualify as housing assistance provided, the units being claimed must be part of a project located outside minority or lower income concentrated areas which has, at a minimum, received a firm commitment from the funding agency.

(iii) Points also may be awarded for efforts which enable low- and moderate-income persons to remain in their neighborhood when such neighborhoods are experiencing revitalization and substantial displacement as a result of private reinvestment. Applicants requesting points under this criterion would not need to meet the requirements of (i) and (ii) in order to receive points. Points will be awarded where more than one half of the families displaced were able to remain in their original neighborhood through the assistance of the applicant. Applicants must show that:

—the neighborhood experienced revitalization;

—the amount of displacement was substantial;

—displacement was caused by private reinvestment;

—low- and moderate-income persons were permitted to remain in the neighborhood as a result of action taken by the applicant.

If the community is inhabited predominantly by persons who are members of minority and/or low-income groups, points will be awarded where there is a balanced distribution of assisted housing throughout the community.

(b) 20 Points - Implementation of a HUD-approved New Horizons Fair Housing Assistance Project or a Fair Housing Strategy that is equivalent in scope to a New Horizons Project.

The applicant must demonstrate that it is implementing a HUD-approved New Horizons Fair Housing Assistance Project or demonstrate participation in a HUD-approved county/State/regional New Horizons Project; or that the

applicant is implementing a fair housing strategy that is equivalent in scope to a New Horizons Project. If the applicant is implementing a New Horizons Project, it must include:

—the date it was approved (by HUD); and
—those actions taken to implement the plan.

If the applicant is implementing an equivalent fair housing strategy, it must include:

—the strategy being implemented;
—those actions taken to implement the strategy.

Please note that a fair housing strategy must include the four elements of a New Horizons Project in order to be considered equivalent in scope:

—Local compliance activities;
—Educational programs to enhance the clarity and understanding of the community's fair housing policy. For communities with few or no minorities, this should include publication in the surrounding communities of the applicant's policy of fair housing for minorities and the disabled;
—Assistance to minority families; and
—Special programs (e.g. utilization of Community Housing Resource Board (CHRB) Programs, efforts to encourage local realtors to enter into voluntary agreements to encourage equal access to financial institutions, etc.).

The fair housing strategy must include goals for each of the above elements. The date of adoption or development of the strategy should be indicated, as well as the date proposed activities will be or have been implemented.

(2) *Entrepreneurial Efforts and Local Equal Employment* (25 points total). Applicants may request points for both of these subfactors and must use the format sheets included in the application.

(a) *Minority Contracting.* 15 points—Outstanding performance points will be given to those applicants who have demonstrated that they have utilized minority businesses to the following degree. The applicant must demonstrate that at least five percent of all its contracts, based on dollar value, have been awarded within the past two years to minority owned and controlled businesses (businesses that are at least 50 percent owned by minorities) provided that the minority population is five percent or less. If the minority population exceeds five percent, then the applicant must have a corresponding percentage of its contracts awarded to minority businesses; however, 20 percent of the total dollar value of its contracts will be sufficient for award of points for any applicant. The applicable percentage of minority population is the percentage of minorities in the applicant's jurisdiction, or is the county percentage, whichever is higher.

The applicant must provide the information as outlined in the suggested format, showing the name, address, telephone number, contract date and contract amount for each contract or subcontract with a minority business. This information is to be provided in addition to information required on the HUD Form 4124.4, and should be for the two-year period ending February 1, 1994.

(b) *Equal Opportunity Employment.* 10 points—In order to be considered for points, if claimed, the applicant must document that its percentage of minority, permanent full-time employees is greater than the percentage of minorities within the county or the community, whichever is higher. Applicants with no full-time employees may claim points based on part-time employment provided that they document that the only permanent employment is on a part-time basis.

II. Application and Funding Award Process

A. Obtaining Applications.

Application kits may be obtained from either HUD's New York or Buffalo Offices. Applicants in New York, in the counties of Sullivan, Ulster, Putnam, and in non-participating jurisdictions in the urban counties of Dutchess, Orange, Rockland, Westchester, Nassau, and Suffolk should submit applications to the New York Office. All other nonentitled communities in New York State should submit their applications to the Buffalo Office. The appropriate addresses for HUD's New York and Buffalo offices are: Department of Housing and Urban Development, Office of Community Planning and Development, Attention: Small Cities Coordinator, 26 Federal Plaza, New York, NY 10278–0068, Telephone (212) 264–6500, or Department of Housing and Urban Development, Community Planning and Development Division, Attention: Small Cities Coordinator, 465 Main Street, Lafayette Court, Buffalo, NY 14203, Telephone (716) 846–5768.

B. Submitting Applications

A final application must be submitted to HUD no later than July 26, 1994. A final application includes an original and two photocopies. In accordance with HUD's regulation at 24 CFR 570.443(a)(1), final applications may be mailed, and if they are received after the deadline, must be postmarked no later than midnight, July 26, 1994. If an application is hand-delivered to either the New York or Buffalo Offices, the application must be delivered by 4:00 p.m. on the application deadline date. Applications must be submitted to the appropriate HUD office at the address listed above in Section A.

The above-stated application deadline is firm as to date and hour. In the interest of fairness to all competing applicants, the Department will treat as ineligible for consideration any application that is not received on, or postmarked by July 26, 1994. Applicants should take this practice into account and make early submission of their materials to avoid any risk of loss of eligibility brought about by unanticipated delays or other delivery-related problems.

C. The Application

An application for the Small Cities Program CDBG Grants is made by the submission of:

(1) a completed HUD Form 4124, including HUD Forms 4124.1 through 4124.6 and all appropriate supporting material;

(2) a completed Standard Form 424;

(3) a signed copy of certifications required under the CDBG Program, including, but not limited to the Drug-Free Workplace Certification, and the Certification Regarding Lobbying pursuant to section 319 of the Department of Interior Appropriations Act for Fiscal Year 1990 (31 U.S.C. 1352), generally prohibiting use of appropriated funds, and, if applicable, Disclosure of Lobbying Activities (SF–LLL);

(4) Form HUD–2880, Applicant/Recipient Disclosure/Update Report, as required under subpart C of 24 CFR part 12, Accountability in the Provision of HUD Assistance; and if applicable,

(5) CHAS or "abbreviated strategy".

D. Funding Award Process

In accordance with section 102 of the Reform Act and HUD's regulation at 24 CFR 12.16, HUD will notify the public by notice published in the **Federal Register** of all award decisions made by HUD under this competition. In accordance with the requirements of section 102 of the Reform Act and HUD's regulations at 24 CFR part 12, HUD also will ensure that documentation and other information regarding each application submitted under this notice of funding availability is sufficient to indicate the basis upon which assistance was provided or

denied. Additionally, in accordance with § 12.14(b) of these regulations, HUD will make this material available for public inspection for a period of five years, beginning not less than 30 calendar days after the date on which assistance is provided.

III. Technical Assistance

Prior to the application deadline, the Buffalo and New York offices will provide technical assistance on request to individual applicants, including explaining and responding to questions regarding program regulations, and defining terms in the application package. In addition, HUD will conduct informational meetings around the State to discuss the Small Cities Program, and will conduct application workshops in conjunction with these meetings. Please contact either the New York or Buffalo Office for further information regarding these meetings. Application kits will be available at these meetings, as well as from the HUD offices previously identified in Section II of this NOFA, and will also be available at the informational meetings. In order to ensure that the application deadline is met, it is strongly suggested that applicants begin preparing their applications immediately and not wait for the informational meetings.

In order to be considered for funding, complete applications (an original and two photocopies of the entire application) must be physically received by the appropriate HUD office on July 26, 1994, by 4 p.m. or, if mailed, postmarked no later than midnight, July 26, 1994. Applications must be delivered or mailed to the appropriate HUD office at the address indicated in Section II.

IV. Checklist of Application Submission Requirements

The following checklist is intended to aid applicants in determining whether their application is complete:

Application Completeness Checklist

Applicant: _____

Comprehensive Grant _____ Single Purpose Grant _____

Amount Requested $_____

1. Is amount of funds requested within established maximum?

2. Part I—Needs Description (HUD Form 4124.1)

(a) Single Purpose Grants

i—Program Area

_____ Housing
_____ Target Area
_____ Non-target Area
_____ Public Facilities
_____ Economic Development (If an "appropriate" analysis is required but is not included, the application cannot be rated.)

ii—Is description of community development needs included in application?

(b) Comprehensive Grants

i—Have four design criteria been selected and discussed in application?

ii—Is description of community development needs included in application?

3. Part II—Community Development Activities (HUD Form 4124.2)

(a) Has national objective been identified for each activity?

(b) Will 70 percent of grant funds primarily benefit low- and moderate-income persons? (If not, the application cannot be rated.)

4. Part III—Impact Description (HUD Form 4124.3)

5. Part IV—Outstanding Performance (HUD Form 4124.4)

6. Part V—Program Schedule (HUD Form 4124.5)

7. Part VI—Maps

(a) Location of proposed activities. (Applicants must show the boundaries of the defined area or areas.)

(b) Location of areas with minorities by census tract. (If there are no minority areas, state so on the map.)

(c) Housing conditions if project involves housing rehabilitation. (Number and location of each standard and substandard unit should be clearly identified.)

8. (a) Is Standard Form 424 complete?

Yes No

(b) Is original signature on at least one copy?

Yes No

9. Is Certification signed with original signature?

Yes No

10. If housing activities have been proposed as part of application, has the Comprehensive Housing Affordability Strategy (CHAS) been prepared and submitted to HUD (or included with this application)?

11. Form HUD–2880, Application/Recipient Disclosure/Update Report, as required under subpart C of 24 CFR part 12.

V. Corrections to Deficient Applications

Under no circumstances will HUD accept from the applicant unsolicited information regarding the application after the application deadline has passed.

HUD may advise applicants of technical deficiencies in applications and permit them to be corrected. A technical deficiency would be an error or oversight which, if corrected, would not alter, in either a positive or negative fashion, the review and rating of the application. Examples of curable technical deficiencies would be a failure to submit the proper certifications or failure to submit an application containing an original signature by an authorized official. Situations not considered curable would be, for example, a failure to submit program impact descriptions.

HUD will notify applicants in writing of any curable technical deficiencies in applications. Applicants will have 14 calendar days from the date of HUD's correspondence to reply and correct the deficiency. If the deficiency is not corrected within this time period, HUD will reject the application as incomplete.

Applicants should note that if a CHAS is required in support of a housing activity, the failure to submit a CHAS in a timely manner is not considered a curable deficiency.

VI. Other Matters

Environmental Impact

A Finding of No Significant Impact with respect to the environment was made in accordance with HUD regulations at 24 CFR part 50, implementing section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332) at the time of development of the FY 1993 NOFA for this program. Because no substantive programmatic changes have been made, that Finding remains applicable to this NOFA and is available for public inspection and copying between 7:30 am and 5:30 pm weekdays at the Office of the Rules Docket Clerk, 451 Seventh Street, SW, Room 10276, Washington, DC 20410.

Federalism

The General Counsel, as the Designated Official under section 6(a) of Executive Order 12612, Federalism, has determined that this NOFA will not have substantial, direct effects on States, on their political subdivisions, or on their relationship with the Federal Government, or on the distribution of power and responsibilities between them and other levels of government. While the NOFA will provide financial assistance to the Small Cities Program of New York State, none of its provisions will have an effect on the relationship between the Federal Government and New York State, or the State's political subdivisions.

Family

The General Counsel, as the Designated Official for Executive Order 12606, The Family, has determined that the policies announced in this NOFA would not have the potential for significant impact on family formation, maintenance and general well-being within the meaning of the Order. No significant change in existing HUD policies and programs will result from issuance of this NOFA, as those policies and programs relate to family concerns.

Accountability in the Provision of HUD Assistance

See Section I.A.4 of this NOFA.

Prohibition Against Lobbying Activities

The use of funds awarded under this NOFA is subject to the disclosure requirements and prohibitions of section 319 of the Department of Interior and Related Agencies Appropriations Act for Fiscal Year 1990 (31 U.S.C. 1352) and the implementing regulations at 24 CFR part 87. These authorities prohibit recipients of Federal contracts, grants, or loans from using appropriated funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a specific contract, grant, or loan. The prohibition also covers the awarding of contracts, grants, cooperative agreements, or loans unless the recipient has made an acceptable certification regarding lobbying. Under 24 CFR part 87, applicants, recipients, and subrecipients of assistance exceeding $100,000 must certify that no Federal funds have been or will be spent on lobbying activities in connection with the assistance.

Indian Housing Authorities (IHAs) established by an Indian tribe as a result of the exercise of the tribe's sovereign power are excluded from coverage of the Byrd Amendment, but IHAs established under State law are not excluded from the statute's coverage.

Prohibition Against Lobbying of HUD Personnel

Section 13 of the Department of Housing and Urban Development Act (42 U.S.C. 3537b) contains two provisions dealing with efforts to influence HUD's decisions with respect to financial assistance. The first imposes disclosure requirements on those who are typically involved in these efforts—those who pay others to influence the award of assistance or the taking of a management action by the Department and those who are paid to provide the influence. The second restricts the payment of fees to those who are paid to influence the award of HUD assistance, if the fees are tied to the number of housing units received or are based on the amount of assistance received, or if they are contingent upon the receipt of assistance. HUD's regulation implementing section 13 is codified at 24 CFR part 86. If readers are involved in any efforts to influence the Department in these ways, they are urged to read the final rule, particularly the examples contained in Appendix A of the rule. Appendix A of this rule contains examples of activities covered by this rule.

Any questions concerning the rule should be directed to the Office of Ethics, room 2158, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington DC 20410–3000. Telephone: (202) 708–3815 (voice/TDD). (This is not a toll-free number.) Forms necessary for compliance with the rule may be obtained from the local HUD office.

Prohibition Against Advance Information on Funding Decisions

Section 103 of the Reform Act proscribes the communication of certain information by HUD employees to persons not authorized to receive that information during the selection process for the award of assistance that entails a competition for its distribution. HUD's regulations implementing section 103 are codified at 24 CFR part 4, and recently were amended by an interim rule published in the **Federal Register** on August 4, 1992. In accordance with the requirements of section 103, HUD employees involved in the review of applications and in the making of funding decisions under a competitive funding process are restrained by 24 CFR part 4 from providing advance information to any person (other than an authorized employee of HUD) concerning funding decisions, or from otherwise giving any applicant an unfair competitive advantage.

Persons who apply for assistance in this competition should confine their inquiries to the subject areas permitted by 24 CFR part 4. Applicants who have questions should contact the HUD Office of Ethics (202) 708–3815 (voice/TDD). (This is not a toll-free number.)

Dated: May 24, 1994.

Andrew Cuomo,

Assistant Secretary for Community Planning and Development.

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