Sunshine Act Meetings

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Thursday, September 1, 1994

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

U.S. COMMISSION ON CIVIL RIGHTS

DATE AND TIME: Friday, September 9, 1994.

PLACE: U.S. Commission on Civil Rights, 624 Ninth Street, NW, Room 540, Washington, DC 20425.

STATUS: Open to the Public.

Agenda

I. Approval of Agenda
II. Approval of Minutes of June Meeting
III. Announcements
IV. Staff Director's Report
V. Approval of The Fair Housing Amendments Act of 1988—The Enforcement Report
VI. State Advisory Committee Appointments for Alabama, Colorado, Kansas, Kentucky, and Pennsylvania
VII. State Advisory Committee Reports
- Campus Tensions in Connecticut: Searching for Solutions in the Nineties (Connecticut)
- Race Relations in Pemiscot County (Missouri)
- Police Protection of the African American Community in Milwaukee (Wisconsin)
- The Employment of Minorities and Women in Wyoming State Government (Wyoming)

VIII. New York Hearing Briefing
IX. Future Agenda Items

Hearing impaired persons who attend the meeting and require the services of a sign language interpreter, should contact Betty Edmiston, Administrative Services and Clearinghouse Division (202) 376–8105 (TDD 202–376–8116) at least five (5) working days before the scheduled date of the hearing.

CONTACT PERSON FOR FURTHER INFORMATION: Barbara Brooks, Press and Communications (202) 376–8312.

Dated: August 30, 1994.

Emma Monroig,

Solicitor.

[FR Doc. 94–21756 Filed 8–30–94; 12:05 pm]

BILLING CODE 6335–01–M

NATIONAL CREDIT UNION ADMINISTRATION

Notice of Previously Held Emergency Meeting

TIME AND DATE: 10:40 a.m., August 29, 1994.

PLACE: Board Room, 7th Floor, Room 7047, 1775 Duke Street, Alexandria, Virginia 22314–3428.

STATUS: Closed.

MATTER CONSIDERED:

1. Administrative Action under Section 206 of the Federal Credit Union Act. Closed pursuant to exemptions (8), (9)(A)(ii), and (9)(B).

The Board voted unanimously that Agency business required that a meeting be held with less than the usual seven days advance notice and that it be closed to the public. Earlier announcement of this was not possible.

The Board voted unanimously to close the meeting under the exemptions stated above. General Counsel Robert Fenner certified that the meeting could be closed under those exemptions.

FOR MORE INFORMATION CONTACT: Becky Baker, Secretary of the Board, Telephone (703) 518–6304.

Becky Baker,

Secretary of the Board.

[FR Doc. 94–21712 Filed 8–30–94; 8:47 am]

BILLING CODE 7535–01–M

federal register

Thursday
September 1, 1994

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 412, et al.

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and FY 1995 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 466, 482, 485 and 489

[BPD–802–FC]

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: Final rule with comment period.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In addition, in the addendum to this final rule, we are describing changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes are applicable to discharges occurring on or after October 1, 1994. We are also setting forth rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems. Finally, we are revising the criteria used by the Medicare Geographic Classification Review Board (MGCRB) to decide on applications by hospitals for geographic reclassification for prospective payment purposes.

DATES: Effective Date: This final rule with comment period is effective on October 1, 1994, except that the changes to § 412.230 (concerning the geographic reclassification criteria used by the MGCRB) are effective on September 1, 1994.

Comments: Comments on the revisions to the criteria for geographic reclassification by the MGCRB will be considered if we receive them at the appropriate address, as provided below, no later than October 31, 1994. We will not consider comments concerning any other issues.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–802–FC, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (1 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–FC. 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).

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) 512–2250. 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**.

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. Summary of the Provisions of the May 27, 1994 Proposed Rule

On May 27, 1994, we published a proposed rule in the **Federal Register** (59 FR 27708) to amend the prospective payment systems for operating costs and capital-related costs as follows:

- We proposed changes for FY 1995 DRG classifications and weighting factors as required by section 1886(d)(4)(C) of the Act. This section requires that we adjust the DRG classifications and relative weights at least annually.
- We proposed to revise the methodology for computing the wage index and to update the wage data. Specific issues addressed included updating the wage index for FY 1995, changes in the reporting of hospital wage index data, revising the wage index based on hospital redesignations, the impact of the revised hospital wage index, occupational mix adjustment, research on refinements to labor market areas, and State labor market options.
- We discussed several provisions of the regulations in 42 CFR parts 412, 413,

485, and 489 concerning the prospective payment system for inpatient operating costs. The proposed changes concerned 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.

• We discussed several provisions of the regulations in 42 CFR parts 412 and 413 concerning the prospective payment for capital-related costs. The proposed changes concerned 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.

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

• In the addendum to the 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 also proposed 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.

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

• In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 1995 capital acquisition model and budget neutrality adjustment.

• In Appendix C of the proposed rule, we set forth our initial estimate of a recommended update factor for FY 1995 for both prospective payment hospitals and hospitals excluded from the prospective payment system, as required by section 1886(e)(3)(B) of the Act.

• In Appendix D of the proposed rule, we provided our recommendation of the appropriate percentage change for FY 1995, as required by sections 1886(e)(4) and (e)(5) of the Act, for the following:

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

• In Appendix E of the proposed rule, we set forth a preliminary framework for developing the annual update factor for inpatient hospital capital-related costs.

In the May 27, 1994 proposed rule, we also discussed in detail the March 1, 1994 recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(e)(2)(A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average standardized amounts. 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 discharges, 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 printed ProPAC's March 1, 1994 report, which includes its recommendations, as Appendix F of the proposed rule. The recommendations, and the actions we proposed to take with regard to them (when an action is recommended), were discussed in detail in the appropriate sections of the preamble, the addendum, or the appendices of the proposed rule.

Set forth below in sections II, III, IV, V, VI, VII, and VIII of this preamble, the addendum to this final rule, and the appendices, are detailed discussions of the May 27, 1994 proposed rule, the public comments received in response to the proposed rule, and the responses to those comments, as well as any changes we are making.

We note that the proposed rule included an extensive discussion of our research concerning refinements to the labor market areas that are used to construct the hospital wage index. Comments on this issue were due on August 31, 1994, and we intend to discuss the comments and respond to them in the FY 1996 prospective payment system proposed rule.

C. Public Comments Received in Response to the May 27, 1994 Proposed Rule

A total of 1339 items of correspondence containing comments on the May 27, 1994 proposed rule were received timely. The main areas of concern addressed by commenters were the following:

• Changes in the reporting of hospital wage index data.
• Definition of and payment for transfer cases.
• New exclusion criteria for long-term care hospitals.
• Revisions to the capital exceptions policy.
• Requests for changes in DRG classifications and relative weights.

II. 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 changes to the DRG classification system and the 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.

We proposed to make several changes to the DRG classification system for FY 1995. These proposed changes and the comments we received concerning them, as well as our responses to those comments and the final DRG changes, 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] As discussed in the proposed rule, we 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 proposed 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. The proposed FY 1995 relative weights of DRGs 46, 47, and 48 (0.7573, 0.4330, and 0.4182, respectively) were approximately equal to those of DRGs 283 and 284 (0.7142 and 0.4358, respectively). Therefore, we proposed to move diagnosis code 694.1 to DRGs 283 and 284. We received only one comment on this proposal, which supported our change. Thus, we are incorporating our proposal in this final rule.

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 evaluate 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.

In the proposed rule, we stated that we had not yet completed this evaluation, so we did not propose MDC 15 revisions for FY 1995. However, we discussed 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

[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.

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 either are 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 proposed to add them to the list of secondary diagnoses that would assign an otherwise normal newborn to DRG 391.

We also reevaluated perinatal jaundice (diagnosis codes 774.0 through 774.7) and its DRG assignments in response to suggestions we received. 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 did not believe that 774.6 should be assigned to DRG 391 when all the other perinatal jaundice codes are considered major problems. Others 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 proposed 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 were based only on clinical considerations and responded 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.

Comment: We received two comments regarding these proposed changes. One commenter supported all of the changes; the other commenter supported the reassignment of diagnosis codes 752.5, 795.4, V05.3, V05.4, and V20.1 from DRG 390 to DRG 391, but disagreed with the proposed changes to the classification of the perinatal jaundice codes. This commenter stated that perinatal jaundice frequently involves significant testing and prolonged hospitalization and that classification changes to these diagnoses should be delayed until HCFA completes the evaluation of the newborn and neonate DRGs.

Response: Under our proposal, two perinatal jaundice diagnoses remain on the major problems list (codes 774.4 and 774.7) and three remain on the significant problems list (codes 774.0, 774.1, and 774.2). The diagnoses that have been redesignated from the major and significant problems list are conditions that are not considered to be clinically significant. That is, our medical staff do not believe that these conditions require the expenditure of significant additional resources by the hospital for treatment.

We note that under the New York All-Patient (AP) DRGs, the only perinatal jaundice conditions considered to be major problems are 774.4 and 774.7. This is consistent with our proposal. In addition, of the remaining codes, only 774.2 is considered a significant problem. The remaining perinatal jaundice codes are not considered problems for newborns under the AP-DRGs. Since New York uses the AP-DRGs to classify and pay hospitals for the treatment of an all-patient population, we believe that their classification of neonate diagnosis codes is a reliable reflection of the actual resources used.

Since there is agreement with the AP–DRGs on the major problems and we have included additional codes under the Medicare significant problem DRGs, we are confident that our proposal is supportable. Therefore, we are

incorporating our proposed changes as final. As a part of our analysis of the MDC 15 DRGs, we will evaluate our revisions to verify that we have appropriately classified the perinatal jaundice diagnoses. We note again that these changes are made in response to public request and do not have a significant impact on the Medicare population. In FY 1993, there were 25 cases classified in DRGs 387 through 391.

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 proposed to modify the surgical hierarchy as set forth below. As discussed in section II.C of this preamble, the final recalibrated weights are somewhat different from those proposed, since they are based on more complete data. Consequently, we have further revised the hierarchy in this final rule using the principles set forth above.

- In MDC 2 (Diseases and Disorders of the Eye), we proposed to reorder Extraocular Procedures Except Orbit (DRGs 40 and 41) above Intraocular Procedures Except Retina, Iris and Lens (DRG 42).
- In MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat), we proposed to reorder Rhinoplasty (DRG 56) above Salivary Gland Procedures Except Sialoadenectomy (DRG 51).

We received no comments concerning the proposed surgical hierarchy. In addition, based on a test of the proposed changes using the most recent MedPAR file and the revised GROUPER software, we find that the changes are still supported by the data and are adopting the proposals in this final rule. However, based on the final MedPAR file, we need to make another change in the surgical hierarchy for MDC 3. In MDC 3, in addition to reordering DRG 56 above DRG 51, we will also reorder DRG 56 above DRG 50 (Sialoadenectomy). Therefore, the final revised hierarchy for these three DRGs is as follows:

Rhinoplasty (DRG 56)
Sialoadenectomy (DRG 50)
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 did not propose 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 proposed a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1994. (See section II.B.7, below, for a discussion of these changes.) These proposed changes were 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 proposed 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 also proposed 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 proposed 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 code 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), 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) as a CC.
- 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.

Comment: We received one comment that supported our revision of the CC Exclusions List. However, another commenter, while agreeing that transplant status (V42.x) is implied in the organ-specific complication codes (996.8x), disagreed with one of our revisions. Specifically, the commenter believes that code V42.8 (Other specified organ or tissue transplant influencing health status) should not be excluded for cases in which the principal diagnosis is 996.86 (Complications of pancreas transplant) or 996.89 (Complications of other specified organ transplant). The commenter notes that code V42.8 includes transplants other than pancreas (for example, intestines). Therefore, to exclude as a CC a code that is not organ specific means that, for example, a pancreatic transplant patient experiencing a complication with an intestinal transplant would not have the V42.8 code associated classified as a CC.

Response: We agree with the commenter that the fact that all the complication codes (996.8x) and the status codes (V42.x) are not perfectly matched in organ specificity occasionally leads to the inability to code certain otherwise allowable CCs. However, we believe the problem is extremely limited in the Medicare population, who do not tend to have multiple transplanted organs. The problem with leaving V42.8 (a "not elsewhere classified" code) as a CC for 996.86 and 996.89 is that it opens the door for incorrect coding in order to gain a higher DRG assignment.

If hospitals followed correct coding guidelines concerning the V status codes, we would not have had to make the proposed changes to the CC Exclusions List. That is, it is not correct to code the status code for an organ transplant when the principal diagnosis is complication of the same organ transplant. However, based on the information in the MedPAR file, hospitals were following this incorrect procedure and were gaining an

inappropriate financial advantage. Therefore, we believe that leaving V42.8 off the exclusion list for 996.86 and 996.89 would cause more incorrect DRG assignments than including it on the list. We note that when a transplant complication is coded as the principal diagnosis, hospitals may code the actual complication and any other secondary diagnoses documented by the physician.

Tables 6f and 6g in section V of the addendum to this final rule contain the final revisions to the CC Exclusions List (including the change for V42.8) that will be effective for discharges occurring on or after October 1, 1994. Each table shows the principal diagnoses with the 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 DRG Definitions Manual, Version 12.0, which includes the changes set forth in this final rule, is available for $195.00, which includes $15.00 for shipping and handling. 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 proposed 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 proposed 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 proposed 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

Two commenters wrote concerning the proposal to add pacemaker and amputation procedures to DRGs 7 and 8.

Comment: One commenter noted that pacemaker procedure codes that are not recognized by the GROUPER unless they are paired with their related codes were excluded from the list of codes to be moved to DRGs 7 and 8. The commenter recommends that all pacemaker procedures with a principal diagnosis assigned to MDC 1 be added to DRG 7 and 8.

Response: The pacemaker codes we proposed to move to DRGs 7 and 8 are only those codes considered to be OR procedures. The pacemaker procedures that are considered to be non-OR procedures were not moved. Coding the initial implantation of a permanent cardiac pacemaker requires that one lead and one device code must be used in combination for DRG assignment. Coding of revision and replacement pacemaker procedures does not require combined codes to be assigned to DRGs.

The pacemaker procedure codes that are non-OR procedures are not recognized by the GROUPER unless they are combined with their related codes. That is, they are considered for DRG assignment only if they occur in pairs. Otherwise they are treated as other non-OR procedures and do not affect DRG assignment. These non-OR procedures are as follows:

37.70 Initial insertion pacemaker lead, not otherwise specified
37.71 Initial insertion of transvenous lead into ventricle
37.72 Initial insertion of transvenous leads into atrium and ventricle
37.73 Initial insertion of transvenous lead into atrium
37.81 Initial insertion of single-chamber device, not specified as rate responsive
37.82 Initial insertion of single-chamber device, rate responsive
37.83 Initial insertion of dual-chamber device

These non-OR procedures were not included in the list of pacemaker codes that we proposed to move from DRGs 7 and 8 when they occurred with an MDC 1 principal diagnosis.

However, we agree with the commenter that these non-OR pacemaker procedure codes, when accompanying an MDC 1 principal diagnosis, should be assigned to DRGs 7 or 8 rather that DRG 468 when they are paired with the related procedure code. Therefore, we are adding the following pacemaker codes, when they occur in combination, to DRGs 7 and 8:

37.70 & 37.81 Initial insertion pacemaker lead and single-chamber device, non-rate responsive
37.70 & 37.82 Initial insertion pacemaker lead and single-chamber device, rate responsive
37.71 & 37.81 Initial insertion of transvenous lead into ventricle and single-chamber device, non-rate responsive
37.71 & 37.82 Initial insertion of transvenous lead into ventricle and single-chamber device, rate responsive
37.72 & 37.83 Initial insertion of transvenous leads into atrium and ventricle & dual-chamber device
37.73 & 37.81 Initial insertion of transvenous lead into atrium and single-chamber device, non-rate responsive
37.73 & 37.82 Initial insertion of transvenous lead into atrium and single-chamber device, rate responsive

We emphasize that procedure codes 37.70, 37.71, 37.72, 37.73, 37.81, 37.82, and 37.83 are not considered by the GROUPER unless used in combination with their related codes. If used singularly, these codes will be ignored for the purpose of DRG assignment. The pacemaker codes originally proposed may occur alone or in pairs, and will be assigned to DRG 7 or 8 when they occur with a principal diagnosis in MDC 1 as proposed.

We are adopting the changes in the proposed rule, with the revisions discussed above.

Comment: We received a comment that objected to the placement of pacemaker procedures and lower limb amputation procedures in DRGs 7 and 8. The commenter stated that unless clinical evidence supported the assignment of these pacemaker cases to DRG 7 or 8, it would be more reasonable to move these cases to DRG 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure, or Shock) or DRG 116 (Other Permanent Pacemaker Implant or AICD Lead or Generator Procedures) in MDC 5 (Diseases and Disorders of the Circulatory System). It was also suggested that the amputation cases be assigned to DRGs in MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders), where diabetic patients with manifestations are classified.

Response: The DRGs were developed as a patient classification scheme consisting of classes of patients who were similar clinically and in terms of their consumption of hospital resources. The concept of clinical coherence requires that the patient characteristics included in the definition of each DRG relate to a common organ system or etiology and that a specific medical specialty should typically provide care to the patients in the DRG. Each case is assigned to a DRG, usually within an MDC. The MDCs are generally based on a common organ system that is identified by principal diagnosis.

Thus, the proposed assignment of procedures from DRG 468 was based on the principal diagnosis that is currently assigned to the DRGs in question. For example, a patient may have a principal diagnosis of idiopathic peripheral autonomic neuropathy (diagnosis code 337.0) and a secondary diagnosis of congestive heart failure (diagnosis code 428.0) that requires the insertion of a pacemaker lead and a single chamber device (procedure codes 37.70 and 37.82, respectively). Cases with the principal diagnosis code 337.0 are assigned to MDC 1; however, the pacemaker procedures have not been assigned to this MDC. Therefore, this case would be grouped to DRG 468. We have proposed to place the pacemaker procedures, when occurring with a principal diagnosis found in MDC 1, to the most appropriate DRG within that category. It would be inappropriate to assign the pacemaker procedures, when they occur with a principal diagnosis classified to MDC 1, to a DRG in MDC 5 or any other unrelated MDC. In the past, these cases have been assigned to DRG 468 because the procedure performed is unrelated to the principal diagnosis.

This is true, also, for the amputation procedures. The principal diagnoses defining diabetes with neurological manifestations are found in MDC 1, although the procedures were not. Clinical experts concurred with the classification of the neurological manifestations of diabetes to MDC 1 as sharing a common body system rather than to MDC 10, which relates to the endocrine and metabolic manifestations of the condition.

• 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 proposed 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 proposed 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 proposed 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 proposed to add procedure code 41.5 to DRG 170 and 171 (Other Digestive System OR Procedures) in MDC 6.

Comment: One commenter, while concurring with the proposed assignment of procedure codes from DRG 468 to relevant MDCs, did not agree with several of our proposed DRG classifications. This objection was based on the DRG relative weight differential between the relative weight of the proposed DRG and the relative weight of other DRGs to which these procedures are already assigned. This commenter believes that new DRGs should be created within the MDCs for the procedures we proposed to move out of DRG 468 with weights similar to the weights they command in other DRG assignments. If we cannot do this, the commenter requested that these cases remain in DRG 468.

Specifically, this commenter agreed with the assignment of pacemaker codes, as well as lower limb amputation associated with diabetes, to MDC 1 but disagreed with their assignment to DRGs 7 and 8. Further, this commenter supported the addition of the lung biopsy codes 33.27 and 33.28 to MDC 5, but objected to their assignment to DRG 120 because the weights of DRG 75 (Major Chest Procedures) and DRG 76 and 77 (Other Respiratory System OR Procedures) in MDC 4 (Diseases and Disorders of the Respiratory System) to which procedure 33.27 and 33.28 are classified, respectively, have a higher relative weight than DRG 120.

Nor did this commenter agree with the assignment of procedure code 41.5 to DRGs 170 and 171 because the weights of these DRGs do not reflect the resources used in these cases. Again, the commenter believes that a new DRG should be created within MDC 6 for this procedure with a relative weight similar to that of DRG 392 (Splenectomy Age > 17) in MDC 16 (Diseases and Disorders of the Blood, Blood Forming Organs and Immunological Disorders), to which these procedures are also assigned, or the cases should remain in DRG 468.

Response: We do not believe it is appropriate to compare the DRG relative weights for the proposed DRG assignments to other DRGs in which the same procedures may be classified. Each surgical DRG classification is determined by a combination of principal diagnosis, secondary diagnoses, surgical procedures, age, and sex. To compare procedure classifications and relative weights without taking into consideration the principal diagnosis and other factors is inappropriate and results in misinterpretation and misleading comparisons.

Many of the procedures we have proposed to move from DRG 468 are assigned to multiple DRGs, depending on the principal diagnosis. Thus, to compare lung biopsies (procedure codes 33.27 and 33.28) to DRG assignments in MDC 4 fails to take into account the principal diagnosis responsible for the MDC assignment. Procedure code 33.28 is currently assigned to 7 DRGs in 4 MDCs, with FY 1995 weights that range from 0.9529 to 3.0551. (The FY 1995 weights for DRGs 7 and 8 are 2.5005 and 0.9185, respectively). Similarly, to compare splenectomy procedures with a principal diagnosis of secondary malignant neoplasm of other digestive organs and spleen (diagnosis code 197.6), for example, to a splenectomy performed in conjunction with a principal diagnosis assigned to DRG 392 in MDC 16 is specious. To interpolate from a DRG assignment with one set of related principal diagnoses to one with another set of related principal diagnoses significantly underestimates the role of principal diagnosis in determining resource intensity.

As noted above, one of the basic principles of DRG classification is that cases assigned to each DRG should be similar both clinically and in resource utilization. As the first step in ensuring clinical coherence, we subject all DRG modifications under consideration to careful, thorough medical judgment and evaluation. Total charges, submitted by hospitals on inpatient claims, serve as a proxy measure of resource use. Similar resource use does not mean identical resource use, but, rather, that the resources used to treat a range of patients within one DRG classification will be relatively consistent and that this level of variation is known and predictable. Thus, although the procedures we have proposed moving from DRG 468 to more specific DRGs may have charges slightly higher or lower than the average for the DRG to which they are assigned, this variation

is well within the expected range and can be accurately predicted.

In each MDC there is usually a surgical class referred to as "other surgical procedures." The "other" classes are not as precisely defined from a clinical perspective and include diagnoses or procedures which are infrequently encountered or not well defined clinically. The "other" surgical category contains surgical procedures which, while infrequent, could still reasonably be expected to be performed for a patient in the particular MDC. We note that the procedures we proposed to move from DRG 468 to specific MDCs are all assigned to the "other" surgical class DRG or DRGs. We believe it is appropriate to assign cases to the DRG that contains clinically similar cases within the most specific MDC possible. DRG 468 exists for those patients who receive surgical procedures that are completely unrelated to the MDC to which the patient was assigned. For the procedures identified to be assigned to specific MDCs, the principal diagnosis was appropriate for the proposed MDC assignment, the cases occurred in sufficient volume and were clinically similar enough to those existing in the proposed DRG assignment to justify our decision to move them. The "other" category exists within each MDC for this express purpose: to classify those cases that are sufficiently related to be assigned to the MDC, but are not clearly defined or occur in low volume. We believe the procedures we have recommended for MDC assignment meet these criteria.

We do not believe it would be prudent policy to create new DRGs within the relevant MDCs to cover the procedures being reassigned from DRG 468. This would represent a departure from the process of defining the surgical classes within MDCs by organizing a DRG based on procedures more appropriately categorized in the "other" surgical class. DRG classification requires physician judgment, statistical analysis, and historical data. Until we have sufficient data to determine the performance of these procedures within the relevant DRGs, we can not justify creating additional DRGs. We will continue to review and evaluate these procedures to determine the appropriateness of DRG assignment. Until we have data documenting the need for further modification, we are adopting the DRG assignment of the procedures as proposed with revisions as discussed.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. For the proposed rule, 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 proposed 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 proposed 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.

We received no comments on the proposed reassignments to DRG 477, therefore, they are adopted as final and will 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 was 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 DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section IV of the addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, comments were solicited 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.

The comments we received regarding the ICD–9–CM coding changes fall into three general categories: Spelling or other technical errors in our Tables 6a through 6e; disagreement with the assignment of a new code or revised code; and comments about coding policy.

Based on the comments and our own review, we have corrected misspellings, added omitted codes, and corrected phrasing in the code descriptions in Tables 6a, 6c, and 6d. The codes for which changes have been made are as follows: Table 6a: 709.01, 760.76, 996.04, V12.00, and V57.22. Table 6c: 305.10, 305.11, 305.12, and 305.13 were added. Table 6d: 440.24.

The remaining comments are addressed below.

Comment: We received one inquiry regarding our assignment of procedure code 998.81 (Emphysema resulting from a procedure) to DRGs 452 and 453 (Complications of Treatment). The commenter suggested that the code be assigned to DRGs 101 and 102 (Other Respiratory System Diagnoses) in MDC 4 (Diseases and Disorders of the Respiratory System).

Response: Procedure code 998.81 is one of three new codes that are 5th-digit expansions of the existing 998.8 category of codes for specific complications of procedures, not elsewhere classified. The new code 998.81 is to be used for a systemic condition, subcutaneous emphysema, that results from a procedure rather than one of the more specific emphysema conditions assigned to a DRG in MDC 4. Therefore, we are not changing its designation in this final rule.

We note that the current 4-digit code 998.8 is assigned to DRGs 452 and 453. Our usual practice is to continue to assign 5th-digit expansions of a code to the same DRGs to which the 4-digit code was assigned unless there is a compelling or practical reason to make a different assignment. As noted by the commenter, we did assign code 998.82 (Cataract fragment in eye following cataract surgery) to DRGs 46, 47, and 48 (Other Disorders of the Eye) in MDC 2 because of the specificity of the coded condition and the similarity of the new code to the other complication codes currently assigned to DRGs 46 through 48. However, this is a very isolated case of change in DRG assignment.

Comment: We received one comment regarding the DRG assignment of code 440.24 (Atherosclerosis of native arteries of the extremities with gangrene). The commenter requested that the code be assigned to DRG 387 (Prematurity with Major Problems) in addition to DRGs 130 and 131 (Peripheral Vascular Disorders) as is indicated in Table 6d.

Response: The DRG assignment of code 440.24, which has a revised title for FY 1995, has not been changed. It continues to be considered a "major problem" for purposes of assignment to DRG 387 and we have corrected this oversight in Table 6d.

Comment: A commenter questioned why we assigned new diagnosis code 677 (Late effect of complication of pregnancy, childbirth, the puerperium) to DRG 469 (Principal Diagnosis Invalid as Discharging Diagnosis) rather than DRGs 373 (Vaginal Delivery without Complicating Diagnoses), 376 (Postpartum and Post Abortion Diagnoses without OR Procedure), and 384 (Other Antepartum Diagnoses without Medical Complications).

Response: This code was created by the National Center for Health Statistics, the group responsible for revisions to the ICD–9–CM diagnosis codes, for use as an epidemiologic tool to trace the physical, long-term effects of childbearing. It should not be used as a principal diagnosis. Rather, the specific complication that has occasioned the inpatient stay should be coded as the principal diagnosis. Code 677 should be included as a secondary diagnosis. Therefore, if 677 is coded as principal, the case will group to DRG 469.

Comment: We received two comments requesting that we reconsider our non-OR designation for new procedure code 41.04 (Autologous hematopoietic stem cell transplant). The commenters both believe that this should be considered an OR procedure based on the resource use associated with it. In addition, one commenter has requested that the code be assigned to DRG 481 (Bone Marrow Transplant) along with the other codes in category 41.0 (Bone marrow transplant).

Response: Currently, these stem cell transplant procedures are included in procedure code 99.73 (Therapeutic erythrocytapheresis), a non-OR procedure. As noted above, our practice is to assign a new code to the same category as its predecessor code. One compelling reason for this practice is our inability to move the cases associated with a new code to a new DRG assignment as a part of DRG reclassification and recalibration. Because we cannot separately identify the stem cell transplant cases from the other cases coded with 99.73 in order to reclassify them and their charges to a new DRG, we are unable to predict the new weights of both the DRGs in which this code currently is classified and the new DRG to which it would be assigned. Therefore, we are prevented from redesignating code 41.04 as an OR procedure.

Regarding the request that this code be reassigned to DRG 481, we note that the procedure represented by this code is not a bone marrow transplant procedure. While it may consume hospital resources similar to those transplant procedures, we will be unable to verify that assumption until we can evaluate the newly coded stem cell transplant cases in the FY 1995 MedPAR file. That file will be available in calendar year 1996 and we will analyze the cases with procedure code 41.04 as a part of our DRG agenda for FY 1997.

Comment: One commenter requested that we publish revised diagnosis code category headings when a formerly valid diagnosis code is made invalid due to a revision of the codes in that group to require a fourth or fifth digit.

Response: We publish the ICD–9–CM coding system changes in the proposed and final rules in order to display our CC and DRG assignments of new and revised codes. We also publish an

informational list of invalid codes that will no longer be recognized by the Medicare GROUPER. The proposed and final prospective payment rules are not a replacement for ICD–9–CM coding manuals. We publish only that coding information that is necessary for public understanding and implementation of the DRG classification system. Therefore, we do not believe that we should publish the information requested by the commenter.

Comment: We received one comment expressing disappointment in the very minor changes made to Volume 3 of the ICD–9–CM (the procedure codes) for FY 1995. The commenter recommends that we do much more to update and revise Volume 3.

Response: There are severe physical space constraints that limit the number of changes that can be made to the procedure codes in Volume 3. HCFA is aware that this Volume does not contain the most current codes to match changing technology, but, due to its current configuration, Volume 3 is limited to 4-digit codes. We have begun the process to revise this Volume, but that work will require several years for completion and implementation.

We again encourage commenters to address questions, comments, and suggestions on issues involving diagnosis codes to Sue Meads and those concerning procedure codes to Patricia E. Brooks at the addresses set forth above

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.

In the proposed rule, we announced the availability of a paper we have prepared that describes our proposed severity DRG classification system as well as the analysis upon which our proposal was formulated. Comments are due to HCFA by September 30, 1994.

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. It could be done in a budget neutral fashion.

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.

We received some comments on the proposed revisions to the DRGs to incorporate a measure of severity. We do not intend to answer any of the specific comments at this time, but rather answer all the comments in the document that sets forth our final proposal. There were, however, two general types of comments that we will respond to in this document

Comment: Several commenters requested that HCFA make more information available to the public so that they can more easily assess some of the changes in case-mix value that result from implementation of the revised DRGs. One commenter noted that it appears that 10 percent of the Medicare inpatient payments are shifted from rural to urban hospitals.

Response: The data we have made available to the public on the severity DRG proposal are similar to the data we make available during the annual rulemaking process addressing changes to the prospective payment system. These include a complete MedPAR file with the current and revised DRG designations, a revised case-mix index file, a revised DRG Table 5, and the AOR/BOR File. We believe that these data, coupled with the description of the changes in the paper, the list of revised CC designations of all diagnosis codes, and the impact analysis are sufficient to allow analysis of our proposal. Since the available MedPAR file lists every case and its revised DRG assignment and the new weights are listed in Table 5, we believe that those who are interested can evaluate why the case-mix index value for specific hospitals or groups of hospitals has changed.

Concerning the commenter's contention that there is a shift of 10 percent of Medicare payments from rural to urban hospitals, we note that the impact analysis of the refined DRGs shows that rural hospitals overall lose 0.6 percent of their payments, other

urban hospitals lose 0.3 percent, and large urban hospitals gain 0.2 percent.

Comment: We received several comments concerning the proposal to recalibrate the DRG weights to 1.0. Some commenters believe that this will eliminate all real case-mix index increase as well as coding "creep." Other commenters stated that HCFA should not pursue this policy as there currently is no way to measure satisfactorily real case-mix index change.

Response: We did not include a proposal to recalibrate the DRG weights to 1.0 in the proposed rule. We presented it as one solution to our current problem of being unable to make DRG reclassification changes in a budget neutral fashion. We agree with commenters that it is important to develop a mechanism to accurately distinguish real case-mix increase from that attributable merely to changes in coding. As noted above, we would make an additional adjustment to include real case-mix change in Medicare payments. We intend to continue to analyze possible solutions to this problem.

9. Other Issues

a. Lung Transplants.

Comment: We received comments urging that we create a new DRG solely for lung transplants. The commenters state that, even though HCFA has not made a national coverage determination for these procedures, Part A fiscal intermediaries are approving some lung transplant cases for coverage. Because there is no specific lung transplant DRG, these cases are classified to DRG 75 (Major Chest Procedures), which the commenters argue results in a DRG payment that is woefully inadequate to cover the costs of the procedure. In addition, one of the commenters understands that HCFA is in the process of approving a national coverage determination for lung transplants that will be effective in the very near future. Therefore, the commenter believes that HCFA should not delay in having a DRG in place for the procedure. This commenter also recommends that heart/lung transplants be assigned to the new DRG.

Response: Because we are considering making a Medicare national coverage determination on lung transplants in the near future, we are establishing a new DRG for lung transplants as a part of this final rule. As noted by the commenters, these cases currently are assigned to DRG 75 in MDC 4 (Diseases and Disorders of the Respiratory System).

Cases will be assigned to the new DRG 495, Lung Transplant, based on the presence of the procedure code for lung transplants (33.5) and will not first be assigned to an MDC based on the principal diagnosis. This is the same procedure we follow for liver and bone marrow transplants.

As is our current policy for organ acquisition costs for kidney, heart, and liver transplant cases paid under Medicare, lung acquisition costs will be paid on a reasonable cost basis and are not included in the prospective payment amount. We are revising §§ 412.2(d)(4) and 412.113(d), which describe payment for organ acquisition costs as a reasonable cost payment, to include lung acquisition costs.

The relative weight assigned to DRG 495 is based on the lung transplant cases in the FY 1993 MedPAR file. When the weight of DRG 495 was initially calculated, the weight was less than the weight of DRG 483, Tracheostomy Except for Face, Mouth and Neck Diagnoses. Since several lung transplant cases also received tracheostomies, we removed these cases from DRG 495 and classified them to DRG 483 to receive the higher payment assigned to that DRG. We note that each of these cases had an average standardized charge that was much higher than the average for all lung transplants. Thus, the final DRG 495 weight of 12.8346 is based on 105 cases of lung transplants in which no tracheostomy was performed in the FY 1993 MedPAR file. This weight places DRG 495 after DRGs 480, 483, and 481 (Bone Marrow Transplant) in the pre-MDC surgical hierarchy. For a detailed discussion of surgical hierarchy, see section II.B. 4 of this preamble.

Regarding the commenter's request that we include heart/lung transplants with lung transplants in the new DRG, we note that heart/lung transplants remain covered on a case-by-case basis as determined by the fiscal intermediaries. Therefore, we do not believe we should move them from their current classification in DRG 103, Heart Transplant. We note that, for FY 1995, the relative weight for DRG 103 (13.5495) is actually higher than the weight for DRG 495.

b. Cochlear Implants (DRG 49).

Comment: We received two comments regarding cochlear implants. Both commenters expressed concern that the cost incurred by cases receiving the implant device far exceeds the Medicare payment these cases receive under DRG 49 (Major Head and Neck Procedures) to which they are assigned. According to these commenters, the cost of the device itself represents more than the total DRG payment and, thus, is not subject to traditional hospital cost control techniques. One commenter noted that the economic facts regarding the costs of this implant procedure require a more expeditious and effective adjustment than has been granted in the past. This commenter suggests that the payment weight assigned to cochlear implants should be appropriately adjusted, either by assignment to a different DRG or by creation of a new DRG specifically for cochlear implants. The other commenter requests that cochlear implant procedures be assigned to DRG 1 (Craniotomy Age > 17 Except for Trauma) in MDC 1 (Diseases and Disorders of the Nervous System).

Both commenters noted that, although we agreed in the September 1, 1993 final rule (58 FR 46273) to continue monitoring cochlear implant cases, we did not discuss them in the proposed rule. One of the commenters requested that we review the FY 1994 data for DRG 49, as this would be the first data to reflect the change in DRG 49 weight as a result of moving a lower cost procedure to another DRG.

In addition to the issue of inadequate payment, one commenter observes that the number of Medicare cochlear implant cases continue to decline. The commenter attributes this decrease to hospitals determining that the financial loss suffered in providing the cochlear implant to the Medicare population precludes a viable ongoing cochlear implant program. This commenter is concerned that cochlear implants may not exist for the Medicare population in the future.

The commenter also observes that the number of extraordinarily low charges submitted by hospitals for the cochlear implant procedure has decreased substantially and may be an indication that our instructions to intermediaries on proper coding for this implant is having an effect.

Response: Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49 (Major Head & Neck Procedures), the highest weighted surgical DRG in major diagnostic category (MDC) 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat). Since that time, the cochlear industry has contended that the weight of DRG 49 is too low and does not adequately reflect the resources necessary for the cochlear implant procedure. In response to these concerns, we have analyzed Medicare data every year since 1986.

Effective October 1, 1993, in an effort to improve the homogeneity of resource use in cases within DRG 49, we moved the lowest charge procedure, partial glossectomy, from DRG 49 to DRGs 168 and 169 (Mouth Procedures). This resulted in a slight increase in the

average charge for DRG 49. We have evaluated the remaining procedures in DRG 49 to determine if further reclassification is appropriate. However, there are no other low charge procedures remaining in DRG 49 that occur in sufficient volume to justify further DRG shifts. We note that FY 1994 does not end until September 30, 1994, so we will not be able to evaluate thoroughly the impact of the modification to DRG 49 until after that date.

We note also that although we do not always publish the results of our analysis in the Federal Register, this does not mean we have failed to honor our commitment to continue monitoring the cochlear implant procedures. On the contrary, we have reviewed and analyzed these data annually. We did not include our results in the May 1994 proposed rule because they did not vary from previous findings and we had nothing new to add to our prior discussions. However, we will present them now.

Using FY 1993 Medicare claims data, we identified a total of 81 cochlear implant cases. These cases represent 3.5 percent of all cases in DRG 49, and incurred an average charge of $22,386 compared to an average charge of $15,679 for all cases in DRG 49. While there is a higher charge for the 81 cochlear cases than for the other cases in DRG 49, we note that the cases are distributed across 54 hospitals, with no more than 7 cases at any one hospital. The majority of hospitals (70 percent) treated only one case (38 of 54 hospitals).

We have repeatedly addressed the recommendation that we assign cochlear implants to DRG 1, most recently in the September 1993 final rule (58 FR 46274). Our objection to this suggestion is that the diagnosis associated with cochlear cases (diagnosis code 389 (Hearing loss)) is not clinically coherent with the diagnosis codes assigned to MDC 1. A basic premise of DRG classification is the assignment of clinically similar discharges within categories based on a common body system or organ system. To reassign cochlear implant cases to MDC 1, we would have to move the principal diagnosis code 389 from MDC 3, which would move all cases with this diagnosis to a clinically inappropriate MDC.

We acknowledge that the Medicare payment for cochlear implant patients has been an issue for several years. However, we find no justification for creating a special DRG for cochlear implants. We have consistently classified clinically similar patients in DRGs who use approximately the same amount of hospital resources. In addition, we prefer to maintain DRGs with enough cases to ensure a normal distribution and relative stability over time. We continue to believe that the low volume of these cases does not justify the establishment of a new DRG specific to cochlear implants. Nor do we generally create DRGs that are specific to a single technology, especially those available through a single source manufacturer.

Although some new technologies may engender a certain amount of fixed costs, and thus, do not lend themselves readily to cost control techniques, there are other occasions within the hospital's performance that are responsive to cost containment. Thus, the incentive is for the hospital to treat a mix of patients and to manage its operations in such a way to offset losses on cases where payment is less than cost with gains on cases where the payment is in excess of cost.

In response to the commenter's concern that cochlear implants may not be available to Medicare beneficiaries in the future, we note that a hospital may not refuse to provide a covered service to a Medicare beneficiary if it provides that service to other patients. Specifically, the Medicare regulations at 42 CFR 489.53(a)(2) provide that HCFA may terminate a hospital's Medicare provider agreement if it finds that the hospital places restrictions on the persons it accepts for treatment and fails to apply them to Medicare beneficiaries the same as to all other persons seeking care.

c. Epilepsy (DRGs 24, 25, and 26).

Comment: We received several comments addressing the classification in DRGs 24, 25, and 26 (Seizure and Headache) of patients with intractable epilepsy, particularly those admitted for neurodiagnostic monitoring. The commenters believe that it is critical that a revision be made to these DRGs for the intractable epilepsy patients to account for the greater resource use and length of stay compared to all other patients admitted under the same DRGs. The commenters state that the financial risk is greatest to the small number of specialized epilepsy centers that treat the majority of these complex patients.

The commenters refer to an analysis conducted by HCFA that reviewed the FY 1993 average charges for all cases with a diagnosis of intractable epilepsy where video/radio-telemetered monitoring (procedure code 89.19) was performed. The commenters believe that the results of the HCFA study support the need for a change in the DRG classification system for certain cases, to be implemented in FY 1995, using the following criteria:

- A diagnosis of intractable epilepsy (diagnosis codes 345.0–345.9 with a 5th digit of 1).
- The performance of video/radio-telemetered monitoring (procedure code 89.19).
- Patient age under 60.

Finally, one commenter believes that we need to address the appropriate diagnosis code to use for patients who receive neurodiagnostic monitoring whose seizures are not epileptic. These patients are currently coded under 780.3 (Convulsions). The commenter would prefer to include these patients under the unspecified intractable epilepsy code of 345.91 so that they can be included in any new DRG we create.

Response: The epilepsy treatment community has for some time expressed concern that the resources used to treat the intractable epilepsy patients far exceeded those needed for other patients in the same DRGs, and that Medicare payment is inadequate to meet these costs. We have previously addressed the issue of Medicare payment for intractable epilepsy cases, most recently in the September 1, 1993 final rule (58 FR 46287). As a result of our previous analyses, we have concluded that although intractable epilepsy patients incur higher average charges than other patients in the same DRGs, there is not a sufficient differential nor a sufficient volume to warrant a DRG change.

In order to respond to the comments, we updated our most recent study and evaluated the June 1994 update of the FY 1993 MedPAR file. We identified 2,284 intractable epilepsy cases with an average charge of $8,820 compared to an average charge of $7,602 for all patients in the same DRGs. Nonintractable epilepsy cases incurred an average charge of $7,423, for 13,412 cases. The incidence of inpatient admissions for all cases of epilepsy has decreased by nearly 30 percent, with intractable inpatient admissions down 19 percent from the FY 1992 data (2,817 to 2,284 cases). The following table summarizes our most recent epilepsy analysis findings, comparing the average charges between epilepsy and other cases assigned to the same DRG (the number of cases is included in parentheses):

DRG	Intractable epilepsy	Nonintractable epilepsy	All epilepsy	All cases
24	$10,605	$8,525	$8,748	$8,630
	(1,152)	(9,595)	(10,747)	(57,041)
25	$7,003	$4,654	$5,192	$4,738
	(1,132)	(3,811)	(4,943)	(20,456)
26	0	$4,003	$4,003	$5,912
		(6)	(6)	(43)
All Cases	$8,820	$7,423	$7,626	$7,602
	(2,284)	(13,412)	(15,696)	(77,540)

Focusing our analysis on intractable epilepsy patients with and without video-telemetered monitoring (procedure code 89.19) confirms our earlier findings; that is, intractable epilepsy patients who receive the neurodiagnostic monitoring do in fact incur charges greater than those of other intractable epilepsy cases and of all other patients in the same DRGs. Although, in the past, there has been a problem with the underreporting of procedure code 89.19 and an inability to identify the extent of use of this procedure, we note that there has been a substantial increase in reporting in the FY 1993 data. The number of cases now appears to more accurately match the volume predicted in the past by the epilepsy treatment centers. The results of this analysis are summarized in the following table:

DRG	Intractable epilepsy	Nonintractable epilepsy
24 with 89.19	$13,493	$9,711
	(104)	(28)
24 w/o 89.19	$10,318	$8,521
	(1,048)	(9,567)
25 with 89.19	$10,178	$9,544
	(359)	(77)
25 w/o 89.19	$5,529	$4,553
	(773)	(3,734)
26 with 89.19	0	0
26 w/o 89.19	0	$4,003
		(6)

The commenters recommend that, in revising the DRGs, we target the under age 60 patients who are hospitalized with intractable epilepsy and receive a neurodiagnostic work-up with video-telemetered monitoring. We used age 65 rather than age 60 in our analysis because that is a natural age break in the Medicare patient population. That is, patients under age 65 who receive Medicare benefits qualify on the basis of disability rather than on the basis of age. We do not believe the difference in age break is significant.

Our analysis identified 335 cases of intractable epilepsy with video-telemetered monitoring in DRG 25 that were under age 65. (We concentrated on DRG 25 as suggested by the commenters because patients admitted for neurodiagnostic monitoring must be relatively healthy and, thus, do not usually have any complicating conditions.) The average charge for all intractable epilepsy patients in DRG 25 with procedure 89.19 was $10,178. When age less than 65 was taken into account, the average charge was $10,368, compared to an average of $7,527 for the 24 patients age 65 and over. The following table summarizes the DRG 25 average charges for intractable epilepsy patients under age 65 compared to other patients:

DRG 25	Age <65	Age >65	All Ages
All Cases	$4,740	$4,737	$4,738
	($7,422)	(13,034)	(20,456)
Intractable Epilepsy Cases	$7,323	$5,313	$7,003
	(952)	(180)	(1,132)
Intractable Epilepsy Cases with 89.19	$10,368	$7,527	$10,178
	(335)	(24)	(359)
Intractable Epilepsy Cases w/o 89.19	$5,670	$4,973	$5,529
	(617)	(156)	(773)
Nonintractable Epilepsy Cases with 89.19	$10,078	$7,913	$9,544
	(58)	(19)	(77)
Nonintractable Epilepsy Cases w/o 89.19	$4,180	$4,808	$4,553
	(1,520)	(2,214)	(3,734)

While we concur with the commenters that the average charges for intractable epilepsy receiving video-telemetered monitoring are indeed greater than those who do not, our findings indicate that this is more a function of the procedure than age of the patient. The highest charges of any group are those intractable epilepsy cases with procedure 89.19 in DRG 24 ($13,493 for 104 cases). The average charge for all intractable epilepsy cases with procedure code 89.19 is $10,922, while those under 65 in DRG 24 have average charges of $13,452 and those under 65 in DRG 25 average $10,368. Thus, based on the FY 1993 data, the majority of the intractable epilepsy cases under age 65 who receive video-telemetered monitoring classify to DRG 25 (79 percent; 335 cases of 423). However, the highest average charges for this age group and procedure are found in DRG 24. In addition, the nonintractable epilepsy patients under age 65 who receive procedure code 89.19 in DRG 25 averaged charges of $10,078, only slightly lower than the average charge for the intractable epilepsy cases in the same DRG and age category.

At the request of one commenter, we reviewed the number of cases with diagnosis code 780.3 (Convulsions) and found this diagnosis accounted for 61 percent of the total cases in DRGs 24 through 26 (47,340 of 77,540 cases). Intractable epilepsy was reported as a secondary diagnosis in only 10 of these cases, with an average charge of $3,502; nonintractable epilepsy was a secondary diagnosis in 81 instances, with an average charge of $6,351. We note that, in response to the commenter's

suggestion that these cases would be more appropriately coded to diagnosis 345.91, the coding notes for 345.91 specifically excludes conditions coded to 780.3. We agree with the commenter this change in coding be pursued through the ICD–9–CM Coordination and Maintenance Committee.

As a result of our analysis, we note that, as a group, the intractable epilepsy cases are not the most resource-intensive set of cases assigned to DRGs 24 through 26. The highest volume of epilepsy cases are coded 345.3 (Epilepsy, Grand Mal status), with 5,708 cases reported in the FY 1993 MedPAR and an average charge of $12,324. Of the epilepsy diagnoses, the average charge for grand mal epilepsy is exceeded only by intractable epilepsy partialis continua (diagnosis code 345.71) with an average charge of $13,346 but only 47 cases.

In response to the commenter's contention that epilepsy centers are at financial risk, we also evaluated the distribution of epilepsy cases across hospitals. We found 830 hospitals admitted patients with intractable epilepsy; 3,141 hospitals treated patients with nonintractable epilepsy. Of those hospitals treating intractable epilepsy cases, only 5 percent of these hospitals (44) treated 10 or more cases, while 2.3 percent treated 20 or more cases. The vast majority (86 percent) treated 3 or fewer cases (711 of 830 hospitals). As in our prior analyses, we found that among the high volume hospitals, charges for these cases were normally distributed, with approximately 50 percent above the average charge and 50 percent below the average.

Of the 30 recognized epilepsy treatment centers, only 23 reported any intractable epilepsy discharges in FY 1993. The remaining epilepsy centers are either children's hospitals and are excluded from the prospective payment system or did not treat intractable epilepsy patients in FY 1993. Approximately 70 percent (16 of 23 centers) treated 10 or more cases; less than 2 percent treated fewer than 4 intractable epilepsy cases. However, of the total 2,284 intractable epilepsy cases, less than 18 percent (405 cases) were admitted to epilepsy treatment centers. The average charge per intractable epilepsy case treated at an epilepsy treatment center was $9,546, only slightly higher than the $8,820 average charge at all hospitals.

Although the distribution of intractable epilepsy patients across hospitals tends to minimize the impact of higher charges on any one hospital, we acknowledge that, even though the volume of hospitals is small, many hospitals treating high numbers of intractable epilepsy patients may incur charges above the average. This is particularly true for the specialized treatment centers. However, we note that these hospitals are for the most part large urban or teaching hospitals or both and, as such, receive some of the highest Medicare payment rates.

We are not recommending any DRG modification for epilepsy cases at this time. Although the intractable epilepsy cases, especially those using procedure 89.19, result in higher charges than other cases in the same DRGs, the difference is neither clearly defined by age category or DRG nor of sufficient volume to justify a separate DRG for these patients. Therefore, we do not accept the commenters' recommendation that we create a DRG for intractable epilepsy patients, under age 60, using video-telemetered monitoring.

Comment: Another commenter expressed concern that the current Medicare payment policy may be having an adverse effect on patient access for those intractable epilepsy cases requiring neurodiagnostic monitoring.

Response: As noted above, in our response to cochlear implant comments, hospitals may not refuse to offer a covered service to Medicare patients if they provide this same service to other patients.

d. Heart Assist Devices.

Comment: We received several comments concerning the DRG assignment of and payment for the implantation of ventricular assist devices. The commenters believe that the current assignment of this procedure (procedure code 37.62) to DRGs 110 and 111 (Major Cardiovascular Procedures) was made based on outdated data and does not reflect current practice.

The commenters note that only one heart assist device, the BVS 5000 biventricular support system, has received approval from the Food and Drug Administration (FDA) and is covered by Medicare when used in patients suffering from postcardiotomy ventricular dysfunction. (See section 65–15 of the Medicare Coverage Issues Manual (HCFA Pub. 6).) One of the commenters, the manufacturer of the BVS 5000, submitted the results of a study it commissioned to analyze the current Medicare payments for that device.

The study analyzed the hospital bills for 36 cases of implantation of the heart assist device that were performed at 13 hospitals. Using the information on the hospital bills, total hospital charges were calculated for each of the 36 cases and then standardized using Medicare formulas and adjustment factors. (The 36 cases are a sample of all patients receiving the BVS 5000 and are not restricted to Medicare beneficiaries.) The results of the study indicated that the average standardized charge for the 36 cases was consistently much higher than the average standardized charge for each of the nine DRGs to which these cases would have been assigned. Overall, the average standardized charge for the 36 cases was $155,396, compared to an estimated average DRG payment of $30,488, exclusive of capital and outlier payments.

Using the average standardized charge of $155,396, the study imputes a DRG weight of 19.3803 for these cases. Even if the cases that would group to DRG 103 (Heart Transplant) and DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses) are excluded, the average standardized charge is still $114,299, implying a weight of 14.2548. Based on this result, the study recommends that the BVS 5000 cases be reassigned from DRGs 110 and 111 to DRG 103, which, with an FY 1994 weight of 14.0215, is the most appropriate DRG assignment in MDC 5 (Diseases and Disorders of the Circulatory System). In addition, from a clinical perspective, both patients assigned to DRG 103 and those who receive a BVS 5000 are seriously ill, have cardiac dysfunction that cannot continue to sustain life, and require lengthy and intensive hospital care.

Finally, one commenter expressed concern that the volume of cases in the FY 1993 MedPAR file with procedure code 37.62 (406 cases) indicates that many of the Medicare patients are receiving nonapproved heart assist devices that should be excluded from Medicare payment. The commenter suggested that hospitals should be directed to use code 37.62 only for procedures involving FDA-approved and Medicare-covered devices.

Response: Our analysis of the FY 1993 MedPAR file identified 406 cases with a procedure code of 37.62. Approximately 10 percent of these cases (38 cases) were assigned to DRGs outside of MDC 5, with the highest volume (25 cases) classified to DRG 483. Of the remaining 368 cases, 266 were assigned to DRGs other than DRGs 110 and 111. Therefore, there were only 102 cases (approximately 25 percent of the total) that were assigned to a DRG based on the presence of a heart assist device (96 cases to DRG 110 and 6 cases to DRG 111). In DRG 110, the average standardized charge for cases with procedure code 37.62 was $39,038 and the average for all cases in that DRG was

$32,939. For the 6 cases assigned to DRG 111, the average standardized charge was $57,375 compared to $18,259 for all cases in that DRG.

Based on the results of our analysis, we do not believe that the cases of implantation of a heart assist system assigned to DRG 110 are vastly underpaid. In fact, the average charge for those cases is only $6,000 higher than the other cases in the DRG and is well within the normal range of charges for DRG 110. In addition, although the average charge for the 6 cases assigned to DRG 111 is much higher than the overall average (almost $40,000 more), the exclusion of one extremely expensive case (standardized charge of $258,172) results in an average charge of $17,218 for the remaining 5 cases, which is below the DRG 111 average charge. We note that the expensive case would have received a large outlier payment in addition to its operating and capital DRG payments.

Unlike the manufacturer's study, which identified specific cases using the FDA-approved device, we are not able to distinguish the approved device from other devices which are still investigational. Based on the volume of cases in the FY 1993 data, we are certain that several different devices are being captured by the 37.62 code for heart assist implants. We note that the cases in this file were all discharged prior to the date the BVS 5000 was approved for coverage (October 1, 1993). Therefore, with the exception of those limited cases in which contractor discretion has been exercised, there are no covered devices in the FY 1993 MedPAR file, including the BVS 5000 cases. The manufacturer of the BVS 5000 declined to honor our request for a list of the hospitals that purchase and implant its device. A list of identified hospitals could help us to narrow our analysis to cases that are likely to be covered under Medicare.

Because of our inability to identify specifically the FDA-approved device, we cannot determine the DRG distribution nor the charges attributable to the implant of the BVS 5000. Nor is it possible to identify those cases where the heart assist device is used as a bridge to heart transplant, for which it is not covered under Medicare policy. Therefore, at this time, we do not believe that we have enough information to recommend any change in DRG classification for this device. Based on the data available, it does not appear that DRGs 110 and 111 are inappropriate designations for procedure code 37.62.

We cannot advise hospitals that they may use procedure code 37.62 only for those devices that are approved and covered under Medicare. The ICD–9–CM procedure codes are not the exclusive domain of Medicare payment policy. These codes are used by many other organizations and agencies for various health-related purposes. We suggest that the commenters contact Patricia E. Brooks, co-chairperson of the ICD–9–CM Coordination and Maintenance Committee, concerning the feasibility of creating a procedure code specific to implant of the FDA-approved biventricular support system. Ms. Brooks' address is set forth in section II.B.7 of this preamble.

e. Automatic implantable cardioverter defibrillator (AICD) procedures (DRG 116). For several years, we have received correspondence concerning the appropriate DRG assignment of certain procedures involving automatic implantable cardioverter defibrillators (AICDs). When a patient whose principal diagnosis is classified to MDC 5 (Diseases and Disorders of the Circulatory System) receives a total AICD system implant or replacement (procedure code 37.94), the case is assigned to DRG 104 or 105 (Cardiac Catheterization). However, prior to October 1, 1992, if a procedure was performed that involved the implantation or replacement of only part of the AICD system (that is, replacement or implant of either the leads or pulse generator only), the case was assigned to DRG 120 (Other Circulatory System OR Procedures). Effective with discharges occurring on or after October 1, 1992, these procedures were assigned to DRG 116 (Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure). Although we proposed no further changes to this DRG assignment for FY 1995, we received several comments.

Comment: Commenters requested that we change the DRG assignment for procedures in which replacement or implantation of only part of the AICD system (either the leads or pulse generator) is performed from DRG 116 to DRG 115 (Permanent Cardiac Pacemaker Implantation with AMI, Heart Failure or Shock). The relevant procedure codes are the following: 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only), 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only), 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only), 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only).

The commenters expressed concern that, even with the revised classification to DRG 116, hospitals are not adequately compensated for these procedures. Based on the results of an August 1992 study commissioned by the only AICD manufacturer at that time, the commenters estimate that these procedures should be assigned to a DRG with a relative weight of 3.7300. (The FY 1995 relative weights for DRGs 115 and 116 are 3.5936 and 2.4514, respectively.) Therefore, the commenters assert that assignment of AICD cases to DRG 115 would be more equitable.

Response: As explained in detail in the September 1, 1992 final rule (57 FR 39749), the current clinical composition and relative weights of the surgical DRGs in MDC 5 do not offer a perfect match with the AICD cases. After reviewing the current DRGs in terms of clinical coherence and similar resource use, we determined that DRG 116 was the best fit possible.

Since reassignment of these procedures to DRG 116, we have annually reanalyzed the cases based on the most recent data. Based on data in the 1993 MedPAR file, the average standardized charge for AICD cases was $27,999 for the 1,933 cases assigned to DRG 116. The average standardized charge for all cases in DRG 116 was $19,456 and, for DRG 115, $29,001. Although the $8,543 difference between the average charge for AICD cases in DRG 116 and all cases in DRG 116 is within the normal range of charges for that DRG, the difference in charges has grown over the last 2 years.

The average length of stay for these AICD cases is 4.6 days compared to 4.6 for all cases in DRG 116. However, the length of stay for cases in DRG 115 is 12.8 days. In general, the patients classified to DRG 115 are seriously ill and the long length of stay supports this contention. We believe that even though the average charge for an AICD case is closer to the average charge in DRG 115 than that of DRG 116, clinically, the AICD patients are much more similar to the patients classified to DRG 116 than those in DRG 115. Thus, it is the cost of the AICD device that is responsible for the high average charge for these cases and not the intensity of hospital services required to treat the patient.

Although originally there was only one AICD device on the market, others have become approved and are now available for hospitals. We believe that with these new devices, increased competition may result in a decrease in the price and a corresponding drop in the average charge for a hospital stay for AICD procedures. In any case, as with the cochlear implants discussed above in this section of the preamble, we are reluctant to provide higher DRG weights

for categories of cases that are made costly due to the cost of a device. We do, however, acknowledge that this problem with new technologies is increasing and we are interested in finding a cost-effective solution to the problem. In the meantime, we believe continued assignment of AICD implant cases to DRG 116 is appropriate. We will continue reviewing this issue during FY 1995.

f. DRG Assignment Issues. Among the comments received on the proposed rule were three inquiries regarding DRG case assignments. These comments, although unrelated to any changes in the proposed rule, are representative of the types of questions that we receive throughout the year concerning DRG assignment. We are responding to these comments in this final rule in the interest of public information and clarification of the DRG classification system.

Comment: One commenter requests an explanation of why a patient with a principal diagnosis of osteomyelitis (diagnosis code 730.xx) who has a toe amputation (procedure code 84.11) is assigned to DRG 225 (Foot Procedures) with a proposed FY 1995 weight of 0.9056 when a patient with the same principal diagnosis who has no surgical intervention is assigned to higher-weighted DRG 238 (Osteomyelitis), with a proposed weight of 1.4971. The commenter suggests that a more appropriate assignment for the toe amputation would be DRGs 233 and 234 (Other Musculoskeletal System and Connective Tissue OR Procedures) with proposed weights of 1.9004 and .9497, respectively.

Response: The classification of a case to a DRG begins with assignment to an MDC based on principal diagnosis. A patient with osteomyelitis is assigned to MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue). The next step is to group the case into the appropriate DRG within that MDC. If an operating room procedure is performed, the case will group to one of the surgical DRGs in MDC 8. A case with the same principal diagnosis code and no surgical procedure will group to a medical DRG.

The DRG relative weights assigned to a particular DRG are based on the average amount of resources used in treating the patients in that DRG, as measured by total charges, relative to the average resources used to treat all patients. The commenter assumes that a case in which surgery is performed has higher resource use and, therefore, should have a weight that is higher than a case in which no surgery is performed. This assumption is unfounded since many other aspects, including length of stay and severity of illness, also account for resource use. In fact, cases in DRG 225 have a much shorter average length of stay (5.2 days) than cases in DRG 238 (12.8 days). One reason we have found for lower relative weights in some surgical DRGs as compared to medical DRGs in the same MDC is the fact that often the patients in the surgical DRG have received a clear diagnosis and begin treatment soon after they are admitted to the hospital. On the other hand, some medical cases involve lengthy medical diagnostic workup and testing to discover both the reason for the hospital stay and the treatment that should be given.

The cases that group to DRG 225 receive one of several well-defined, relatively low-resource use procedures and are discharged within a few days. However, the cases that group to DRG 238 encompass a large range of principal diagnoses, many of which can take several days to diagnose and treat.

Comment: The same commenter is also concerned about a case in which a patient is admitted with chest pain, has a cardiac catheterization, and is ultimately diagnosed with a noncardiac diagnosis such as gastritis. In this scenario, the case is assigned to a DRG consistent with the principal diagnosis of gastritis, and the cardiac catheterization does not affect the DRG assignment. The commenter, therefore, believes that the hospital is not being adequately compensated for the resources expended. If the same patient had been determined to have a cardiac condition, the catheterization would have counted in DRG assignment.

Response: As discussed above, the classification of a case to a DRG begins with assignment to an MDC based on the principal diagnosis. In order to maintain the integrity of the system, cases must be assigned to DRGs to which they are most clinically related. Cardiac catheterization is a non-OR procedure that is considered for DRG assignment within MDC 5, but is treated as any other non-OR procedure in all the other MDCs. This policy recognizes the fact that catheterization is an important determinant in the resources used in the cardiac cases in MDC 5. However, it is not generally associated with treatment or diagnosis in other MDCs.

Under the prospective payment system, Medicare does not pay for the costs of individual cases. Because it is a system based on an averaging process, some cases in a particular DRG will incur costs in excess of payment while others will receive payment in excess of costs. Thus, although a patient with a principal diagnosis of gastritis who receives a cardiac catheterization may consume more resources than the average patient with that diagnosis, there will no doubt be patients with the same principal diagnosis and DRG assignment who consume fewer than average resources.

Comment: Another commenter questions the assignment of a patient with pulmonary edema and heart disease (principal diagnosis code 428.0 (Congestive heart failure)) who requires mechanical ventilation to DRG 127 (Heart Failure and Shock) with a final FY 1995 relative weight of 1.0239. However, a patient with acute pulmonary edema and no heart condition (principal diagnosis code of 518.4 (Acute edema of lung, unspecified)) who requires mechanical ventilation is assigned to DRG 475 (Respiratory System Diagnosis with Ventilator Support) with a FY 1995 relative weight of 3.7005. Again, the commenter cannot understand the different payment amount for the same type of case.

Response: Although these cases exhibit the same symptom (pulmonary edema), the principal diagnoses are assigned to two different MDCs. Under our current system, mechanical ventilation is a determining factor in the assignment of cases in MDC 4. Therefore, the case that groups to that MDC is classified to a DRG based on the mechanical ventilation. In all other MDCs, the use of mechanical ventilation is not considered in the assignment of the case. In the September 1, 1993 final rule, we discussed our intention to analyze cases with mechanical ventilation in all MDCs and to consider the appropriate placement of these cases as a part of our larger DRG refinement work (58 FR 46285.) As we have discussed above in section II.B.8 of this preamble, that refinement will not be implemented before FY 1996.

C. Recalibration of DRG Weights

We proposed 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 proposed to recalibrate the weights based on charge data for Medicare discharges. However, we proposed to use the most current charge information available, the FY 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 were 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 at that time included data for approximately 10.5 million Medicare discharges. The MedPAR file updated through June 1994 includes data from approximately 10.7 million discharges and is the file used to calculate the weights set forth in Table V of the addendum to this final rule.

The methodology used to calculate the DRG relative weights from the FY 1993 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the revised 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) and liver transplants (DRG 480) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart and liver transplant centers, respectively, that have cases in the FY 1993 MedPAR file. Similarly, we limited the lung transplant cases that were used to establish the weight for DRG 495 (Lung Transplant) to those hospitals that are established lung transplant centers.
- Acquisition costs for kidney, heart, liver, and lung transplants are 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); DRG 480 (Liver Transplant); and DRG 495 (Lung 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 proposed to use that same case threshold in recalibrating the DRG weights for FY 1995. Using the final 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 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.

Although we received no comments on the recalibration of the DRG weights, we did receive two comments that relate to that process.

Comment: Two commenters were concerned that the proposed FY 1995 DRG weights for certain transplant cases were lower than the weights that were in effect for FY 1994. The DRGs in question are those for liver transplants (DRG 480) and heart transplants (DRG 103). The commenters believe that these cases are getting more costly, not less, as the lower weights would lead one to believe. The commenters suggest that we further investigate the data on these cases.

Response: Every year when the relative weights are recalibrated, we use charge information from the most recent Medicare data available. That is, we use the charges reported by hospitals for the cases paid under each DRG. Therefore, any change in the relative weight of a DRG is directly related to the average charge of the cases classified to that DRG compared to the average charge of all the cases.

The average charges used to calculate the weight for DRG 103 actually increased between the FY 1992 data used to calculate the FY 1994 weights and the FY 1993 data used to calculate the FY 1995 weights; however, the average charge for DRG 480 decreased. The average charge for DRG 103 increased from $105,748 to $107,489 and the average charge for DRG 480 decreased from $146,824 to $144,843. These changes reflect an increase of less than 2 percent in the charges for DRG 103 and a decrease of slightly more than 1 percent in the charges for DRG 480. However, the average charge of all cases in the 2 years increased from $10,483 to $11,108, an increase of 6 percent. Thus, the weights of DRG 103 and 480 both decrease between FY 1994 and FY 1995 because the change in the average charges for those DRGs is less than the increase in the average charge for all cases.

We note that the relative weight of DRG 103 has been slightly erratic in the last 5 years, with a low of 12.5568 in FY 1993 and a high of 14.0323 in FY 1992. This is not unusual for a relatively low volume DRG (under 400 cases) with a large range of reported charges (approximately $25,000 to $600,000). A few very low or very high charge cases can make a dramatic difference in the DRG weight. Regarding DRG 480, we note that the weight has been steadily decreasing since FY 1992 (relative weight of 22.8213).

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 final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

III. Changes to the Hospital Wage Index and Medicare Geographic Classification Review Board Guidelines

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.

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, 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 1995, 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 1991 (that is, cost reporting periods beginning on or after October 1, 1990 and before October 1, 1991). 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 of 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.

In the May 27, 1994 proposed rule, we proposed to use updated wage data to construct the FY 1995 wage index as required by section 1886(d)(3)(E) of the Act. In addition, we proposed changes in the future reporting of hospital wage index data. The changes we proposed to the wage index are discussed in detail below.

In the proposed rule, we also presented our research and analysis concerning several options for alternative labor market areas and solicited public comment. The deadline for comments concerning any of the labor market alternatives was August 31, 1994. As stated in the proposed rule, we will consider all comments received by this date as we continue to evaluate possible options for revising wage index labor market areas.

In addition, we are revising the guidelines for reclassification by the MGCRB by eliminating the adjacency requirement for individual hospital reclassifications. This change is discussed below in section III.F. of this preamble. We welcome public comments on the elimination of this requirement.

B. FY 1995 Wage Index Update

We proposed 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 proposed to use all of the categories of data collected from Worksheet S–3, Part II. Therefore, the 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. Midyear Wage Data Corrections

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 to HCFA through HCRIS by early January 1994. In the proposed rule, we discussed in detail the review of the cost report data (59 FR 27718), as well as the process that hospitals could use to verify their wage data and to submit corrections if necessary.

The wage file used to construct the proposed wage index included data obtained in late January 1994 from the HCRIS database and subsequent changes we received from intermediaries through March 14, 1994. To allow sufficient time to process any changes, we instructed hospitals to submit requests for corrections to their fiscal intermediaries by May 15, 1994. To be reflected in the final wage index, any wage data corrections had to be reviewed by the intermediary and transmitted to HCFA via HCRIS on or before June 15, 1994. In the proposed rule, we noted that we would make a diskette available in mid-August that would contain the finalized raw wage data used to construct the wage index values in this final rule. We also noted that we were making the August diskette available for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the tabulation of finalized wage data, not for the initiation of new wage data correction requests (59 FR 27719).

If, after reviewing the diskette made available to hospitals in August or after reviewing the data published in this rule, a hospital believes that its wage data is incorrect due to a fiscal intermediary or HCFA error, it should immediately 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, 1994. 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 we noted in the proposed rule, after mid-August, we will make changes to the hospital wage data only in those very limited circumstances involving an error by the intermediary or HCFA that the hospital could not have known about before review of the August diskette.

We stated that if hospitals followed the steps outlined in the proposed rule, errors in the final wage index should be eliminated. However, we proposed to allow midyear corrections to the wage data under limited circumstances. Accordingly, we are revising § 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 a tabulation error, 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. Since a hospital will have the opportunity to verify its data and the intermediary will notify the hospital of any changes, we foresee few, if 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 to the wage index values are made, we will take their effect into account in establishing the standardized amounts for the following Federal fiscal year in accordance with § 412.63(s)(4).

Comment: We received numerous comments about our proposed midyear correction process. One commenter suggested that we allow providers to change their wage data at any point in the fiscal year. Another agreed with our plan for allowing midyear corrections only in cases of intermediary or HCFA error but wanted us to apply any changes retroactive to October 1, 1994. Another commenter suggested that we expand the midyear correction process to include cases in which the intermediary should have known the data was wrong and therefore should have investigated any obvious discrepancy as well as cases in which the intermediary should have reviewed a hospital's data because the hospital's average hourly wage decreased from the prior fiscal year.

Response: We do not believe that it is appropriate to allow hospitals to change their wage data at any point in the fiscal year or to expand the midyear correction process as the commenter has suggested. As we stated in the proposed rule (59 FR 27719), we believe that midyear corrections should not be made in most cases. The wage data correction process described above and in the proposed rule has provided hospitals with sufficient opportunity to bring errors made in the preparation of Worksheet S–3 to the intermediary's attention. Moreover, because hospitals have had access to the raw wage data in mid-August, they will have had the opportunity to detect any ministerial tabulation errors made by the intermediary or HCFA before the implementation of the prospective payment rates. We believe that if hospitals have availed themselves of the opportunity to review their FY 1991 wage data, the wage index implemented on October 1 should be free of errors.

We believe our policy is consistent with section 1886(d)(3)(E) of the Act, which requires that the wage index be updated annually beginning with October 1, 1993. In so providing, Congress has essentially created an annual wage data review process that ends with the publication of the payment rates for the fiscal year at issue. Moreover, as we noted in the September 1, 1992 final rule (57 FR 39765), implementation of midyear corrections in previous years resulted in several problems related to the reclassification of hospitals by the Medicare Geographic Classification Review Board. Allowing hospitals to continue to raise wage data issues beyond the deadlines described in this rule would also divert resources that would otherwise be used to ensure that the following year's wage index is as accurate as possible. Accordingly, we believe that it is incumbent that HCFA and the hospital community direct their energies to reviewing and correcting wage data *before* the prospective payment system rates for a given year are constructed.

We also disagree with the commenter's suggestion that the failure of an intermediary to detect an error made by a hospital in reporting its wage data should be characterized as an intermediary error or should require a midyear correction. Hospitals are required to complete the Worksheet S–3, Part II, along with the rest of the cost report and to attest to its accuracy at the time the cost report is filed. The cost report is signed by an Officer or Administrator of the hospital certifying that the cost report is "a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions * * *." Thus, the ultimate responsibility for the accuracy of the wage data reported on the Medicare cost report rests with the hospital. Moreover, we have repeatedly stressed in the **Federal Register** and other communications with the hospital industry the importance of reporting accurate wage data to both the development of the wage index and to the geographic reclassification process.

We have also expended considerable time and effort to review hospital wage data for potential errors. Because our initial examination of the FY 1991 wage data detected 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, which we described in detail in the proposed rule (59 FR 27718). In September 1993, we sent each fiscal intermediary a listing of its hospitals' wage data. In November and December of 1993, our fiscal intermediaries performed desk reviews for each hospital to ensure the reasonableness of the data. As a result of this effort and our own review of the wage data, edits for over 1,300 providers were resolved prior to constructing the proposed hospital wage index published in the proposed rule.

Intermediaries were also responsible for reviewing hospital requests for data changes submitted by the May 15, 1994 deadline and for transmitting any corrections to HCFA on or before June 15, 1994. After receiving any new wage data from fiscal intermediaries by June 15, 1994, we once again completed our own review of the wage data in early July. Finally, on July 26, 1994, we sent each intermediary a listing of the wage data for all their hospitals and requested one final review to ensure that our database reflected the latest wage data for each hospital.

In short, we are confident that we have created as accurate a database as possible under existing time and resource constraints. Moreover, as we described in detail in the proposed rule, we have provided ample opportunities to hospitals to review for accuracy the wage data used to construct the wage index. We note that the diskette made available to the public in mid-March 1994 contained the raw hospital wage data for all prospective payment system hospitals. This not only enabled individual hospitals to detect errors concerning their own data, but also allowed all hospitals in an MSA or rural area to check for any obvious discrepancies in the wage index data of

other hospitals in their area, as well as any reduction in the average hourly wage from previous years. In light of the above, we do not believe that it is appropriate to make midyear changes to the wage index to correct substantive wage data reporting errors.

We have also taken steps to ensure that the wage index that will go into effect October 1, 1994 is free from any ministerial tabulation errors. As noted above, in mid-August we made available a diskette with all the wage data used to construct the wage index set forth in this final rule. We believe hospitals will have ample opportunity to verify their data prior to the September 23 deadline. Therefore, we foresee few, if any, circumstances under which midyear corrections would be made to correct a tabulation error. In those limited cases where a midyear correction is warranted, the wage index change for the affected area will be made prospectively from the date the correction is made. This is consistent with our longstanding policy to allow wage index corrections on a prospective basis only. This policy was originally set forth in the preambles to the September 1, 1983 interim final rule (48 FR 39765) and the January 3, 1984 final rule (49 FR 258) implementing the prospective payment system and was later codified at § 412.63 as part of the September 4, 1990 final rule (55 FR 36042).

Comment: One commenter suggested that we establish an appeals process for disputes over corrections submitted by hospitals to intermediaries. The commenter was concerned over the inability of hospitals to make final corrections to wage index data before it is submitted to HCFA. The commenter noted that, even with hospitals having time to verify their data, any decisions on the changes submitted by hospitals are left to the discretion of the intermediary without an appeal process for the hospital.

Response: We do not believe a formal appeals process is necessary. Moreover, we do not believe that a formal appeals process would be feasible, since the process could not be completed before the development of the final wage index. In the few cases where the hospital and the intermediary have disagreed on specific cost items reported on Worksheet S–3, the issue has been resolved by contacts between the hospital or intermediary and HCFA. We continue to believe that this informal method is sufficient to resolve disputes between hospitals and intermediaries.

In the proposed rule (59 FR 27718), we detailed the steps that a hospital must follow to ensure that any corrections to its wage data are included in the final wage index. We stated that to be reflected in the final wage index, any wage data corrections had to be reviewed by the intermediary and transmitted to HCFA via HCRIS on or before June 15, 1994. This deadline was necessary to allow sufficient time to download and edit the data so that the final wage index calculation could be completed for development of the final prospective payment rates to be published in this final rule. After reviewing requested changes submitted by hospitals, intermediaries transmitted any revised cost reports to HCRIS and forwarded to the hospitals a copy of the revised Worksheet S–3, Part II. If requested changes were not accepted, fiscal intermediaries notified hospitals in writing of reasons why the changes were not accepted. This procedure ensured that hospitals had an opportunity to verify the data that will be used to construct their wage index values.

We continue to 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, hospitals may request that intermediaries re-review the issue and receive HCFA's concurrence. The intermediary was to submit a written request to HCFA for concurrence describing its handling of the issue raised by the hospital. After evaluating the facts, HCFA contacted the intermediary with the decision, and the intermediary notified the hospital.

This process was designed to resolve all substantive wage data correction disputes before we finalized the raw wage data for the FY 1995 payment rates. However, we note that this process must be completed at least 3 months before the publication of the final rule, to allow the intermediary sufficient time to submit wage data changes. Therefore, to initiate a change to the FY 1991 data, a hospital had to submit such requests to its intermediary by May 15, 1994. The hospital can evaluate the data HCFA is using either by requesting from the intermediary a copy of the Worksheet S–3, Part II that has been transmitted to HCRIS or, as indicated in the proposed rule, by requesting a copy of the public use wage file.

Comment: Several commenters raised concerns about inconsistent auditing of wage data by the fiscal intermediaries. They indicated that while certain fiscal intermediaries acted stringently in applying HCFA guidelines, other fiscal intermediaries were not as restrictive in their auditing processes. Specifically, commenters cited instances in which providers have been allowed to include questionable fringe benefit costs, such as parking expenses, and salaries for Part B physicians' services. One commenter recommended that our desk review program include a specific check for Line 1B of the Worksheet S–3, Part II, to ensure that Part B physicians' services are removed.

Response: We are concerned about all instances of inconsistent auditing by the fiscal intermediaries and have taken several steps that we believe should have eliminated most inconsistencies. Specifically, in November and December of 1993, the fiscal intermediaries performed desk reviews on the wage data reported by each hospital. These reviews were conducted based on reasonableness parameters established by HCFA. Additionally, all fiscal intermediaries have been given a fringe benefit guideline to assist them in determining if certain reported fringe benefits are allowable for purposes of the wage index. We have also instructed fiscal intermediaries to contact a HCFA staff member in cases where questions arise. In addition, intermediary performances on the desk reviews are evaluated by HCFA regional office personnel.

Regarding the commenter's concern about Part B physician services, we agree that there should be a more thorough review of the Line 1B of the Worksheet S–3, Part II, where that data are reported. Therefore, we are adopting the commenter's suggestion and will incorporate additional instructions in the next version of the desk review program to ensure consistent Part B physician reporting.

In addition, if a hospital has knowledge that an intermediary may be incorrectly handling a particular issue, the hospital is encouraged to bring it to our attention. We will continue our efforts to ensure uniform reporting of wage data. We believe that the changes we are making to the reporting of wage data for future cost reporting periods will greatly enhance the uniformity and equity of the hospital wage index.

Comment: We received two comments from Richmond, Virginia hospitals requesting relief for an error in the data used to calculate the FY 1994 wage index. They requested that the wage index for the Richmond, Virginia MSA for FY 1995 be increased to compensate for the "deflation" in its FY 1994 wage index.

Response: The issue of whether an error was made in calculating the FY 1994 Richmond, Virginia wage index is not related to the contents of this regulation. Accordingly, we intend to respond to the Richmond, Virginia hospitals concerning this matter in separate correspondence. We note, however, that section 1886(d)(3)(E) of the Act provides that we revise the wage index each year based on updated wage data. Given this provision, we do not believe it would be appropriate in any circumstance to adjust an MSA's FY 1995 wage index, which is based on FY 1991 data, to account for additional wages paid in FY 1990.

Comment: We received one comment addressing various aspects of the availability of wage index data for review by providers. Generally, the comment centered on the data included in the file and the creation of a wage data bulletin board that could be updated regularly.

Response: HCFA has continued to work to improve the availability and distribution of wage index data for provider information.

First, the commenter requested that MSA classifications and MGCRB redesignations be added to the wage data file that is released before publication of the proposed rule. It was also suggested that we compile separate wage data files by State so that hospitals do not have to purchase the entire file. The purpose of the preliminary diskette is to allow hospitals to review the database from which the wage index will be derived, prior to publication of the wage index. It is not intended to provide data that would allow hospitals to construct the wage index. Data on MSA classifications and reclassified hospitals can be purchased on separate diskettes once the wage index is published (59 FR 27756). With respect to maintaining the wage file on a computer bulletin board, we do not have resources to maintain and update such a bulletin board on an ongoing basis as revised wage data is transmitted to HCRIS. Also, given the modest price of the diskette ($145.00) and the fact that provider numbers are in State order on the current file, we do not see the need to provide separate files for each State.

The commenter also asked that we include prior year's data on the current file, so that hospitals can readily tell what changes have occurred. The wage data from previous years are made available on diskette after publication of each year's final wage index. Therefore, we do not see the need to replicate this information on the subsequent year's wage file. We advise hospitals to retain this year's diskette for comparison with next year's wage data information. We see this as an efficient and inexpensive alternative to repeating information.

With respect to the format of the data included on the diskette, we plan to evaluate this issue to determine if a more "user friendly" format can be developed that would be easily adaptable to most computer systems.

Comment: We received several comments expressing confusion about the responsibility of the providers and the fiscal intermediaries in the submission of the corrections to the final wage index data by the June 15th deadline.

Response: As we previously indicated, we believe that each provider has the ultimate responsibility to ensure the accuracy of its data, and we allow providers ample opportunity to make needed corrections. If, after reviewing the data used in calculating the proposed rule wage index (either from the published proposed rule or the diskette that was made available to all hospitals), a hospital believed that its FY 1991 wage data were incorrectly reported, the hospital should have submitted corrections along with complete supporting documentation to its intermediary in time to allow for proper review, verification, and transmission of the data before the development of the final wage index. We established a May 15 deadline for submission of revised data by hospitals in order to allow fiscal intermediaries ample time to review the submission. We also noted there was no guarantee that submissions of revised data after that date would be processed in time for the final wage index. That is, handling of data correction requests received after May 15 was dependent on the fiscal intermediaries' workload. The fiscal intermediary was then responsible for sending any corrected information to HCRIS before the established deadline of June 15, 1994.

This deadline was necessary to allow sufficient time to download and edit the data, so that the final wage index calculation could be completed in time for the development of the final prospective payment rates. We could not guarantee that corrections transmitted to HCFA after June 15 would be reflected in the final wage index. Therefore, we suggested 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 wage index. Intermediaries were also instructed to inform providers about the disposition of any data correction requests and, where changes were made, to supply a copy of any revised Worksheet S–3, Part II, to providers to alert them that a correction had been made.

2. Computation of the Wage Index

As noted above, we are basing the FY 1995 wage index on wage data reported on the FY 1991 cost report. The wage index is based on data from 5,290 hospitals paid under the prospective payment system and short-term acute care hospitals in waiver States. The method used to compute the FY 1995 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 76 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 $18.2626.

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.

Comment: A few commenters suggested that we eliminate from the wage index computation, hospitals that have terminated their participation in the Medicare program. The commenters believe that wage data from terminated hospitals do not reflect the wages paid in a labor market area, since the terminated hospital may have no incentive to ensure accurate reporting of wage data in the final cost reporting period.

Response: We have always maintained that any hospital that is in operation during the data collection period should be included in the database, since the hospital's data reflects conditions occurring in that labor market area during the period surveyed. Moreover, we believe that, in general, this is the most practical and equitable way to administer the data collection process, because it would be difficult to determine which terminated hospitals should be excluded. For example, if a hospital's participation in the Medicare program is terminated just before the publication of the prospective payment system proposed rule in May, or between the proposed rule and the publication of the final rule, it would be very difficult to ensure that such a hospital was identified as terminated, since our analysis of the database is accomplished well before the final rule is published.

However, we agree that it is appropriate to eliminate data for terminated hospitals when there is reason to believe that the data are incorrect, and the data cannot be verified due to the facility's closure. We believe this is appropriate since in most cases any aberrant data reported by terminated hospitals cannot be evaluated for reasonableness because hospital records may not be available to the intermediaries.

Each hospital is responsible for accurately completing the cost report and must attest to the accuracy of the data at the time the cost report is filed. If the wage data for a terminated hospital did not fail any of our edits for reasonableness, the hospital remains in the database and its data are used in developing the wage index for the labor market area. In preparing the data for the final wage index, we identified 76 terminated hospitals that reported questionable data and therefore were eliminated from the wage index database.

Comment: Two commenters suggested that for wage index purposes we require hospitals to report Full Time Equivalent employees on a standardized basis of 2,080 hours worked. Commenters are concerned that inconsistent reporting of total hours results in inequities in the calculation of the average hourly rate. One commenter indicated that a hospital could manipulate this policy to increase its average hourly wage by recomputing the average hourly wage for an employee based on a 7.5 hour day, thereby reporting 37.5 hours per week per employee.

Response: We have always used total paid hours as opposed to total hours worked for calculating the average hourly rate. Total paid hours more accurately reflect all elements of total salary. We clarified the definition of total hours in the cost reporting instructions to specify that total hours mean total paid hours. Paid hours include regular hours, overtime hours (counted as a regular hour), and paid holiday, vacation, and sick leave hours or any other hours associated with paid time off such as jury duty or bereavement pay. These are included to achieve comparability among hospitals and to recognize all work hours for which the hospital paid wages. Salaries are based on a standard work period (such as 40 hours or 37.5 hours per week) that is specified by the hospital employer. This work period includes any time covered by paid leave, as well as any non-productive time for which the employee receives a salary (such as a paid lunch period or a 15-minute break). Hospitals are not asked to account for and/or subtract this non-productive time, because the employee is being paid for the time. If a hospital elects to pay its employees based on a 7.5 hour day because employees are not paid for lunch and are free to leave the

work site, and the overtime rate and other fringe benefits are based on the hourly rate computed based on the 7.5 work day, the hospital's labor distribution report would appropriately report hours based on 37.5 hours per week.

Additionally, we emphasize that hours reported must correspond to the salaries reported. If a salary is paid there should be corresponding hours. We anticipate that this clarification will result in more consistent reporting of total paid hours for wage index purposes.

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 comprised hospital, intermediary, and HCFA representatives. The MTAG task force recommended, and we are implementing, 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 changes in the reporting of hospital wage index data, outlined below, are effective for cost reporting periods beginning on or after October 1, 1994. Therefore the changes will not affect the 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 (currently, 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 prevent hospitals from directly hiring physicians. Hospitals in these States are forced to contract out for physicians. The inability of these hospitals 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.

As outlined in the proposed rule, we are providing on the Worksheet S–3, Part II, for the exclusion of all Part A physician costs regardless of whether the physician is a hospital employee or contractor. For purposes of this exclusion, physicians' salaries are defined as salaries applicable to positions for which a licensed physician is normally a prerequisite, such as a medical director of a department. Salaries for physicians employed in other positions that do not necessarily require a physician, such as hospital administrator, are not excluded.

All hospitals must separately report any physicians' salaries (both Part A and Part B related) as part of the wage data reported on the Medicare cost report. 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). Regarding Part A CRNA (certified registered nurse anesthetist) costs, we are requiring hospitals to exclude these salaries from the wage data reported on the cost report. In addition, salaries for interns and residents will be separately reported (see comments below).

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.

Comment: We received over 50 comments concerning our proposal to exclude from the computation of the wage index all physician salaries (including those associated with teaching physicians) and CRNA Part A services. Many commenters supported this proposal; some suggested that we also eliminate other salaries related to services paid outside the prospective payment system, such as the salaries of interns and residents. Other commenters suggested that rather than eliminate all physicians' salaries, we add contracted Part A physicians' services to the wage index computation. Some of these commenters argued that the administrative portion of physicians' salaries are included under the prospective payment system and should therefore continue to be included in the wage index. A number of commenters indicated concern about the redistributional effect of this change and suggested we collect all the necessary data components before implementing the new policy. In particular, several teaching hospitals stated that they would be affected adversely by the elimination of physician salaries from the computation of the wage index. Finally, several commenters asked that we clarify that only those salaries for positions that require a licensed physician be excluded from the wage data.

Response: Consistent with past refinements of the hospital wage index to exclude those costs related to services not covered under the prospective payment system, we believe it is appropriate to exclude all salary costs associated with graduate medical education programs. Therefore, in addition to the exclusion of teaching physicians' salary costs, we are adopting the commenters' suggestion and will provide for the separate reporting (and possible exclusion from the wage index) of salary costs for interns and residents, since none of the costs associated with these services are paid under the prospective payment system. We believe that any redistributional effect on Medicare payments resulting from this change would be appropriate since teaching hospitals may be unfairly advantaged relative to other hospitals by the inclusion of graduate medical education costs in the prospective payment system wage index. Although this change may significantly affect teaching hospitals, we believe the timing of the change, which would not take effect for wage index purposes until FY 1999, will enable hospitals to anticipate a possible reduction in their wage index values. With respect to the exclusion of other Part A physicians's salary costs, we do not believe the redistributional effects would be significant given that these costs would be excluded for all hospitals nationwide. 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 revision would promote payment equity and provide more uniformity in the wage data across areas.

With regard to the suggestion that we include all Part A physician costs (whether salaried or under contract) in computing the wage index, we continue to believe that eliminating all physicians' salaries is more appropriate than that alternative. As discussed in the proposed rule (59 FR 27721), we do not believe that physician costs are driven by normal labor market conditions and, in many cases, hospitals must hire physicians from outside of their recruiting areas. Second, many hospitals have indicated that they have difficulty 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. Thus, we believe that inclusion of all Part A physician costs would not accurately reflect relative wages across areas.

We believe that the exclusion of all Part A physician costs (even though a portion of these costs not related to teaching activities is recognized under the prospective payment system) is the approach that would provide the greatest uniformity across areas. Since most hospitals incur costs associated with Part A physicians contracts, we do not believe the relative wage index values would vary greatly across areas under either approach. However, as suggested by commenters, we will revise the cost reporting form, effective for cost reporting periods beginning on or after October 1, 1994, to collect separately additional data elements needed to evaluate the appropriateness of this change as part of the FY 1999 wage index update.

With respect to the elimination of CRNA Part A services, we note first that 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 the wage index. In addition, we have seen several examples during our editing process where the hours associated with these services are difficult to determine. CRNAs bill on 15-minute intervals during surgery; however, time before or after the billing time (that is, actual surgery time) is difficult to determine from time records yet is part of the time CRNAs devote to a particular patient.

Finally, as specified in the proposed rule, salaries for physicians employed in positions (such as hospital administrator) for which a licensed physician is not normally a prerequisite, would not be reported as physician's salaries. The hospital is responsible, however, for providing its fiscal intermediary with the necessary documentation to allow an appropriate determination with respect to these salaries.

Therefore, effective with cost reporting periods beginning on or after October 1, 1994, we are revising the Medicare cost report to provide for the separate reporting of all salary costs for physicians (including teaching physicians), interns and residents, and CRNAs. After evaluating these data, we will propose appropriate changes to the FY 1999 wage index update.

Comment: One commenter suggested that we exclude the salaries associated with several other services that could be billed under Part B, such as the services of nurse midwives, nurse practitioners, clinical psychologists, and clinical social workers. The commenter believes these services should be eliminated since they are similar to Part B physician services, which are currently excluded from the wage index data.

Response: While we believe it is appropriate to remove from the wage index data salaries not included in the prospective payment system, we think that it would be difficult to accurately distinguish between Part A and Part B services for the services mentioned by the commenter. It is also unclear to us if the hospitals and intermediaries will have the documentation to distinguish between the time spent on Part A services performed by these employees and time spent on Part B billable services. In addition we believe that these costs are relatively small, and therefore would have an insignificant effect on the wage index. However, we will continue to examine this issue, and, if we find these costs are substantial and can be documented, we will propose future changes to the reporting of hospital wage data.

2. Management Contracts

The second major 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 are expanding 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.

Hospitals (via HCFA–339 form) will be required to provide fiscal intermediaries 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 will continue to exclude all 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 will 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.

Comment: One commenter suggested that contract labor be included in the wage index calculation if it is for services for which many hospitals in the country routinely employ contract personnel.

Response: The services for which hospitals employ contract personnel vary considerably across the country. Furthermore, the cost of contract labor is generally higher than the cost of non-contract labor for the same service. Many times, the cost of contract labor will include costs for other non-wage related items such as supplies or equipment, and thus may not accurately reflect relative hospital wage rates across labor market areas.

Before FY 1994, the wage index did not include any costs associated with contract services. However, in response to the concerns of hospitals in areas experiencing nursing shortages that must rely on contract labor sources, we included in the computation of the wage index contract labor costs for services directly related to patient care. Because of the difficulty in accurately determining hours and isolating wage-related costs for contract services not directly related to patient care, the wage data will continue to exclude all non-patient care contract services except certain top management contracts, which will be reported separately on the Worksheet S–3, Part II.

Comment: A few commenters asked why we did not include the position of Medical Director in the definition of the top management contract personnel at the hospital that may be included on Worksheet S–3 of the cost report.

Response: The position of Medical Director must be filled by a licensed physician. Thus, the duties performed by the Medical Director would be described as a Part A physician's salary. Therefore, excluding these types of management contracts is consistent with our revised reporting policy and potential exclusion of physician salaries from the wage index data.

Comment: We received one comment requesting that HCFA clarify the status of direct patient care service contracts. The commenter was confused about whether one hospital may report the cost and hours related to contract services furnished at another prospective payment system hospital.

Response: We believe there are two situations for which clarification is needed. In each case, hospitals must take care to avoid duplicate reporting of the costs and hours of the contract services.

In the first case, Hospital A may contract out the services of its nurses to Hospital B. In this case, Hospital A may not claim the salaries paid to those nurses on the Worksheet S–3, Part II, while they are working at Hospital B. Instead, Hospital A must deduct the salaries and corresponding hours associated with the time the nurses worked at the other facility. Hospital B, however, can include the payment and corresponding hours for the nurses as direct patient care related contract labor.

In the second case, Hospital A sends a patient to Hospital B for tests and procedures that Hospital A cannot provide. Hospital A cannot claim the labor portion of the amounts paid to Hospital B for contract labor. We consider this type of arrangement as a purchased service rather than contract labor. In this situation, the scope of the contracted service involves more than the services of nurses or technicians. The associated ancillary services provided also include costs for supplies, equipment, etc. In many cases hospitals are unable to accurately provide a breakdown of their charges to show how much is attributable to direct patient care services as opposed to the supplies and equipment used to provide those services. Because of the difficulty of accurately determining the labor portion of such contracted services, and given the fact that the employees do not work on the hospital's premises, Hospital A cannot claim this as contract labor for purposes of the wage index. We believe that this is consistent with our goal of establishing a uniform method for collecting wage data.

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 making 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 revising 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 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 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)
- Worker'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—employer's portion only
- Medicare taxes—employer's 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 a wage-related cost that does not appear on the core list if it meets all of 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).

• The wage-related cost would be a fringe benefit if reported to the IRS as a fringe benefit in accordance with IRS requirements.

• 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, beginning on or after October 1, 1994, hospitals are required to follow 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. Medicare principles, however, 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 GAAP applies *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.

Comment: One commenter believes that the internal administration costs of many types of core wage-related costs, such as health and insurance costs, dental, prescription drug plans, etc., should be included as part of the wage-related cost. The commenter states that some organizations administer these wage-related costs internally as a cost-saving measure and that these administration costs should be included, just as fees paid to external organizations are included in the calculation of the core wage-related cost. To do otherwise, the commenter suggested, would encourage a more costly method of administration and penalize a more efficient one.

Response: In the proposed rule we listed core wage-related costs including health and insurance costs. We did not intend to exclude internal administration costs from this list. For example, the proposed rule included a parenthetical reference that specified that health insurance costs could be purchased or self-funded (59 FR 27722). We encourage hospitals to be cost-conscious and efficient in their administration of health and insurance costs. However, amounts paid to employees within the hospital are already accounted for in the total wages paid, and therefore should not be included as part of this wage-related cost.

Comment: Several commenters addressed the proposed changes to the reporting of wage-related costs on the Worksheet S–3, Part II. Virtually all commenters supported the establishment of a core list of wage-related costs, although many suggested variations in the items included on the core list. Specifically, commenters suggested we add items such as: moving expenses, health related costs (that is, physicals, discounted inpatient and outpatient services), parking expenses, malpractice expenses, employee assistance programs, hospital sponsored continuing medical education, professional organization dues, cafeteria discounts, outpatient services, and any fringe benefit that is reported to the IRS.

We also received a number of comments with respect to our proposed criteria for including additional wage-related costs that were not reflected in

the core list. Some stated that the 1 percent criterion for qualifying as an "Other" wage-related cost was too high. A few commenters suggested that we apply the 1 percent test on total salaries and wage-related costs prior to the elimination of wages and related costs for the excluded areas. Other comments stated that the second and third criteria for qualifying as other wage-related costs are repetitive, and that we should eliminate the IRS reporting requirement.

Response: We developed the list of core wage-related costs in conjunction with the MTAG Task Force. Our goal was to establish a list of commonly recognized costs that contribute significantly to the wage costs of a hospital and are readily identifiable on the hospital records. We believe the final core list includes virtually all significant wage-related costs, including those costs that are required by statute. As part of the process of developing the core list, members of the MTAG Task Force conducted a limited analysis to determine what percentage of total fringe benefits or wage-related costs would be captured using the core list. On average, this percentage exceeded 90 percent for hospitals that were included in the analysis. However, we were concerned that individual hospitals might incur unusually large wage-related costs that are not reflected on the core list but that may represent a significant wage-related cost. Therefore, the task force recommended that hospitals be allowed to include other wage-related costs if they meet *each* of the three criteria listed above.

The provision to include wage-related costs other than those reflected on the core list is intended to recognize only those limited circumstances where a hospital incurs any additional wage-related cost items that truly represent a significant financial burden to the hospital, but that also meet the current definition of a fringe benefit cost. We believe the 1 percent threshold is an appropriate measure of significance, and that the exclusion of any cost representing less than 1 percent of total salaries would not significantly affect the hospital's overall average hourly wage. We consider the 1 percent test critical in ensuring that providers only include other wage-related costs that contribute significantly to their wage costs and that are not accounted for in the core list. In addition, we believe the 1 percent test should be calculated using total salaries net of all direct excluded salaries since the excluded salaries and wage-related costs are removed from the wage index calculations.

Finally, we believe it is appropriate to retain the IRS reporting requirement, where applicable. Since there are many cost items that may or may not qualify as a fringe benefit depending on the individual hospital's circumstances, we believe this requirement delineates certain of those costs (such as employee meal costs) as a recognized fringe benefit cost. Therefore, we believe that the second and third criteria play important parts in determining the allowability of the other wage-related costs.

Comment: We also received specific comments concerning retiree health care costs and professional liability insurance costs. With respect to retiree health care costs, some commenters requested we allow not only the current year cost, but also any extraordinary accruals. One commenter stated that these costs should be eliminated from the core list because they are unrelated to the current employee workforce. With respect to professional liability insurance costs, commenters requested that we clarify those situations where these costs would be recognized as an "other" wage-related cost for purposes of the wage index.

Response: With respect to retiree health insurance costs, we believe that the extraordinary accruals should be excluded because such accruals are not representative of the current wage costs to the hospital. Although costs associated with retired employees also do not reflect the current workforce, we believe that the availability of retiree health insurance benefits is a significant factor affecting the employment decisions of the current workforce and therefore should be included as a core wage-related cost.

To clarify the allowability of malpractice insurance costs for purposes of the wage index, only those policies that list actual names or specific titles (for example, President of the hospital) of covered employees may be included in the wage index. General malpractice liability coverage maintained by hospitals is not recognized as a wage-related cost for purposes of the wage index. We note that effective with cost reporting periods beginning on or after October 1, 1994, malpractice insurance costs related to salaried physicians should be separately reported since physicians' salary costs may be excluded from the wage index in FY 1999.

Comment: One commenter requested that HCFA release a summary of the results of the fringe benefit survey conducted last summer to determine what costs the health care industry thought should be recognized as fringe benefits.

Response: We will make the results of the survey available to anyone requesting the data in writing. Requests may be sent to the following address: Division of Hospital Payment Policy; Attn: Lana Price; 1–H–1 East Low Rise; 6325 Security Boulevard; Baltimore, Maryland 21207.

Comment: A few commenters addressed the exclusion of wage-related costs associated with excluded areas within the hospital. Commenters requested detailed guidelines to follow when determining the wage-related costs for excluded areas.

Response: As indicated in the proposed rule, we are revising the Worksheet S–3, Part II, to incorporate an additional line to ensure that wage-related costs for any areas excluded from the wage index calculation are removed from the total wage-related costs reported by the hospital. Our policy on the removal of fringe benefits associated with excluded salaries is not new. Since not all hospitals are able to specifically identify wage-related costs attributable to individuals who work in the excluded areas, we believe it is appropriate to exclude a percentage of wage-related costs based on the relationship between the salaries paid in the excluded areas of the hospital to total salaries paid. The hospital must make available to its intermediary calculations used to determine these excluded wage-related costs.

Comment: Many commenters supported the utilization of Generally Accepted Accounting Principles (GAAP) in reporting wage-related costs beginning October 1, 1994. However, a few commenters raised concerns over its implementation, citing differences between the requirements of GAAP and the IRS. Since GAAP is not always consistent with IRS rules, they suggested that IRS rules should not be applied with respect to items such as tuition reimbursement, automobile/transportation allowances, or the unrecovered costs of employee meals.

Response: We continue to 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.

We have added to the form HCFA–339, Exhibit 7, Part 3, a reconciliation worksheet to aid hospitals and fiscal intermediaries in moving between GAAP when developing wage-related costs and Medicare principles when

determining reimbursable costs. All providers must complete this reconciliation form.

The differences between GAAP and IRS requirements, relate to the reporting of expenses on an entity's tax return and do not relate to whether a specific item is a fringe benefit that must be reported to the IRS as income to the employee receiving the benefit. We believe that following IRS requirements with respect to the reporting of fringe benefits as employee income is appropriate. Thus, items such as the unrecovered cost of employee meals, tuition reimbursement, and auto allowances will only be allowed as a wage-related cost for purposes of the wage index if properly reported to the IRS on an employee's W–2 form as a fringe benefit.

Comment: Five commenters suggested that, in addition to excluding the direct salaries and hours for sub-provider components of the hospital, HCFA should also exclude the general service, or overhead, wages and hours that are associated with these areas. Most of the commenters believe that exclusion of only the direct salaries is unfair to hospitals with sub-providers since the average hourly wages of the general service cost centers, such as Dietary/Food Service, and Housekeeping and Laundry Services, are usually lower than a particular facility's nursing unit costs. Further, the commenters state that these hospitals do incur additional general service costs relative to the exempt area, and these costs should be accounted for in the excluded wage data. They believe that, by removing the higher nursing costs and leaving in the lower general service costs, the hospital's average wage per hour is artificially weighted downward.

Response: In 1993, we considered making an allocation of overhead salaries and hours for the excluded components of the hospital. In response to requests from the hospital industry for exclusion of additional costs, we initiated a special data collection to obtain the hours associated with workers in the general service areas of those hospitals that reported excluded salaries and hours. We received general service hour data for 3,811 of the 5,436 hospitals for which we had wage data. We analyzed this special survey data in conjunction with the wage data from the cost report to determine whether we could reasonably allocate the overhead wages and hours to the excluded areas of the hospital. For several reasons, we concluded that it was not feasible to allocate overhead wages and hours to the excluded areas of the hospital.

Our analysis revealed that the average hourly wage for a large proportion of hospitals would decrease rather than increase as a result of performing the allocation. This unexpected result contributed to our conclusion that the data collected regarding overhead hours were inaccurate. Because of the large number of hospitals removed through the edit process, which was discussed in detail in the May 26, 1993 proposed rule (58 FR 30237), the large number of hospitals with large swings in their average hourly wages, and the large proportion of hospitals whose average hourly wage would decrease rather than increase, we continue to believe it would be inappropriate to employ the allocation of general service salaries and hours to the excluded areas of hospitals in constructing the FY 1995 wage index.

We agree with these commenters that it would be reasonable to exclude some portion of the general service costs associated with those areas of the hospital that are excluded from the wage index calculation once an accurate and uniform allocation method is devised. Although many hospitals have attempted to make this calculation independently, we have instructed the fiscal intermediaries that independently determined allocation methods are unacceptable. We do not believe it is appropriate to allow some hospitals to allocate certain overhead salaries to the excluded areas, while other hospitals do not. We plan to re-examine this issue based on the data reported on the FY 1992 cost report, which include the general service hours reported on line 16 of the Worksheet S–3, Part II, and hope to propose an allocation method all hospitals can use. In addition, we have proposed a change to the Worksheet S–3, Part III, to collect overhead cost data for excluded areas effective with cost reporting periods beginning October 1, 1994. Therefore, we will continue to collect data and attempt to produce a more accurate and uniform allocation method that can be used by all hospitals with excluded areas and that will provide data the intermediary can verify. We will discuss our analysis of the FY 1992 overhead data in the FY 1996 proposed rule.

Comment: Several of the commenters who supported the proposed revisions to the reporting of wage data with respect to Part A physician costs, management contracts, and wage-related costs advocated the immediate implementation of such changes. They suggested that we reopen previous cost reports and collect the necessary data to effect a revised wage index based on these changes as early as FY 1995. They stated that making these changes effective with cost reports beginning on or after October 1, 1994 will extend inequities until FY 1999.

Response: Making immediate changes in the wage index based on the revised reporting requirements would be inappropriate for several reasons. First, the data necessary to institute these changes immediately are not available. Currently, relevant detailed data have not been collected for Part A physician salaries, CRNA services, fringe benefits or management contracts that would enable us to immediately implement these changes. Moreover, the collection of additional data applicable to prior periods would create a significant reporting burden for hospitals. As indicated earlier, we are revising the Worksheet S–3, Part II, to identify separately Part A and Part B physician services for potential exclusion from the wage data.

In addition, it has always been our policy not to apply policy changes retroactively. The revisions to our policies regarding the reporting of wage-related costs represent a change in policy. The current policies are still in effect for the FY 1992 cost reports that will be used in computing the FY 1996 wage index. Since the prior cost reporting periods have already ended or are about to close for many providers, we do not believe it is appropriate to change the reporting rules retroactively. Further, it would not be fair to hospitals to require that they retroactively revise their recordkeeping systems to accommodate these changes.

Finally, while it is true that adjustments to the wage index will not be reflected until FY 1999, this allows time for hospitals that may be adversely affected to adjust their fiscal plan. The changes we are implementing on the reporting of wage data are extensive and will likely result in some payment shifts. We believe that it is incumbent upon us to allow hospitals sufficient time to adjust their operations so they can continue to provide efficient and quality services to all beneficiaries. Therefore, to ensure that hospitals have ample time to adjust for the changes in the reporting of wage data, all changes will be effective for cost reporting periods beginning on or after October 1, 1994, and thus are scheduled to be reflected in the wage index for FY 1999.

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 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 final 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. Hospitals may use the average hourly wage published in the final rule for purposes of applying to the MGCRB for wage index reclassifications in 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 FY 1995 wage index values incorporate all reclassification decisions made by the MGCRB for FY 1995. At the time the final wage index was constructed, the MGCRB had completed its review. Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process have also been incorporated into the wage index values published in this final rule. There were 425 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).

Comment: One commenter suggested that we incorporate the MSA code for each area in table 4A.

Response: Since many users may have a need for the MSA code, we have revised Table 4A by including the 4-digit MSA code to the left of the name of each area.

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 represents the second annual update to the wage data. We used 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 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	2	13
Increase between 5 and 10 percent	4	24
Decrease between 5 and 10 percent	13	58
Decrease more than 10 percent	10	14

Under the FY 1995 wage index, 90.6 percent of all prospective payment hospitals (5,325 hospitals) would experience a change in their wage index value of less than 5.0 percent. Approximately 4.7 percent (248 hospitals) would experience a change of between 5 and 10 percent, and 4.8 percent (255 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 because 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	98	70
Decrease between 5 and 10 percent	24	61
Change between −5 and +5 percent	2,116	2,706
Increase between 5 and 10 percent	41	122
Increase more than 10 percent	68	19

F. Medicare Geographic Classification Review Board—Elimination of the Adjacency Requirement for Individual Hospital Reclassifications

1. Background

Section 1886(d)(10) of the Social Security Act (the Act) provides for the establishment of the Medicare Geographic Classification Review Board (MGCRB). The MGCRB is responsible for issuing decisions on applications submitted by hospitals seeking reclassification to another geographic area for purposes of payment under the prospective payment system. The MGCRB is required by statute to issue decisions on hospital applications no later than 180 days after October 1, the first day of the Federal fiscal year (FY) preceding the Federal fiscal year for which the hospital is seeking reclassification. Hospitals may be reclassified individually for purposes of their wage index, standardized amount, or both. Hospitals may also be reclassified as a group for purposes of both the wage index and the standardized amount, but not solely for one of these measures.

Guidelines concerning the criteria and conditions for hospital reclassification are located at 42 CFR §§ 412.230 through 412.236. Currently, § 412.230(a)(2) specifies that to qualify for reclassification, an individual hospital must be located in a county or MSA that is adjacent to the area to which it seeks reclassification ("the adjacency requirement"). In addition, under § 412.230(a)(3), a hospital must meet one of the geographic proximity criteria set forth at § 412.230(b) ("the proximity requirement"). Specifically, to meet the proximity requirement, either the distance from a hospital to the adjacent area to which it seeks reclassification must be no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital, or at least 50 percent of the hospital's employees must reside in the adjacent area. (Under § 412.230(a)(4), rural referral centers and sole community hospitals are not subject to the adjacency or proximity requirements.)

On May 6, 1994, in *Athens Community Hospital, Inc. v. Shalala*, 21 F.3d 1176 (D.C. Cir. 1994) ("*Athens*"), the United States Court of Appeals for the District of Columbia Circuit ruled on the validity of the adjacency requirement as applied to individual rural hospitals. The Court of Appeals noted that the Secretary had already demonstrated in previous litigation that geographic proximity is relevant to determining whether a hospital competes in a particular area for labor. *Athens* at 1175. In *Universal Health Services of McAllen v. Sullivan*, 770 F. Supp. 704 (D.D.C. 1991), *aff'd mem.*, 978 F.2d 745 (D.C. Cir. 1992), the court had upheld the proximity criterion that requires a rural hospital seeking reclassification to an urban area to demonstrate that it is no more than 35 miles from the area to which it seeks redesignation.

In the *Athens* decision, the Court of Appeals found that the proximity requirement's mileage criteria ensure that a hospital is geographically proximate to the county to which it seeks reclassification. *Athens* at 1176. The court further concluded that, as a supplement to the proximity requirement, the adjacency requirement has no additional role to play in determining the labor markets in which a hospital competes. The court invalidated the adjacency requirement for individual rural hospital reclassifications. *Athens* at 1176.

2. Elimination of the Adjacency Requirement

We have decided to acquiesce in the *Athens* decision by eliminating the adjacency requirement for individual hospitals seeking geographic reclassification for purposes of the prospective payment system. (Although the court's ruling specifically pertains only to the adjacency requirement as it is applied to individual rural hospitals, we are eliminating the requirement for individual urban hospitals as well.) As a result of our acquiescence in the *Athens* decision, an individual hospital will no longer be required to demonstrate that the county or MSA in which it is located is adjacent to the area to which it seeks reclassification. However, individual hospitals seeking reclassification to another area still must meet the proximity criteria at § 412.230(b) (except for sole community hospitals and rural referral centers, as specified in current § 412.230(a)(4)).

This change, which eliminates the adjacency requirement for individual hospitals, is effective for applications submitted by October 3, 1994, for hospitals seeking reclassification for FY 1996. We also are removing the provision in § 412.230(a)(4)(i) that excepted sole community hospitals and rural referral centers from the adjacency requirement. Since the adjacency requirement will no longer apply to any individual hospital applying for reclassification, this provision is unnecessary.

Although we are eliminating the adjacency criteria for individual hospital reclassifications, our policies regarding hospitals seeking group reclassifications under § 412.232 and § 412.234 remain unchanged. As discussed above, the *Athens* decision applies only to individual hospital reclassifications. The court found that the proximity requirement alone is sufficient to determine whether an individual hospital is geographically proximate to the area to which it seeks reclassification. Thus, the court found that for an individual hospital, the adjacency requirement is an unnecessary supplement to the proximity requirement. However, urban and rural hospitals applying for reclassification as a group are not required to meet proximity requirements similar to those set forth at § 412.230(b). Thus, we have determined that the adjacency requirement is necessary to guarantee geographic

proximity for hospitals applying for reclassification as a group.

Accordingly, the elimination of the adjacency requirement only applies to individual hospitals that are required to meet the proximity requirements set forth at § 412.230(b). Finally, we note that the alternative reclassification criteria for hospitals located in a New England County Metropolitan Area (NECMA), as set forth under § 412.236 (b) and (c), are also unaffected by this final rule.

3. Provisions of This Final Rule Concerning Geographic Reclassification Criteria

To implement the policies discussed above, we are amending § 412.230 as follows:

- We are eliminating the adjacency requirement for individual hospital reclassifications by deleting paragraph (a)(2);
- We are redesignating paragraphs (a)(3) through (a)(5) of § 412.230 as (a)(2) through (a)(4);
- We are removing the exception to the adjacency provision for sole community hospitals and rural referral centers, which is now unnecessary, by deleting redesignated paragraph (a)(3)(i). (Paragraphs (a)(3)(ii) through (a)(3)(v) are redesignated as (a)(3)(i) through (a)(3)(iv)); and
- We are making a series of technical changes to § 412.230 to eliminate references to "adjacent area" and to correct internal cross references.

G. Application for Geographic Reclassification in FY 1996

Hospitals that intend to apply for geographic reclassification for FY 1996 should make note of the following information regarding the submission of applications to the MGCRB. First, the statutory deadline for filing applications with the MGCRB for FY 1996 reclassifications is October 1, 1994. However, since this date falls on a Saturday, the MGCRB will accept applications through October 3, 1994, the first Federal working day following the usual deadline. This extension is consistent with the provisions in section 216(j) of the Act, which apply to the Medicare program by virtue of section 1872 of the Act. Applications must be received by the MGCRB by close of business on October 3, 1994, in order to be considered timely. Untimely applications will not be accepted. Hospitals are expected to undertake the appropriate measures to ensure that their applications are received by the MGCRB in a timely manner.

In addition, we note that the MGCRB has moved to a new address. All MGCRB applications should be sent to the following address: Medicare Geographic Classification Review Board, Professional Building, 6660 Security Boulevard, Suite 13, Baltimore, Maryland 21207–5187. The MGCRB is not responsible for applications that are not received timely due to an incorrect address. We received one comment on the MGCRB application process.

Comment: One commenter noted that hospitals have 45 days from publication of the proposed rule to withdraw their applications for geographic reclassification. The commenter asserted that since changes may occur in the wage index values between the publication of the proposed rule and the final rule due to editing and the correction of errors in the FY 1991 data, hospitals should be permitted to withdraw their applications up to 15 days after the publication of the final rule.

Response: We continue to believe that the proposed rule constitutes the latest feasible resource for providing hospitals with the necessary information to decide whether to withdraw requests for reclassification. We recognize that the proposed wage index values may change somewhat as a result of withdrawal requests, the effect of any decisions by the MGCRB or the Administrator that were not issued in time to be taken into account in the proposed rule, and the effect of any further corrections to the wage data.

It is important to note, however, that withdrawals that occur after the 45-day deadline have a direct impact on the area wage index values both for the area in which the hospital is located and the area to which it had previously been reclassified. Therefore, we cannot extend the 45-day deadline, because doing so would not provide sufficient time to take withdrawals into account in the development of the final wage index and prospective payment system rates. We note that although hospitals are permitted to withdraw their applications for reclassification at any time during the 45-day period, if an MGCRB decision has already been made, a hospital that requests that its application be withdrawn may not request that the MGCRB decision be reinstated after publication of the prospective payment system final rule.

IV. Other 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.

For the most part, inpatient hospital services furnished by hospitals and 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 paid 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 18.9 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.

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 may provide 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 may exist whether the acute-care hospital is transferring patients to its hospital-based excluded units or to other excluded hospitals.

For these reasons, we proposed 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 believed 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. The proposed policy would have applied to cases transferred to all excluded hospitals and units, Veterans Administration hospitals, other Federal hospitals, and hospitals not participating in Medicare. However, discharges to nonhospital 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, which first implemented the prospective payment system, recommended that the transferring hospital should either receive the full DRG amount or 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).

In 1993, as a part of a study of transfer case payment, 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 the second day are about 1.215 times the per diem payment amount, and the costs after the second day are about 10 percent more than the applicable per diem amount. Among surgical cases, the costs per day beyond 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.

Despite these concerns, we proposed 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 believed that the potential improvement in payment equity outweighed the concerns of the proposal. We proposed 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 proposed, 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 did not propose 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 proposed, 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.

We received over 1000 comments on the transfer policy proposals, the majority of which disagreed with our proposed revision in the transfer definition. Based on these comments and further analysis we are not making the proposed changes to our transfer policies in this final rule. However, we intend to continue to analyze our policies.

Comment: The most frequent comments were objections to our rationale for proposing the change. Many stated that this proposal was an overreaching attempt to address a small number of inappropriate transfers by penalizing all transfers to excluded hospitals and units. Many of the commenters stated that the problem should be addressed through Peer Review Organizations rather than through our proposal.

Other commenters questioned our analytic basis for the change, pointing out that they believe we misinterpreted the studies referenced in the proposed rule, and that the real reason for the increase in the number of excluded hospitals and units and the corresponding increase in the number of transfers is the clinical needs of the Medicare patients. Similarly, many commenters asserted that, contrary to the assertions in the proposed rule, the distinctions between the types of services provided in short-term acute care settings and excluded hospital settings is more significant now than it was in 1983.

Response: We believe that the majority of the commenters misunderstood our rationale for this proposed change. A primary objective in proposing this change was to improve the extent to which payments match the cost of the services provided in each of the various settings involved in the course of treatment of a particular patient. Our proposal to pay the transferring acute care hospital a per diem amount is based upon the premise that an increasing number of patients are being transferred to excluded hospitals or units and that these patients are still in the acute care phase of treatment when they are transferred (we note that many commenters agreed with this premise). As these excluded settings are treating more severely ill patients and receiving correspondingly higher payment amounts from Medicare (particularly through adjustments to the limits on the rate-of-increase in their operating costs per case), we believe it is more appropriate to define these cases as transfers under the same logic applied to cases transferred from one acute care hospital to another; that is, the transferring hospital generally is not providing the entire course of treatment associated with the DRG.

As noted in the proposed rule (59 FR 27735), when the prospective payment system was implemented in 1983, we believed that the transfer of patients to excluded hospitals or units indicated that the acute phase of their treatment was completed and that payment in full to the transferring hospitals for that treatment was warranted. We believe this has changed. Patients who 10 years ago would have stayed in an acute care hospital throughout their course of treatment are now being transferred to excluded settings, and these transfers are occurring earlier during the acute hospital stay. Consistent with the data we cite in the proposed rule indicating increased utilization of excluded facilities, many of the commenters noted that there is an increasing emphasis on beginning rehabilitative therapy as soon as possible.

We did not mean to imply (as some commenters inferred) that we view this trend as inappropriate. On the contrary, we developed the proposal under the assumption that increasing transfers to excluded settings would continue in the future. The important point is simply that we believe that there is now substantial overlap in the care being provided by acute care and excluded facilities, particularly with regard to inpatient rehabilitation settings. As one rehabilitation professional commented, "Inpatient rehabilitation units are equipped medically and staffed to handle many continuing medical problems."

Our second objective in proposing this change was to ensure that the payment methodology, as much as practicable, is neutral in terms of any incentives affecting where and how patients are treated. To the extent that the transfer payment methodology is representative of the average per diem costs hospitals incur for these cases, we disagree with the argument that our proposal would penalize acute care hospitals for transferring patients to excluded facilities. To the contrary, paying the full DRG amount for these cases rewards hospitals for transferring patients as soon as possible, particularly as excluded facilities have equipped themselves to treat more acutely ill patients. Again, we wish to emphasize that we are not under the assumption

that the general trend toward earlier discharges is in itself inappropriate. We agree with the commenters that we do not have evidence that patient care has suffered overall as a result of this trend. Rather, we proposed the change in definition of a transfer because we believed that a per diem payment, based on average costs per day within specific DRGs, would more appropriately compensate the acute care hospital.

Comment: Numerous commenters questioned whether our objective was to create an incentive to send patients to skilled nursing facilities (SNFs) or other postacute or subacute settings. They noted that, although SNFs are increasingly providing rehabilitative services and, in some cases, competing with inpatient rehabilitation facilities, few, if any, SNFs are accredited by the Commission on Accreditation of Rehabilitation Facilities. Many commenters opined that, rather than neutralizing the incentives affecting where patients are treated, the proposed change would create a financial incentive for acute care hospitals to transfer patients to SNFs instead of rehabilitation facilities, since they would receive a full DRG payment for these cases. Most of the commenters expressed a belief that the proposal would have a detrimental impact on patient care.

Response: Our proposal was not intended to create an incentive for hospitals to transfer patients to SNFs for rehabilitation services in order to save money. Rather, we remain committed to ensuring that the payment system not unduly influence the choice of setting in which patients are treated. We did not propose to consider discharges to SNFs as transfers because we do not consider SNFs to be hospital settings; thus, there is generally little overlap with acute care hospitals in the services provided. In fact, the unanimous opinion expressed by the commenters was that SNFs and other post-hospital care providers do not generally provide the same intensity of services as rehabilitation hospitals and units.

Nevertheless, we are concerned that the criteria used to indicate the most appropriate rehabilitation setting may not be well understood. Although we believe that decisions regarding appropriate settings will predominantly be made based on the clinical needs of the patient, we intend to study this issue further. In particular, we will explore the implications associated with use of the Uniform Needs Assessment Instrument for determining appropriate post-acute hospital settings.

Comment: We received some comments stating that we failed to document the impacts our proposal would have on hospital payment.

Response: In Appendix A (Regulatory Impact Analysis) to the proposed rule (59 FR 27847), we analyzed the impacts on hospital payment of all of the proposed FY 1995 changes, including the transfer changes. That analysis found that the combined impacts of the proposed changes to the transfer policy (that is, to the payment methodology and the definition of transfers) was budget neutral across all hospitals. The higher payments for transfer cases due to the proposed graduated per diem methodology were offset by the reduction in payments for transfers to excluded settings. Among specific categories, the changes generally affected urban hospitals negatively (0.1 percent) and rural hospitals positively (0.5 percent). The impact on small hospitals was also positive.

In response to the commenters, we have also evaluated the impact of the proposed transfer definitional change by itself. Transfers to rehabilitation settings account for nearly 78 percent of the total transfers from acute care to excluded settings (rehabilitation units account for over one-half of these transfers). Because rehabilitation settings receive such a large percentage of transfers, and because the vast majority of comments we received pertained to the impact on rehabilitation facilities of the change, we focused our analysis on cases going to rehabilitation settings. Of these transfers, three DRGs stood out because of the large number of such transfer cases: DRG 14, Specific Cerebrovascular Disorders Except TIA; DRG 209, Major Joint and Limb Reattachment Procedures—Lower Extremity; and DRG 210, Hip and Femur Procedures Except Major Joint Age >17 With CC. We also examined DRG 483, Tracheostomy Except For Face, Mouth and Neck Diagnoses. Although it presently constitutes a much smaller percentage of transfer cases, it is of special concern because of its high DRG weight (and payment) and long average length of stay.

We analyzed how well our payment methodology would compensate hospitals for the costs of cases in these DRGs when patients are transferred to excluded settings prior to reaching the geometric mean length of stay for the DRG, minus one. (Based on the proposed change in payment methodology, a full DRG payment is received at that point). The results of our analysis are as follows. First, for each of these DRGs, over 90 percent of the cases are transferred to excluded settings after the geometric mean length of stay minus one, and, thus, would be unaffected by the change in definition of a transfer (except for cases that may qualify as a day outlier, since transfers are ineligible for this adjustment). Second, for DRGs 14 and 483, the costs of these cases progress evenly with length of stay, indicating that a per diem payment methodology would adequately compensate for the costs incurred prior to transfer.

A problem arises, however, with DRGs 209 and 210. Consistent with RAND's analysis of the per diem costs of transfers of surgical DRGs between two acute care settings, the bulk of the costs appear to occur during the first day of the acute care stay. In fact, costs in DRGs 209 and 210 appear to be even more heavily skewed toward the first day than RAND found. This is of significant concern, given that these DRGs account for such a high proportion of transfers to excluded facilities. (RAND found, consistent with prior analyses, that surgical DRGs comprise only a fraction of transfers between acute care hospitals). Even with the proposed change in the per diem payment methodology, hospitals would be systematically underpaid for short-stay cases on DRGs 209 and 210 if we were to adopt the proposed change in transfer definition.

Therefore, we have decided to withdraw this proposal at this time. Thus, transfers from acute care hospitals to hospitals and units excluded from the prospective payment system will continue to be considered discharges. We wish to emphasize that we remain concerned about the appropriateness of this policy and intend to continue our research in this area.

Comment: The comments we received regarding the change to the per diem payment methodology were generally favorable. One commenter recommended that we provide for different gradations to the per diem for medical and surgical cases. Another, while supporting the change in principle, felt that we should pay more than twice the per diem for the first day of a transfer stay. Several commenters indicated their belief that the standardized amounts for all hospitals would have to be recalculated to reflect our proposed changes to transfer policy.

Response: We are also withdrawing the proposed change to the payment methodology for transfer cases. In assessing the appropriateness of the proposed change, we must balance the merits against the problems. As discussed above and in the proposed rule (59 FR 27736), we have several concerns with a graduated payment methodology, such as problems in specifying the gradation and possible

incentives to transfer. (See also the discussion in the September 1, 1993 final rule (58 FR 46307).) Nevertheless, we proposed to change the payment methodology because we believed the benefits outweighed the problems.

In the proposed rule, we estimated that the proposed change to the transfer payment methodology in conjunction with the proposed change to the definition of transfer would result in zero net impact on overall spending (59 FR 27854). However, as explained above, we are withdrawing the proposal to change the definition of transfers. Accordingly, the financial impact of the proposed payment methodology must be reevaluated. We estimate that the costs of the proposed change in payment methodology, standing alone, would be just over $150 million.

This cost must be considered together with the other factors arguing for and against a change to the payment methodology. Given those other factors, and given current Federal budgetary constraints, we do not feel it would be appropriate to change the transfer payment methodology absent an offsetting savings provision. We note that, in its March 1, 1993 report to Congress, ProPAC recommended that Congress provide authority to HCFA to implement a graduated payment methodology in a budget neutral manner; as yet, no such legislative change has been enacted.

Comment: We received several other more general comments with respect to our proposed transfer changes. Some commenters believe that the prospective payment system is a self-correcting system; thus, it is inappropriate to reduce payments for discharges made before the mean length of stay without similarly adjusting payments upward for discharges made beyond the mean length of stay. Reducing payment alone penalizes efficient hospitals, which is contrary to the objectives of the prospective payment system. Other commenters, including ProPAC, noted the health reform movements toward a continuum of care, although ProPAC did not express the view of some commenters that the proposed change to transfer definitions was contrary to this movement. In its comments, ProPAC also discussed its findings with regard to hospitals that receive high percentages of transfer cases, primarily that these incoming transfers frequently become outlier cases. The Commission referred to its comments on outlier policy in this regard.

Response: During the next year, we intend to continue our evaluation of all aspects of transfer payment policy. Our analysis has indicated several areas for potential improvements that we believe should be addressed in a comprehensive manner. We disagree with the comment that it is inappropriate to reduce payments for transfers without increasing payments beyond the mean length of stay, since we do increase payments at the high cost end through our outlier policy, but we do intend to carefully examine the overall symmetry of the prospective payment system in terms of payment equity at both the low and high ends of inpatient stays. As part of that examination, we will approach this analysis from a perspective that recognizes the increasing movement of patients in and out of various treatment settings.

B. Review of DRG Assignments (§ 412.60, 466.71, and 466.78)

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 proposed to revise § 412.60(d)(2) to conform the regulations to current practice. At the same time, we proposed to 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).

We received one comment on this proposal, which was in favor of the change. Thus, we are incorporating the proposed change concerning the PRO review of DRG assignments in this final rule. In addition, we are making technical changes §§ 466.71(c)(2) and 466.78(a) to conform the text of those sections to this revised policy.

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 proposed 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 final rule, we provide a description of the updates 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 modifies 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 of 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 for discharges occurring 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 proposed to set 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 are establishing 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 (for a detailed discussion of the methodology, see section II.A.4.c of the addendum to this final rule). 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. As proposed, we are revising § 412.80 to reflect this provision. We are also revising § 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 for each fiscal year during the day outlier phase-out in the annual prospective payment system rulemaking process.

We stated that 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 proposed 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 FY 1994 and FY 1995 outlier policies. Based on these simulations, in the proposed rule 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. In this final rule, based on updated simulations, we are establishing a marginal cost factor of 47 percent in FY 1995, a reduction from the 55 percent in FY 1994.

We are also establishing a fixed loss cost outlier threshold in FY 1995 equal to the prospective payment rate for the DRG plus $20,500 ($18,800 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 using the fixed loss threshold pursuant to 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.)

To further focus Medicare's cost outlier payments on the costliest cases, we are increasing the marginal cost factor from 75 percent to 80 percent, as proposed. 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 have used 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 are:

- 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 $27,000.

We estimate that the final FY 1995 outlier thresholds that we are establishing would result in 55 percent of outlier cases paid using the cost outlier methodology and 45 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 22 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 paid as day outliers would receive approximately 24 percent of operating outlier payments in FY 1995.

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	36.0	12.0	10.0	12.0
Meets day and cost thresholds, paid using day methodology	9.0	12.0	10.0	12.0
Meets day and cost thresholds, paid using cost methodology	22.0	49.0	47.0	49.0
Subtotal—All cases meeting day threshold	67.0	73.0	67.0	73.0
Meets cost threshold only	33.0	27.0	33.0	27.0
Total	100.0	100.0	100.0	100.0

When we modeled the combined operating and capital outlier payments, we find 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 estimated that the final thresholds for FY 1995 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.9 percent of capital payments based on the Federal rate.

The following is an example of how additional payment to a hospital paid using the fully prospective payment methodology will be determined for an outlier case in FY 95.

Example: Hospital X is a 150 bed hospital located in the San Francisco, California MSA, which is a large urban area. Hospital X has a ratio of interns and residents to beds of .1, a ratio of interns and residents to average daily census of .085, and a disproportionate patient percentage of 30.2%. Mr. Jones is admitted to Hospital X on October 1, 1994 and is discharged on November 30, 1994. The billed charges for Mr. Jones' stay are $100,000. Mr. Jones is classified in DRG 286. Because Mr. Jones' 61 day stay exceeds the 30 day length of stay outlier threshold for DRG 286, Hospital X is eligible for payment for 31 outlier days in addition to the otherwise applicable prospective payment. The amount of Hospital X's outlier payment (excluding the usual Federal payments for operating and capital costs that apply for both outlier and non-outlier cases, and the hospital-specific portion of the capital payment) is calculated as follows:

Day Outlier:

Step 1: Computation of the Federal Rate (excludes capital, indirect medical education (IME) and disproportionate share hospital (DSH) payments):

National Large Urban Standardized Amounts:	
Labor-Related	$2,709.42
Nonlabor-Related	1,085.29
San Francisco MSA Wage Index	1.4120
DRG 286 Relative Weight	2.2621

DRG Relative Weight × [(Labor-Related National Large Urban Standardized Amount × San Francisco MSA Wage Index) + Nonlabor-Related National Large Urban Standardized Amount] = Federal Rate for Operating Costs:

2.2621 × [($2,709.42 × 1.4120) + $1,085.29] =	11,109.15

Step 2: Computation of Federal Capital Payments:

Federal Capital Rate	376.83
DRG 286 Relative Weight	2.2621
Federal Portion of Capital Rate	40% [1]
Geographic Adjustment Factor	1.2665

DRG Relative Weight × Federal Capital Rate × Federal Portion of Capital Rate × Geographic Adjustment Factor × Large Urban Add-On = Federal Rate for Capital Costs:

2.2621 × $376.83 × 0.40 × 1.2665 × 1.03 =	444.79

Step 3: Computation of Day Outlier Payments:

Arithmetic Mean Length of Stay for DRG 286	9.3 days
Outlier Days	= (61 − 30) = 31 days
Marginal Cost Factor	47%
A. Operating Outlier Payment (excludes IME and DSH) = Number of outlier days × (Operating Federal Payment ÷ Arithmetic Mean Length of Stay for DRG 286) × Marginal Cost Factor = 31 × ($11,109.15 ÷ 9.3) × .47 =	17,404.34
B. Capital Outlier Payment (excludes DSH) = Number of outlier days × (Capital Federal Payment ÷ Arithmetic Mean Length of Stay for DRG 286) × Marginal Cost Factor = 31 × ($444.79 ÷ 9.3) × .47 =	696.84

Step 5: Computation of IME Adjustment For Day Outliers:	
i. IME Operating Factor	.0744
Operating Outlier Payment × IME Operating Factor = IME Operating Outlier Adjustment:	
$17,404.34 × .0744 =	1,294.88
ii. IME Capital Factor	.0243
Capital Outlier Payment × IME Capital Factor = IME Capital Outlier Adjustment:	
$696.84 × .0243 =	16.93
Step 6: Computation of DSH Adjustment for Day Outliers:	
i. Operating DSH Adjustment Factor	.1413
Operating DSH Adjustment Factor × Operating Outlier Payment = DSH Operating Outlier Adjustment:.	
.1413 × $17,404.34 =	2,459.23
ii. Capital DSH Adjustment Factor	.0631
Capital DSH Adjustment Factor × Capital Payment = DSH Capital Outlier Adjustment:	
.0631 × $696.84 =	43.97
Step 7: Total Day Outlier Payments:	
Regular Operating Outlier Payment	17,404.34
Regular Capital Outlier Payment	696.84
IME Operating	1,294.88
IME Capital	16.93
DSH Operating	2,459.23
DSH Capital	43.97
Total	21,916.19
Cost Outlier:	
Step 1: Computation of Hospital X's Standardized Costs:	
Billed Charges	100,000
Hospital X's Operating Cost-to-Charge Ratio	.72 [2]
Hospital X's Capital Cost-to-Charge Ratio	.06
IME Operating Adjustment Factor	.0744
IME Capital Adjustment Factor	.0243
DSH Operating Adjustment Factor	.1413
DSH Capital Adjustment Factor	.0631
(Billed charges × Operating Cost-to-Charge Ratio) ÷ (1 + IME Operating Adjustment Factor + Operating DSH Adjustment Factor) = Standardized Operating Costs:	
($100,000 × .72) ÷ (1 + .0744 + .1413) =	59,225.14
(Billed Charges × Capital Cost-to-Charge Ratio) ÷ (1 + IME Capital Factor + Capital DSH Factor) = Standardized Capital Costs:	
($100,000 × .06 ÷ (1 + .0243 + .0631) =	5,517.75
Step 2: Determination of Cost Thresholds:	
A. Computing the Operating Threshold Amount:	
Operating Federal Rate for DRG 286	11,109.15
Fixed Loss Threshold	20,500
Labor-Related Share, Operating	.7140
Nonlabor Share, Operating	.2860
i. Operating standard cost a share of total costs Operating Cost-to-Charge Ratio ÷ (Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio) = Operating Cost as a Share of Total Costs: .72 ÷ (.72 + .06) = [.9231]	
Wage Index Adjusted Operating Cost Outlier Threshold = {[Fixed Loss Threshold × ((Labor-Related Share × San Francisco MSA Wage Index) + Nonlabor-Related Share) × Operating Standard cost as a share of total costs] + (Operating Federal Rate for DRG 286]}	
{[20,500 × ((.7140 × 1.4120) + .2860) × .9231] + 11,109.15□ =	35,599.40
B. Computing the Capital Threshold Amount:	
Federal Capital Rate	376.83
Fixed Loss Threshold	20,500
DRG 286 Relative Weight	2.2621
San Francisco Geographic Adjustment Factor	1.2665
i. Capital Standard Cost as a Share of Total Costs Capital Cost-to-Charge Ratio (Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio) = Capital Cost as a Share of Total Costs: .06 ÷ (.72 + .06) =	.0769
Geographic Adjustment Factor Adjusted Capital Cost Outlier Threshold = [(Fixed Loss Threshold × Geographic Adjustment Factor × Large Urban Add-On Factor × Capital standard cost as a share of total costs) + (Federal Rate × DRG 286 Relative Weight × San Francisco MSA Geographic Adjustment Factor × Large Urban Add-On Factor)]	3,168.46
[(20,500 × 1.2665 × 1.03 × .0769) + (376.83 × 2.2621 × 1.2665 × 1.03)] =	
Computation A Result, Operating	35,599.40
Computation B Result, Capital	3,168.46
Threshold = $35,599.40 + $3,168.46 =	38,767.86
Step 3: Determination of Cost Outlier Payment:	
Marginal Cost Factor	.80
A. Operating Outlier Payment:	
Operating Outlier Cost = Standard Operating Costs − Operating Threshold:	
$59,225.14 − $35,599.40 =	23,625.74
Operating Outlier Payment = Operating Outlier Cost × Marginal Cost Factor:	
$23,625.74 × .80 =	18,900.59

B. Federal Portion of Capital Outlier Payment:	
Capital Outlier Cost = Standard Capital Costs − Capital Threshold:	
$5,517.75 − $3,168.46 =	2,349.29
Capital Outlier Payment = Capital Outlier Cost × Marginal Cost Factor:	
$2,349.29 × .80 =	1,879.43
Federal Portion of Capital Outlier Payment = Federal Portion of Capital Rate × Capital Outlier Payment:	
$1,879.43 × .40 =	751.77
Step 4: Cost Outlier Payment for IME:	
i. Operating Outlier Payment × IME Operating Adjustment Factor = Cost Outlier Payment for IME Operating:	
$18,900.59 × .0744 =	1,406.20
ii. Capital Outlier Payment × IME Capital Adjustment Factor = Cost Outlier Payment for IME Capital:	
$751.77 × .0243 =	18.27
Step 5: Cost Outlier Payment for DSH:	
i. Operating Outlier Payment × Operating DSH Adjustment Factor = Cost Outlier Payment for DSH Operating:	
$18,900.59 × .1413 =	2,670.65
ii. Capital Outlier Payment x Capital DSH Adjustment Factor = Cost Outlier Payment for DSH Capital:	
$751.77 × .0631 =	47.44
Step 6: Total Cost Outlier Payments:	
Operating	18,900.59
Federal Portion of Capital	751.77
IME Operating	1,406.20
IME Capital	18.27
DSH Operating	2,670.65
DSH Capital	47.44
Total	23,794.92
Determination of Outlier Payment:	
Total Day Outlier Payment	21,916.19
Total Cost Outlier Payment	23,794.92

Hospital X receives the greater of the two payments, which is $23,794.92, the cost outlier payment.

[1] a. If Hospital X were a hold harmless hospital, it would use the lesser of:
- The hospital-specific ratio of new to total capital, or
- The national average ratio of new to total capital.

b. If Hospital X were a 100% Federal hospital, the Federal portion would 1.0.

[2] This is the same cost-to-charge ratio currently used to determine outlier payments using operating costs only. The capital cost-to-charge ratio, when added to the operating cost-to-charge ratio, will yield a total cost-to-charge ratio. (This occurs because the denominator in both cases is total charges. The charges are not divided into operating and capital charges.)

Comment: Several commenters disagree with the change in the cost outlier methodology, from the higher of 2.0 times the DRG rate or a fixed dollar amount to the DRG amount plus a fixed dollar amount (the "fixed loss" method), asserting that although the statute permits us to make this change, it does not require it. These commenters believe the revised formula adversely affects various hospital groups with low payment-to-cost ratios for outlier cases. The commenters stated that we should continue to calculate the cost outlier threshold using the current method, since the provisions of Public Law 103–66 allows us the option of using either method.

Response: We believe that the change to the fixed loss method of calculating the cost outlier threshold is appropriate because it addresses concerns regarding outlier payments. Under the current method of calculating the thresholds, cases with losses of up to $100,000 might not qualify for outlier payments. Under the fixed loss method, all cases at a given hospital, regardless of the DRG to which they are assigned, will face no more than a fixed loss amount at which time they would begin receiving outlier payments. While the language of section 13501(c)(2) of Public Law 103–66 may be somewhat ambiguous, we note that the conference report accompanying Public Law 103–66 states that the conference agreement includes the House provision regarding the phase-out of day outlier payments "with an amendment to *require that* the payment threshold for cost outlier cases be set at the applicable DRG payment plus a fixed dollar amount" (emphasis added) (H.R. Conf. Rep. No. 213, 103d Cong., 1st Sess. 749 (1993)). We believe that it would be inappropriate to use any other method of calculating the cost outlier threshold, given this indication of Congressional intent.

Nevertheless, as a result of the comments we received on this issue, we performed additional analysis of the impact on payment-to-cost ratios for outlier cases and for all cases using the data available for this final rule. Our analysis indicated that under this change in cost outlier payment methodology, overall payment-to-cost ratios change only slightly, with the majority of hospital groups facing changes in their payment-to-cost ratios of less than 0.2 percentage points. The payment-to-cost ratios for all rural hospitals decrease by 0.1 percentage points while those for sole community hospitals increase by 0.3 percentage points. The payment-to-cost ratios for teaching hospitals with 100 or more residents increase 0.3 percentage points, while those for urban disproportionate share hospitals with at least 100 beds are unchanged. Payment-to-cost ratios for outlier cases increase 1.2 percentage points for all hospitals. Outlier case payment-to-cost ratios decrease 0.1 percentage points for rural hospitals and increase for urban hospitals (as they do for the majority of hospital groups). We believe that the results of our analysis, which show outlier payment-to-cost ratios increasing overall, indicate that we are more appropriately targeting outlier payments to those cases that face the greatest losses. As a result, we continue to believe that the change to the fixed loss cost outlier methodology is appropriate, as well as consistent with Congressional intent.

Comment: The Prospective Payment Assessment Commission (ProPAC) believes that, in the calculation of the cost of an outlier case, we should no longer standardize to remove the effects

of indirect medical education (IME) and disproportionate share hospital (DSH) adjustments. In addition, they believe that once this change is implemented, we should no longer make IME and DSH payments on the outlier portion of a hospital's payment.

Response: Currently the operating and capital costs of an outlier case are calculated as follows:

Cost = (Charges × CCR) ÷ (1 + IME + DSH), where:
CCR = the operating or capital cost-to-charge ratio, as appropriate;
IME = the indirect teaching adjustment for operating or capital PPS payments; and,
DSH = the disproportionate share adjustment for operating or capital PPS payments.

By dividing the charges, adjusted to cost, by (1 + IME + DSH) we are removing from the costs of the case the effects of teaching and serving a disproportionate share of low income patients. We remove these costs because sections 1886(d)(5) (B) and (F) of the Act require that we make additional payments for IME and DSH on outlier payments. If we did not remove the effect of IME and DSH from the estimated costs of outlier payments, we would be paying IME and DSH twice: once through the estimate of the marginal cost of treating these patients, which would include the effects on cost of IME and DSH, and again through the additional payments made on outlier payments. Thus, it would be inappropriate to eliminate the standardization since we are required by statute to make additional IME and DSH payments on outlier payments.

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.

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

The values in the proposed rule were based on discharges occurring during FY 1993 (October 1, 1992 through September 30, 1993) and included bills posted to HCFA's records through December 1993. Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 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. (See table set forth in the May 27, 1994, proposed rule at 59 FR 27739.)

Based on the latest data available (through June 1994), the final national case-mix value is 1.3040 and the median case-mix values for each region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.1986
2. Middle Atlantic (PA, NJ, NY)	1.2040
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3091
4. East North Central (IL, IN, MI, OH, WI)	1.2185
5. East South Central (AL, KY, MS, TN)	1.2492
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2047
7. West South Central (AR, LA, OK, TX)	1.2835
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3488
9. Pacific (AK, CA, HI, OR, WA)	1.3090

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

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, we proposed to update the regional standards. The proposed regional

standards were 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 proposed 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. (See table set forth in the May 27, 1994, proposed rule 59 FR 27739.)

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

Region	Number of discharges
1 New England (CT, ME, MA, NH, RI, VT)	6,814
2. Middle Atlantic (PA, NJ, NY)	8,878
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,157
4 East North Central (IL, IN, MI, OH, WI)	7,024
5. East South Central (AL, KY, MS, TN)	5,659
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,180
7. West South Central (AR, LA, OK, TX)	4,517
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,409
9. Pacific (AK, CA, HI, OR, WA)	5,788

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 or 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.

We received no comments on the rural referral center policies; therefore, they are adopted as proposed.

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 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. The 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 to at least 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 who argue 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 proposed 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 stressed 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 also proposed to make a technical change to § 412.105(d)(1) to correct a reference.

Comment: We received several comments in opposition to our proposed clarification. One commenter stated that this was a policy change requiring public comment that cannot be applied retroactively. Other commenters claimed that since

Medicare has little or no utilization in these areas, all of the beds should be excluded from the available bed count. One commenter stated that including these beds in the hospital bed size determination was incongruous with the determination of Medicare allowable costs.

Response: As explained in the proposed rule and repeated above, we are only clarifying our longstanding policy position regarding neonatal intensive care beds and are not making a change in policy. We note that the United States Court of Appeals for the Eighth Circuit recently upheld this long-standing policy *Sioux Valley Hospital* v. *Shalala*, No. 93–3741SD (8th Cir. July 20, 1994).

We disagree with the position that neonatal intensive care beds should be excluded based on the degree of Medicare utilization. Rather, we believe it is appropriate to include these beds because the costs and days of these beds are recognized in the determination of Medicare costs (nursery costs and days, on the other hand, are excluded from this determination). We also note that time spent by residents working in these areas is included in the resident-to-bed ratio calculation, irrespective of Medicare utilization.

Comment: Another commenter elaborated on the definition of a newborn, pointing out that *Dorand's Illustrated Medical Dictionary*, 27th Ed., makes no distinction with regard to the physical status of newborn infants, describing them only as "a recently born infant." This commenter then contends that the term "newborn" in § 412.105(b) includes infants regardless of whether they are in an intensive care unit. The commenter goes on to state that by including neonatal intensive care unit beds, we are placing an undue burden on these facilities.

Response: Our policy to include the costs, days, and beds of neonatal intensive care units has been in place since prior to the prospective payment system and has been the subject of considerable attention. We believe we have a responsibility to apply this policy consistently over time and across providers. Excluding these beds from the determination of bed size would have an adverse impact on some hospitals. Several other prospective payment system special adjustments are based on bed size; for example, thresholds and adjustments for the disproportionate share (DSH) adjustment for urban hospitals with 100 or more beds. If we no longer considered neonatal intensive care beds in determining bed size, DSH adjustments to some hospitals would be sharply reduced. To prevent any future confusion about the term "newborn" in § 412.105(b), we are revising the proposed language to reference "nursery beds."

We reiterate that our policy is unchanged and that we are merely clarifying the regulations at § 412.105(b). We are adopting the proposed change with technical revisions.

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.

In the proposed rule, we did not propose changes to any part of § 412.106. 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 proposed 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 proposed 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 proposed 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 proposed 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 noted 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 proposed 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.

In response to our proposal to provide for appeals of EACH designation decisions under 42 CFR Part 405, Subpart R, we received one comment.

Comment: A commenter indicated that the proposed regulations are not clear with respect to when the 180-day time period for filing appeals of a HCFA determination on a hospital's EACH status begins. The commenter recommended that the regulations be revised to state whether the time period begins on the date of notice to the hospital of the determination, or on the date of the Notice of Program Reimbursement (NPR) that reflects the determination.

Response: The regulations at § 405.1801, concerning provider reimbursement determinations and appeals, define an "intermediary determination" as "a determination of the amount of total reimbursement due the provider pursuant to § 405.1803 following the close of the provider's cost reporting period * * *." Section 405.1811(a) states that a provider that has received a NPR may request an intermediary hearing if the amount in controversy exceeds a specified level and the request is in writing and is filed with the intermediary within 180 calendar days after the date of the notice. In addition, the regulations at § 405.1841(a)(1) allowing Provider Reimbursement Review Board (PRRB) hearings provide a similar time frame for filing appeals for Board hearings.

We believe it is appropriate to make appeals of determinations affecting EACH status subject to the same time limitations as other determinations affecting the amount of payment due providers. Thus, a determination that a hospital does not qualify (or no longer qualifies) as an EACH will be considered to be made on the date of the NPR that reflects the non-EACH status of the hospital.

To clarify this point, we have revised § 412.109(e) to state that a determination by HCFA on the EACH status of a hospital for a cost reporting period is considered to be an intermediary determination subject to review under 42 CFR Part 405, subpart R, including the time limits for filing requests for hearings as specified in §§ 405.1811(a) and 405.1841(a)(1) and (b).

We received no comments on the other changes described above. Therefore, we are adopting those changes as proposed.

I. Clarification of Payment to RRC/EACH Hospitals

In the preamble to the proposed rule, we stated that 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.

We did not propose to revise any regulations in connection with this clarification, and no comments on the clarification were received.

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 proposed 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 proposed to revise the language at § 413.86(f)(1)(ii) to be consistent with the IME definition specified at § 412.105(g).

Comment: A commenter noted that in making the language for determining the part-time status of a resident for purposes of GME payments consistent with the IME language at § 412.105(g), we limited the determination to time spent by the intern or resident working "in the hospital." Limiting the determination to time spent in the hospital is inconsistent with the regulation at § 413.86(f)(iii).

Response: It was not our intent to limit the determination only to time spent by the intern or resident in the hospital. Our intent was solely to make the language regarding the comparison to the total time necessary to fill a full time internship or residency slot, consistent for both GME and IME. The reference to time worked in the hospital was inadvertent. The reference should have been to the allowable time the resident worked in the program, as specified at § 413.86(f). Accordingly, we have revised the language at § 413.86(f)(1)(ii) as follows:

> A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

We also proposed to make a technical change to § 412.113(b)(3) to correct a reference to § 413.86 and we are adopting the proposal in this final rule.

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. 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.

In the interests of maintaining an equitable policy for those hospitals, we proposed 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 received two comments on the proposal to extend the deadline for putting assets into use for patient care under the obligated capital provision to the later of September 30, 1996 or 4 years from the date of CON approval. Both commenters supported the proposal. Therefore, we are adopting as final the proposed change in the deadline, under the special obligated capital provision for CON states, for putting assets into use for patient care.

B. Specific Adjustment for Taxes to the Capital Prospective Payment System Federal Rate (§ 412.312)

In our May 27, 1994 proposed rule, we discussed an adjustment to the capital prospective payment system for capital-related taxes (59 FR 27744–27746). We described the background of this issue, our data collection efforts and

preliminary results, approaches to making a hospital-specific tax adjustment, and the costs and concerns we could initially identify with making such a change. We noted that it was premature to make a regulations proposal at that time due to the problematic nature of the data currently available on taxes and on payments in lieu of taxes. We stated that we would seek clarifying information on the 23 percent of proprietary hospitals not reporting tax costs and the 13 percent of non-proprietary hospitals reporting taxes or payments in lieu of taxes. We requested comments from the entire hospital community on the appropriateness of and preferred methodology for any capital prospective payment system adjustment for tax costs.

Based on the comments we received and our analysis of the property tax component of capital-related costs, we agree that specific adjustments for tax costs should be made, along with a corresponding adjustment to the capital prospective payment system Federal rate, at such time that we have substantially completed and verified data necessary to implement both adjustments. We intend to complete this process in time for the FY 1996 proposed rule.

We concur with commenters that maintain that capital-related taxes, as defined by Medicare regulations, may be a unique cost imposed on certain hospitals that are readily defined and distinct from other capital-related costs. Therefore, it may be inequitable to continue to include those costs in the Federal rate payment made to all hospitals, as hospitals move to capital payments based on 100 percent of the Federal rate. We also agree that a payment adjustment for tax costs should not be limited to proprietary hospitals. Non-proprietary hospitals that can document costs that meet the criteria for taxes as specified at § 413.130(a)(2) and (i)(5) should also be eligible for such an adjustment. An assessment in lieu of property taxes may also qualify as a capital related payment if the assessment is based specifically on the assessed value of the hospital's land or depreciable assets which are used for patient care. An assessment that is made on a hospital that is not based on the value of those assets would not qualify as a capital related payment in lieu of taxes and would therefore not be subject to this adjustment. We intend to institute a change in cost reporting instructions which will restrict entries of tax information on Worksheet A–7 to capital-related taxes that meet the criteria for taxes as specified at § 413.130(a)(2) and (i)(5).

Although we are committed to implementing specific adjustments for capital-related tax costs, we find that we are not in a position to make an appropriate adjustment in the FY 1995 Federal rate to account for the tax adjustment. After two additional updates to the FY 1992 cost report data on the Hospital Cost Report Information System (HCRIS) since the May 27, 1994 proposed rule discussion, we still lack tax data for nearly 22 percent of proprietary hospitals. Also, we have no data on the amount of payments in lieu of taxes that could meet the criteria specified above for non-proprietary hospitals. Based on the information provided by our regional offices, it appears that in many instances hospitals have included other costs (for example, sales taxes) as payments in lieu of taxes that do not qualify as capital-related tax costs.

In order to avoid making duplicate payments to hospitals that would receive a payment adjustment for taxes, the Federal capital prospective payment system rate must be adjusted to adequately offset the total of hospital-specific tax adjustment payments that will be made with implementation of this initiative. These missing or questionable amounts are potentially too significant to make an accurate Federal rate adjustment. In addition, we believe that since nearly 5 out of 6 hospitals will face a Federal rate reduction without any increase in payments, and that the level of the Federal rate adjustment may be even more substantial than our earlier data indicated (2 to 3 times the 0.77 percent reduction to the base capital rate reported at 59 FR 27745), every effort must be made to make an accurate adjustment to the rate.

We believe that we need to develop the methodology and complete any data analysis prior to publishing the proposed rule for the FY 1996 capital prospective payment system in order to ensure that we will be in a position to finalize an appropriate tax adjustment for FY 1996. Thus, solicitation of data and comments on the methodology must be essentially completed no later than December 15, 1994.

In order to meet these objectives, we are initiating (through Medicare intermediaries) data collection and verification of Medicare capital-related tax costs incurred during a hospital's cost reporting period(s), totalling 12 months, beginning on or after October 1, 1991, but before October 1, 1992. In order for a hospital to be eligible for a hospital-specific tax payment adjustment for discharges occurring on and after October 1, 1995, all tax costs that meet the definition of capital-related tax costs (including payments in lieu of taxes) cited above along with supporting documentation must be submitted to the intermediaries no later than December 15, 1994. Furthermore, payment eligibility for this adjustment to the capital prospective payment system rates may be dependent on accurate data being provided by the hospital on Worksheet A–7 of the hospital's cost report in all future fiscal periods. Medicare intermediaries will contact each hospital in writing requesting verification of the amount of and exact source and basis for taxes or payment in lieu of taxes reflected in the hospital's FY 1992 Form 2552–92, Worksheet A–7, Part III, column 6, line 5, or for submittal of that information if it was not reflected on Worksheet A–7.

Using this verified data and other pertinent FY 1992 cost report information for each hospital, an adjustment to the Federal capital prospective payment system rate for FY 1996 removing taxes and payments in lieu of taxes, would be developed along the following lines: We would propose an adjustment to the Federal capital prospective payment system rate to remove amounts for taxes and payments in lieu of taxes. The adjustment will be based on data from cost reports beginning in FY 1992. The adjustment would reflect the allowable capital-related taxes from Worksheet A–7, supplemented by Medicare fiscal intermediary data as described in the previous paragraph, and may be allocated through step-down to Medicare cost amounts. The total capital-related taxes allocated to Medicare would be subtracted from total Medicare capital-related costs for all hospitals, yielding Medicare capital-related costs without taxes. An adjustment reflecting the ratio of Medicare capital costs without taxes to total Medicare capital-related costs (including capital-related taxes) would then be applied to the Federal capital prospective payment system rate. This adjustment is necessary in order to remove tax costs currently reflected in the Federal capital prospective payment system rate.

With respect to a hospital-specific tax payment methodology, two approaches were presented in general outline in the proposed rule (59 FR 27745). In any method ultimately selected, we would use only a hospital's verified FY 1992 tax cost data based on the intermediary initiative described above. Hospitals (other than new hospitals) that have no taxes or payments in lieu of taxes

verified by the intermediary for FY 1992 would not receive an adjustment for taxes in the future. Based on the FY 1992 tax data and other pertinent information from the hospital's FY 1992 cost report, a Medicare tax cost per discharge in the FY 1992 base year would be established for each eligible hospital.

In our May 27, 1994 proposed rule (59 FR 27745) we discussed a method whereby the tax cost per discharge amount would be calculated as part of the property tax factor (PTF) approach. Under that methodology we would determine a ratio of the FY 1992 base year tax cost per discharge to the base year FY 1992 Federal capital prospective payment system rate. This percentage would then be applied to the Federal rate for each eligible hospital for cost reporting periods beginning on or after October 1, 1995. This percentage (or property tax factor (PTF)) adjustment would be applied on a discharge basis to the Federal capital prospective payment system rate for FY 1996 and future years.

However, we no longer believe that this approach is desirable. Since the payments would increase or decrease as a function of changes to the Federal capital prospective payment system rate, the total amount paid to hospitals eligible for this adjustment in FY 1996 could differ substantially from FY 1992 total Medicare tax costs trended forward to FY 1996. This is because some factors affecting changes in the Federal rate may not be correlated with a change in capital-related taxes.

The second option discussed in the proposed rule was to apply a hospital-specific Medicare tax cost per discharge amount from the FY 1992 base year as a direct add-on amount to each discharge for eligible hospitals, beginning October 1, 1995. Again any hospital for which the intermediary has not documented FY 1992 taxes or payments in lieu of taxes (except for new hospitals) will not receive a tax add-on in future years. The direct add-on approach has the advantages of separating the tax adjustment from changes in the Federal rate, thereby limiting the potential for a divergence in payments for taxes as compared to the hospital's original tax experience. In addition, it would improve comparability of the Federal rate adjustment to the total amount of hospital-specific tax adjustment payments.

Under this approach each hospital's FY 1992 Medicare tax cost per discharge would be calculated and then subsequently updated by an appropriate factor for periods after FY 1996. We are using each hospital's FY 1992 tax cost per discharge as the base year because it is the hospital's first cost reporting period under capital prospective payment system and is the most recent data available. Changes in tax policies after the base period will not be recognized. In establishing the update factor we would evaluate the appropriateness of applying an index consistent with the update index used for the Federal capital rate.

In the event that a unique tax update factor is necessary, we believe that one possibility is to use 2 or 3 years of reliable cost report tax data from which we can calculate either a national or regional rate of change in tax costs. However, any update methodology would necessarily need to be insulated from the effects of arbitrary actions by taxing jurisdictions. Under this methodology we would anticipate utilizing the applicable Federal rate update factor until an alternative tax cost specific or other appropriate factor is developed.

Finally, we would assure that new hospitals would have the benefit of a similar adjustment in the future. The hospital's first full cost reporting year's tax amount could be used to establish its tax adjustment factor. Timely comments on this option are sought.

Again, we reiterate the importance of hospitals cooperating with their servicing intermediary in providing capital-related tax information and documentation, and in submitting specific comments on the issues and options discussed in this section on hospital tax adjustments to the Federal rate and capital prospective payment system payments. Submissions of tax data must be made to the intermediary no later than December 15, 1994. Comments must be received by the same date. Mail all comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Bureau of Policy Development, Attention: Tzvi Hefter, Room 1–H–1 ELR, 6325 Security Blvd., Baltimore, MD 21207–5187.

Comment: Comments were received that objected to any consideration of a specific property tax adjustment. One basis for the objection was that many hospitals are currently required to provide certain levels of charity care or other specified services in order to maintain their tax-exempt status. The commenters stated that such requirements were in effect the equivalent of paying real estate and personal property taxes which are then used by these same tax jurisdictions to pay for the provision of medical and other services. Since we do not provide an adjustment to any Medicare payments in such instances, the commenters believe that none should be considered for taxes paid by proprietary hospitals or any others.

Response: While we recognize that charity care and other payments in the way of services or other charges are being imposed on hospitals by communities and this trend may be increasing, we believe that these costs are of a different nature than taxes paid on the value of land and depreciable assets which form the definition of taxes for Medicare program purposes. Such costs are, in large part, operating costs rather than capital-related costs. It is conceivable that these costs were recognized in the base year amounts used to establish the operating prospective payment systems rates and, to some degree, are represented in the adjustments (for example, disproportionate share adjustment) to those rates. These considerations (that is, charity care, bad debts, etc.) apply to all hospitals to a greater or lesser extent whether they are proprietary or non-proprietary facilities.

We believe that due to the special and identifiable nature of capital-related tax costs used in setting the Federal capital prospective payment system rate, we should discontinue general distribution of those specific costs to all hospitals when only about 1 in 6 hospitals are subject to this unique cost. We also believe that the relationship of capital-related tax costs to other factors that affect the number or intensity of patient care services that communities are imposing on a hospital is tenuous at best and, therefore, only the former should be treated separately in developing Medicare payment policies.

Comment: We received several comments supporting adjustment of capital prospective payment system for tax costs originally included in the Federal rate determinations. A commenter expressed concern that HCFA was underestimating the impact of the payment inequity arising from failure to establish an immediate property tax adjustment. The commenters recommended that HCFA exclude the cost of taxes from the Federal capital prospective payment system rate and report on, or make an immediate adjustment for, taxes and payments in lieu of taxes through a hospital-specific adjustment to capital prospective payment system payments. Two comments recommended using the actual amount in each hospital's most recently settled cost report to make the payment adjustments, in a manner similar to wage index adjustments to prospective payment system payments.

Only one commenter suggested using the Property Tax Factor (PTF) method discussed in the proposed rule (59 FR 27745).

Response: For the reasons cited in the previous response, we agree that adjustments for capital-related tax costs should be implemented for both proprietary and non-proprietary hospitals at the earliest feasible time. As explained in the foregoing discussion, it would not be appropriate to attempt payment adjustments on the basis of the preliminary and unaudited information available at this time. This adjustment could have a significant redistributional effect on capital payments to hospitals.

Equally important is the fact that we have not resolved issues regarding the appropriate methodology to use in providing for capital-related tax cost adjustments. We received differing suggestions in the comments regarding which periods to use to make the adjustment and only one comment recommended a specific methodology. We, therefore, believe it is necessary to seek additional guidance from interested and affected parties in the hospital industry and the public before implementing an adjustment.

We appreciate that in a few instances the burden on a hospital with high capital-related tax costs may be exacerbated by any delay in changing the payment policy on the treatment of these tax costs. However, we maintain that there is no significant and general adverse impact on proprietary or other hospitals. The capital prospective payment system transition methodology for payments is based, in large measure, on the actual historical capital cost components and levels experienced by hospitals before capital prospective payment system implementation in FY 1992. Therefore, we believe the rationale discussed in the proposed rule (59 FR 27745) for delaying the implementation of any adjustment continues to be appropriate in spite of the commenter's assertions that tax costs are assumed to have increased an average of 10 percent since FY 1991 or the commenter's use of one extreme hypothetical case.

More than 75 percent of affected hospitals are receiving capital prospective payment system payments on the basis of either the hold-harmless or the fully prospective methodology less than half-way through the transition period. Accordingly, the payments they are receiving are still substantially based on their hospital-specific pre-transitional cost experience, which includes taxes.

Comment: A commenter objected to the discussion in the proposed rule (59 FR 27744–27746) where we stated that we believed it was premature to develop a proposal for a property tax adjustment due to current data limitations including non-reporting by hospitals, the status of payments in lieu of taxes and the preliminary nature of the data contained in the Hospital Cost Report System (HCRIS).

Response: The importance ascribed to adequate data is addressed in the preceding response. We would also like to point out that regardless of the reasons that hospitals do not report properly on matters that directly impact on their payment status, fiscal intermediaries must perform a substantial amount of work to obtain and verify the necessary tax data to implement a property tax adjustment. We do not believe that reliable changes can be made when 20 to 25 percent of the basic information is missing.

With respect to alleged problems in reporting of tax information due to problems with the instructions for completing Worksheet A–7 of the cost report (Form HCFA 2552–92), we believe that the assertion that it is impossible to report taxes properly is not supported by the fact that over 77 percent of proprietary hospitals and over 13 percent of non-proprietary hospitals were able to complete the information and pass the comprehensive cost report submission editing program required for submission and entry into HCRIS. We will, however, examine the specific technical comments provided on the cost report procedures to determine whether further refinement of the form or instructions for its completion are needed.

Comment: A commenter addressed our concern with the potential divergence of the payments that would be made under a percentage adjustment methodology from the actual ratio of tax costs to Medicare inpatient costs originally used to establish the property tax factor adjustment. The commenter suggested that the PTF approach should be implemented regardless of our concern. The commenter suggested that when and if data becomes available that conclusively showed that taxes do not vary consistent with other capital-related costs, another methodology could be developed.

Response: We concur with the commenter's assumption that several years of cost report tax data will be needed to analyze and determine whether changes in taxes and other capital costs are sufficiently consistent for updating purposes. However, we do not believe that a parallel function between the cost of taxes and other capital-related costs, which would only address the need for a separate update factor, should impact on our decision as to which payment methodology should be adopted. Our specific concerns with the PTF methodology were discussed previously. Arbitrarily selecting the PTF method does not satisfactorily address our concerns.

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. Therefore, 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 therefore proposed 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. We proposed that this special protection would provide a 70 percent minimum payment level for up to ten years beyond the transition period, and would be available only to the following classes of hospitals:

- Sole community hospitals that have a current ratio less than or equal to 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, we proposed that 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 proposed 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. 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). The first part of the age-of-asset test was designed to determine whether a hospital had an urgent need for replacement or renovation of facilities because of 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 proposed that the threshold for qualifying under this part of the test would be the 75th percentile. Under the proposed rule, 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.

We proposed that 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 therefore proposed 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 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, we proposed that a hospital cannot qualify for an exception unless it has received any required approval from a State or local planning authority. We also proposed that, 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.

We proposed that hospitals qualifying for exceptions under this special provision could continue to receive exceptions payments for up to 10 years beyond the transition. Exceptions payments would be available under the proposal 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 proposed to continue to determine the amount of the exceptions payments under this special provision on a cumulative basis. That is, we proposed to determine the hospital's exception payment under the special provision 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 be deducted from the additional payment that would otherwise be payable for the cost reporting period. In addition, we proposed to apply another test designed to limit the amount of exceptions payments under this special provision. We proposed to 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. The calculation would include payments under both the capital and operating prospective payment systems but, not graduate medical education payments, outpatient service payments, or payments for any other services covered under Medicare Part B. We proposed 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.

We received 14 comments from individual hospitals and hospital associations on our proposal to extend capital prospective payment system exceptions payments for some hospitals for up to 10 years beyond the current transition period. The commenters focused on the use of the current ratio, the proposed age of asset test, the proposed minimum payment level, and the proposed exception payment offsets.

Comment: A number of commenters objected to the proposal that sole community hospitals and urban DSH hospitals demonstrate financial need in the exception year by maintaining a current ratio less than or equal to 1.75. Some commenters objected to the use of a single indicator, and of that particular indicator, to measure financial need. These commenters contended that liquidity is not the sole indicator of financial need, and that the current ratio is often not the best measure of liquidity. These commenters variously recommended consideration of measures such as the debt service coverage ratio, operating or total margin, liability to fund balance, and days in accounts receivable. A commenter recommended that a high disproportionate share percentage serve as an indicator of financial need. Other commenters objected to including any financial need test in the proposed exceptions provision. One of those commenters noted that the remaining criteria (that is, those related to community service and capital burden) and the payment restrictions are very restrictive even without the financial need test. A commenter recommended adoption of a project size test as a financial need indicator, on the grounds that major capital projects necessarily create financial stress. That commenter recommended that hospitals qualify if total project costs exceed between 75 percent and 100 percent of allowable operating costs in the year the construction began. Another commenter stated that the 1.75 threshold for the proposed current ratio test was too high, and recommended a threshold of 1.5 instead.

Response: We agree with the commenters that a separate financial need test is unnecessary, provided that the other criteria remain relatively stringent. As we discuss below, we are strengthening the qualifying requirements so that all hospitals must meet a project size test, hospitals in CON states must demonstrate CON approval, and hospitals in non-CON states must meet the age of asset test to demonstrate the need for capital renovation or replacement. Projects of sufficient magnitude to pass the project size and/or age of asset tests would necessarily place a financial strain on hospitals. Furthermore, the 70 percent minimum payment level and the offsets would prevent financially robust hospitals from benefiting very much under the provision. Therefore, we are not adopting the proposed current ratio test.

Comment: Several commenters objected to the use of the average age of assets test as the only measure to establish a hospital's need for major replacement or renovation of capital assets. Some of these commenters contended that the age of assets measure contains a distortion. Under the formula which determines age as the ratio of accumulated depreciation to current depreciation, the true age of hospitals can be masked by a vintage effect: the inclusion of some assets acquired more recently at higher relative price levels would have a disproportionate effect on the ratio, thus making some hospitals appear to be younger than they really are. A commenter recommended determining the average age of assets on a price-level adjusted basis rather than a historical cost basis in order to correct for this distortion. Other commenters contended that such a test is unnecessary in states with CON requirements. Some of these commenters recommended that hospitals be given the alternative of meeting the average age of asset test or a test of capital project size, for example, undertaking a capital project that expends a minimum of the lower of $100 million or 25 percent of average annual operating costs on a CON-approved project over a specified period. Another commenter simply recommended that we reconsider the age of asset test and develop an alternative qualification criterion based upon hospital-specific expenditures for capital projects over a period of time. A commenter recommended that the 75th percentile for average age of assets should be determined on a statewide basis rather than nationally.

Response: Analysis and consultation with industry experts confirms the possibility of the distortion cited by commenters in the age of asset measure. However, there is a countervailing distortion in the measure: the effect of any fully depreciated assets that are still in use for patient care is to make a hospital appear older than it really is. We cannot determine the degree to which the two distortions tend to cancel each other out. However, we cannot accept the recommendation to determine age of assets on a price-level adjusted basis for two reasons: (1) a price-level adjusted determination would eliminate only the distortion identified by the commenters, leaving nothing in the measure to counteract the effect of the other distortion, and (2) as the commenter conceded, price-level adjusted depreciation is contrary to generally accepted accounting principles and thus cannot be applied to most hospitals. We believe that the measure has sufficient validity to retain it within the proposed policy.

We do not agree with the commenter who suggested determining the 75th percentile in age of assets on a state-by-state basis. Adopting the commenter's recommendation would provide an advantage to hospitals in states with facilities that are generally newer than the national average, and a disadvantage to hospitals in states with facilities that are generally older than the national average. Our intention in developing this special exception provision is to protect hospitals with the greatest need for replacement or renovation of their facilities. It would therefore be inappropriate to adopt the commenter's recommendation.

We agree with those commenters who contended that an age of asset test is unnecessary for hospitals in CON states. We proposed the age of asset test as a

method for determining whether there was a need for a major renovation or replacement of capital projects and whether a hospital had indeed undertaken and completed such a project during the transition period. The CON process is specifically designed to require that hospitals demonstrate the need for capital projects that they undertake. We are therefore requiring that only hospitals in states that do not require CON approval satisfy the age of asset test in order to qualify for extended exceptions. However, for reasons that we will discuss below, we are modifying the age of assets test so that those hospitals must meet only the first part of the test as we proposed it, i.e., a hospital that is not required to obtain CON approval must demonstrate only that its average age of buildings and fixed equipment was at or above the 75th percentile nationally in the first year of the capital prospective payment system transition.

We agree with various commenters that a project size test should be incorporated into the qualifying criteria. A project size test could be based on a relative scale (that is, a percentage of one year's operating cost), an absolute dollar threshold (for example, $200 million), or both, over a designated period of time (for example, FY 1986 through FY 2001). A relative scale test accommodates the needs of smaller hospitals. An absolute dollar threshold favors larger hospitals. In order to accommodate both smaller and larger hospitals, we have decided that a project size test should allow hospitals to meet either an absolute threshold or a relative scale threshold. Available information about the major projects planned for this decade indicates that most exceed 75 percent of annual operating expenses, and many exceed 100 percent. Since we have always intended this special exceptions provision to apply to circumstances in which hospitals must undertake significant replacement or renovation of their facilities, we believe that a relative scale threshold at the level of 100 percent of annual operating costs is reasonable. (As we noted previously, one commenter recommended a project size test at the level of 75 to 100 percent of operating cost as a replacement for the current ratio test.) Similarly, available information concerning the cost estimates for large hospitals undertaking capital projects in this decade indicates that a dollar threshold of $200 million is reasonable.

Commenters variously recommended adoption of a project size test as a replacement for the age of asset test, or as an option to the age of asset test for demonstrating the need for major renovation or replacement of capital assets. We have decided to require that all hospitals must meet the project size test. One reason is a concern that the qualifying criteria be comparable for hospitals in CON states and non-CON states. Applying a project size test to all hospitals provides a set of equivalent criteria: all hospitals must meet both a project need test (either CON approval or the age of asset test) and a project size test. In addition, we are persuaded by the argument of the commenter cited above that a project size test is a reasonable replacement for our proposed financial need test. Therefore, in addition to meeting an appropriate project need test (that is, either receiving CON approval or meeting the age of asset test), hospitals will be required to show that they have expended, during their capital prospective payment system transition period, either 100 percent of average annual operating expenses for that period or $200 million on a project to renovate or replace capital assets.

Adopting the project size test for all hospitals does, however, render the second part of the age of assets test redundant. The requirement that a hospital's average age of buildings and fixed equipment must decline by at least 50 percent during the transition period was designed to assure that the hospital had undertaken a major project of capital renovation or replacement. The project size test obviously fills that role. We are therefore requiring that a hospital in a non-CON state demonstrate only that its average age of buildings and fixed equipment is at or above the 75th percentile nationally in the first year of the capital prospective payment system transition.

Comment: A commenter suggested that a project need criterion could be based simply on the chronological age of the hospital. The commenter pointed out that there comes a point when hospital buildings need to be replaced because they can no longer be renovated to accommodate new technologies and patterns of patient care. The commenter suggested that major renovation and replacement programs to replace patient care buildings with core original plants older than 50 years old.

Response: It may well be true, as the commenter contends, that a hospital building of a certain age necessarily has an antiquated structural design. However, we simply know of no objective criteria that could be used to establish "how old is too old." In the place of such criteria, we believe that our tests should effectively screen hospitals that genuinely require renovation or replacement of capital assets.

Comment: Several commenters recommended that the exceptions provision be designed to protect hospitals undertaking major modernization programs during the period from 5 years before the beginning of the capital prospective payment system transition period to the end of the transition. A commenter stated specifically that the exclusion of hospitals who completed their major modernization projects in the years just before the beginning of the capital prospective payment system transition was inappropriate. Other commenters recommended proposed expenditure tests based on capital expenditures over the 15-year period from 1987 through 2001.

Response: We believe that it is entirely appropriate to exclude hospitals who completed their major modernization programs during the years immediately before the implementation of the capital prospective payment system. Hospitals who completed major modernization programs during those years have gained from the protections offered under the old capital and obligated capital provisions in the capital prospective payment system regulations. The proposed exceptions policy was specifically designed to address the situation of hospitals that were not in the position to benefit from those provisions because of the timing of their capital projects. Therefore, it would be inappropriate to expand the proposed exceptions policy to provide additional protection for those hospitals. The average age of asset and project size tests adopted under this final rule will therefore apply only to projects completed during the period of the capital prospective payment system transition.

Comment: A commenter contended that the selection of 1992 as a base for the age of asset test is arbitrary. The commenter recommended calculating the base at a time just before the capital acquisition is undertaken.

Response: We proposed 1992 as the base year for the age of asset test because it is the first year of the capital prospective payment system transition period, and the test was designed to accommodate the situation of hospitals that, as previous commenters had informed us, entered the transition period with a need for major replacement or renovation of their facilities. We are therefore maintaining this feature of the age of asset test.

Comment: A commenter recommended that the base for

calculating the age of assets should be separated into components instead of being grouped together since there are often multiple generations of plants among a hospital's assets.

Response: We do not believe that a component test is feasible or desirable. Since the exceptions provision will include a minimum level of payment relative to the Medicare inpatient capital costs of the entire facility, we do not believe that the qualifying test should measure only the ages of discrete assets within the hospital.

Comment: A number of commenters objected to adoption of a 70 percent payment floor for all providers under the proposed exceptions policy. The commenters recommended maintaining the payment floors established under the current exceptions policy (90 percent for sole community hospitals, 80 percent for large urban DSH hospitals, and 70 percent for all other hospitals) during the post-transition period. Several commenters stated that the 70 percent level is inappropriate for providers with a high volume of Medicare beneficiaries and for providers in states in which cost-shifting is legally precluded. Two commenters acknowledged that we would want to reduce support for hospitals receiving exceptions payments at the higher minimum payment levels over time. These two commenters contended, however, that reduced support for these hospitals would occur naturally over time even if we maintained the higher minimum payment levels because the eligible hospitals' need for exceptions payments will have waned.

Response: We agree with those commenters who acknowledged that it is understandable to expect hospitals to reduce their dependence on cost-based payments from Medicare over time. We will retain the proposed 70 percent minimum payment level precisely to give effect to that reasonable expectation. If, as the commenters contend, hospitals' need for exceptions payments will naturally wane over time, the difficulty posed by a 70 percent minimum payment level should also wane. Furthermore, most hospitals are already at the 70 percent minimum payment level during the transition period. We believe that it is entirely reasonable that those hospitals for whom we are providing this special exceptions provision for the period 10 to 20 years after the beginning of prospective payment for capital receive the same minimum payment level which most hospitals have been receiving from the beginning of the transition.

Comment: A number of commenters objected to the proposed cumulative payment level of 70 percent. The commenters pointed out that the theory of capital prospective payment system is to allow hospitals to accrue equity during low capital cost years to reduce the need for borrowing during high cost capital years. Thus, the commenters contended that it is inappropriate to deny exceptions payments for hospitals because they had lower levels of losses in some years. The commenters recommended that only payments in excess of a hospital's capital costs in prior years should be offset against the exceptions payment that the hospital would otherwise receive.

Response: The cumulative minimum payment level limitation is an existing feature of the transition period exceptions provision. We continue to believe, as we did when we established the final rule on exceptions payments during the transition period (see 56 FR 43409), that it is a reasonable measure to limit the amount of exceptions payments. We see no reason to exempt the hospitals who qualify under this exception provision from a requirement imposed on hospitals under the current exceptions policy.

Comment: A commenter expressed concern about requiring a rebate of excess capital payment in prior years. The commenter emphasized that his hospital had used all the capital it has accumulated to replace needed equipment and to provide the equity required to obtain funding.

Response: We did not propose a requirement that hospitals "rebate" excess payments received in previous years, but rather to offset payments above a certain level in prior years against the amount of the exception payment that a hospital would otherwise receive. Thus hospitals will not be required, as the commenter seems to believe, to return any previous excess payments to HCFA. Rather, we will simply reduce the exception payment amount in any year when prior year payments have exceeded the minimum payment level.

Comment: Two commenters contended that the proposed eligibility criteria ignore hospitals that provide significant community benefits through their outpatient services. The commenters proposed adding criteria that reflect a significant amount of outpatient services to the poor and underserved.

Response: Since the capital prospective payment system is intended for inpatient capital-related costs, we feel it would be inappropriate to consider any outpatient services when determining eligibility. Any outpatient capital-related costs would be reimbursed under Medicare Part B payments to hospitals.

Comment: Several commenters objected to the proposal to offset any positive Medicare hospital inpatient margin (including both capital and operating prospective payment system payments, but excluding 75 percent of operating disproportionate share payments). A commenter stated that it would be inappropriate to apply a means test based on a prospective payment system margin, since a hospital's total margin is a better measure of its ability to retain earnings for capital formation. Another commenter opposed means testing as contrary to the philosophy of Medicare prospective payment to encourage efficient hospital operations. That commenter stated that the limitation would penalize efficient, low-cost hospitals that would otherwise benefit under the proposed exceptions policy. Another commenter contended that this proposed policy, together with the cumulative payment limitation, leads to a cyclical underfunding of hospital Medicare operations.

Response: The offset of any positive margin of Medicare inpatient prospective payment system over costs is new to this exceptions provision. We believe it is reasonable to provide an additional limit on exceptions payments for the period 10 to 20 years after the beginning of capital prospective payments. We believe that such an offset promotes the goals of a prospective payment system by further restricting the amount of cost-based exceptions payments which hospitals may receive. We believe that the Medicare prospective payment system margin, rather than total margin, is the proper standard for determining this additional offset, since total margin reflects the effects of costs and payments attributable to other payers. We do not believe that this measure penalizes efficient hospitals or contributes to cyclical underfunding.

Comment: A commenter expressed concern that the proposed offset of positive prospective payment system margins, in conjunction with the cumulative minimum payment offset, would result in a "double dip" against providers. The same commenter asked for clarification on several technical points concerning the offsets. The commenter asked us to:

(1) Clarify whether the comparison of prospective payment system operating and capital payments to costs is made solely on a year-to-year basis or cumulatively;

(2) State explicitly in the regulations text that only 25 percent of prospective payment system inpatient operating DSH payments are included in that comparison; and

(3) State that GME and other services that are not paid for as part of the prospective payment system are also excluded from the comparison.

Response: We do not agree that the proposed offsets contain a "double dip" against providers. While both comparisons consider capital payments, they do not consider the *same* capital payments, but rather capital payments from different years (that is, capital payments from prior years in the case of the cumulative minimum payment offset, and capital payments during the current year in the case of the positive prospective payment system margin offset). There is thus no double counting. We are revising § 412.348 to clarify each of the other issues raised by the commenter:

- The positive prospective payment system margin offset will be made on a year-to-year basis, rather than cumulatively.
- 75 percent of operating prospective payment system disproportionate share payments, if applicable, are excluded from the comparison of prospective payment system operating and capital payments to prospective payment system operating and capital costs; and
- The comparison of prospective payment system operating and capital payments to prospective payment system operating and capital costs considers only services paid for under the prospective payment system.

Comment: A commenter pointed out the difficulties that some hospitals will have in maintaining a high disproportionate share percentage in emerging managed care environments. Medicaid managed care tends to decrease the average length of stay for Medicaid patients, render identification of Medicaid patients by hospitals more difficult, and limit the ability of hospitals to control or predict Medicaid utilization. The commenter recommended that we allow hospitals to meet the 20.2 percent DSH threshold under the proposed exceptions policy in FY 1992. Alternatively, the commenter suggested the adoption of a graduated minimum payment level based on DSH percentage or changing the basis of determining disproportionate share utilization to the higher of utilization determined on the basis of patient days or admissions.

Response: The intention of the 20.2 percent threshold was to provide additional financial relief to those hospitals serving a significant disproportionate share population. When a hospital falls below this threshold, whether or not it is beyond their control, it fails to fit the intended criteria for special payment protection.

Emerging managed care environments will increase hospitals' incentive to keep costs competitive with other neighboring hospitals. This should provide additional incentive for hospitals to make judicious capital expenditures. In a managed care environment, hospitals that fail to have competitive costs will lose Medicaid managed care patients to more cost-efficient providers. When that occurs, we do not believe that the Medicare program should continue to pay those hospitals as if they were still treating larger numbers of Medicaid patients.

For hospitals that continue to serve a large disproportionate share population, properly identifying Medicaid patients by hospitals will have to become a priority. We feel that it is not unreasonable to expect that hospitals adopt reasonable measures to obtain the information needed to compute the disproportionate share percentage as a condition of receiving additional financial protection for serving these patients. We will, however, examine whether the special difficulties of identifying Medicaid patients in states with Medicaid managed care programs warrants additional measures to assist hospitals in obtaining the required information.

Comment: A commenter supported the inclusion of hospitals with combined Medicare/Medicaid utilization of 70 percent among the hospitals eligible for exceptions under the proposal. The commenter contended that providers with high Medicare utilization should be given the same benefits as currently enjoyed by sole community and disproportionate share providers. Another commenter disagreed with the special protection afforded under the Medicare prospective payment system for hospitals with high Medicaid utilization. The commenter contended that, since Medicare and Medicaid are financed from separate trust funds, it is inappropriate to employ criteria that allocate Medicare funds on the basis of Medicaid utilization. The commenter recommended adoption of a threshold based only on Medicare utilization at the 60 percent level.

Response: During the transition period, we have made special protection available to urban as well as rural sole community hospitals, and to urban hospitals with at least 100 beds that either have disproportionate share patient percentages of at least 20.2 percent or receive at least 30 percent of revenue from state or local funds. We believe that concerns about access to care are most properly focused on hospitals that serve vulnerable populations, and we have made special payment protection available to them as a result.

In addition to the exceptions categories above, we proposed to provide exceptions for up to 10 years after the end of the current capital prospective payment system transition period for certain hospitals with major renovation or reconstruction projects during the transition period. We have extended this exception to hospitals with heavy utilization by beneficiaries of the Federal health programs. We believe this additional special protection should continue to focus on hospitals that serve vulnerable populations. We believe that a combined Medicare and Medicaid utilization rate is a reasonable qualifying condition for this type of protection. The average hospital utilization by Medicaid beneficiaries is approximately 10 percent. As one commenter mentioned, a 60 percent Medicare utilization rate can be considered high. We believe that a combined Medicare/Medicaid utilization threshold of 70 percent is thus reasonable.

Comment: Two commenters objected to the eligibility period under the proposed exceptions policy. The commenters maintained that, if there is a continued need for exceptions payments, they should be allowed to continue through September 30, 2011.

Response: The proposed exceptions policy was designed to address the situations of hospitals who were unable to qualify for the protection offered under the old capital and obligated capital provisions. The special protections for old capital and obligated capital were limited to the duration of the transition period and were thus, in effect, limited to no more than 10 years. Old capital assets, which by definition were in use for patient care by December 31, 1991, could receive 10 years of payment based on reasonable cost. Obligated capital assets in most cases have come into use for patient care since the beginning of the transition period and therefore will receive less than 10 years of reasonable cost payment. We therefore believe that it is fair and reasonable to extend exceptions payments for hospitals who must undertake major renovation or replacement of facilities during the transition period only for 10 years after the date they meet the qualifying criteria.

Comment: A commenter stated that implementing such strict requirements on hospitals so soon after the transition period, which already affected so many hospitals negatively, will be devastating to many hospitals.

Response: We do not believe that it is unreasonable to impose strict requirements as a condition for receiving cost-based exceptions payments a full 10 years and more after the beginning of prospective payment for capital costs.

Comment: A commenter objected that the proposed exceptions provision is too narrowly defined to benefit most hospitals.

Response: The proposed exceptions provision was intended to be narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund the projects.

In the design of the capital prospective payment system, we made every effort to consider the circumstances of hospitals for whom the transition to prospective payment poses special difficulties. We believe this exceptions policy provides appropriate protection for these disadvantaged hospitals.

Comment: A commenter stated the expectation that extended exceptions payments would be funded through a budget neutrality discount applied to either the capital prospective payment system rate or the combined operating and capital rate.

Response: We are revising § 412.308(c)(3) to provide that an exceptions payment adjustment factor will continue to be applied to the Federal rate through any period for which an exceptions policy will be in effect. This revision assures that estimated payments under the new policy will be funded through a reduction in the Federal rate, as is the case under the current exceptions policy.

We received no comments on our proposal to require that urban hospitals in states without CON provisions demonstrate either that they are located in MSAs with overall occupancy levels at 80 percent or above, or that they have replaced no more than 80 percent of their previous capacity (in terms of bed size). We are therefore adopting that provision as proposed.

In this final rule, we are therefore providing at § 412.348 a special exception provision for some hospitals that are undertaking major projects to renovate or replace aging plant during the transition period. This special exception provision will provide a minimum payment level to eligible hospitals for ten years after they meet the qualifying criteria. The eligible classes of hospitals are:

- Sole community hospitals;
- 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
- Hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

To qualify, an eligible hospital must meet both project need and project size requirements. For hospitals in states with CON requirements, the project need test is satisfied by obtaining CON approval. For other hospitals, the project need requirement is satisfied by meeting an age of asset test. To meet the age of asset test, a hospital must have an average age of buildings and fixed equipment (determined on the basis of information on the current Medicare cost report, HCFA 2552–92, specifically 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) at or above the 75th percentile nationally in the first year of capital prospective payment. In the June 1994 update of the cost report file, the 75th percentile for buildings and fixed equipment is 16.4. We will make a final determination of the 75th percentile at a later date on the basis of more complete cost report information for FY 1992.

In addition, all hospitals must meet a project size requirement. A hospital must complete, by the end of the capital prospective payment system transition period, a project whose costs for replacement and/or renovation of fixed assets related to patient care equal or exceed either 100 percent of annual operating expenses for FY 1992 or $200 million. Annual operating expenses are the sum of net expenses for all reimbursable cost centers, before cost allocation. This information is found on the Medicare cost report, Form HCFA–2552–92, Worksheet B, Part I, Column 0. It includes the following cost centers (and corresponding Worksheet B line numbers): general service (lines 1–24), hospital inpatient service (lines 25–30), other hospital inpatient (line 31 and lines 33–36), ancillary service (lines 37–59), outpatient service (lines 60–63), other reimbursable centers (lines 64–68 and lines 70–82), and special purpose centers (lines 83–94).

For hospitals in states without CON requirements, 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).

A hospital will be eligible for exceptions payments for 10 years after completion of the project that meets the project need and project size requirements. We will determine the hospital's exception payment under the special provision 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 will be deducted from the additional payment that would otherwise be payable for the cost reporting period. In addition, we will 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 comparison will consider costs and payments under both the capital and operating prospective payment systems, but not costs and payments for graduate medical education, outpatient services, or for any other services covered under Medicare Part B. We will 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 policies are subject to reevaluation in the light of passage of comprehensive health care reform by Congress. The hospitals for whom we are providing special protection under this exceptions provision 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 above to determine whether such legislation justifies revision of those policies.

We are making the following revisions to the regulations text to implement the changes discussed above:

- We are making a conforming technical change to § 412.308(c)(3).
- Under new § 412.348(a), we would define annual operating expenses, average age of fixed assets, and fixed assets.
- The new special exceptions requirements are set forth at § 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 making 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 proposed 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).

In § 412.348(e)(1), we proposed 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. Our discussion in the proposed rule (59 FR 27748) cited the August 30, 1991 final rule preamble's instruction to consider payments from other sources in determining the threshold. However, in the original 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.

Since 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, we proposed to revise current § 412.348(e)(1) to conform with the preamble instructions 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 received no comments on this proposal; therefore, we are adopting it as proposed.

We also proposed 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 proposed 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.

We received no comments on this proposal. However, we are modifying the proposed change to § 412.348(e)(2) by deleting the specific reference to the Director of the Office of Payment Policy because a reorganization of the Bureau of Policy Development is under consideration and may make that designation obsolete during FY 1995.

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 proposed 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 proposed 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. 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; therefore, we believe that 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 proposed 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 after the determination 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 if 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 agreed and proposed 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 proposed 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 the 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 proposed to revise §§ 413.134(e) and 413.153(d) to clearly address both situations.

We also proposed to make a technical change to § 413.134(d)(1) to correct a reference.

Comment: We received one comment on the proposals regarding the funding of depreciation. The commenter recommended that we specify that the policy changes set forth in §§ 413.134 and 413.153 are effective for cost reporting periods beginning on or after October 1, 1994. In addition, the commenter made a series of recommendations related to the proposed revisions to §§ 413.134 and 413.153. The recommendations are as follows:

- Consistent with section 226.2 of the Provider Reimbursement Manual, § 413.134(e)(1) should explicitly state that, in order for the investment income earned on a funded depreciation account to be exempt from offset against interest expense, the investment income must be deposited in, and become part of, the funded depreciation account.
- Consistent with section 226.D of the Manual, § 413.134(e)(4) should state that when a provider invests or transfers assets of the fund to a related organization, these assets continue to be treated as the provider's funds and are subject to all the provisions governing funded depreciation, notwithstanding the transfer.
- Section 413.134(e)(4) should clarify that loans from the provider's funded depreciation account may not be used to purchase depreciable assets for that provider. The provider's funded depreciation account must be used, rather than loaned, for that purpose. Section 226.1 of the Manual reflects such a restriction with regard to loans to the provider's own general fund, and the same restriction should be extended to loans of funded depreciation funds to related organizations.
- Section 413.134(e)(4) should be revised to prohibit using the proceeds of a loan from a provider's funded depreciation for the purpose of acquiring depreciable assets of the related organization borrowing the funds. The commenter believes that "investing" funded depreciation in depreciable assets of a related organization is not an appropriate interpretation of the concept of "available funds."
- Section 413.153 should be revised to include a definition of "investment income." The commenter believes that our current definition of investment income, which is set forth in the Manual rather than in regulations, is inconsistent with generally accepted accounting principles.
- HCFA should revise § 413.153(d)(3) to explain explicitly how the allocation of repayments is made between the principal and interest portions of the loan in paying off necessary borrowing. The commenter believes that any repayments must be applied to both the allowable principal and interest portions of the loan before applying any repayments to the unallowable portion of the loan. In addition, HCFA should include in the final rule an example illustrating the application of the policy regarding repayments for the necessary and unnecessary portions of a loan.
- If any funds that are generated from the provider's patient care activities are diverted to pay for an unallowable borrowing, that diversion should be considered an investment of the provider's patient-care-related funds, and any investment income generated should be used to reduce the provider's otherwise allowable interest expense. The commenter recommends that we revise § 413.153(d)(3) to reflect this concept.

Finally, the commenter suggested editorial changes to improve the clarity of § 413.153(d)(2) and (3).

Response: As noted by the commenter, the revisions to § 413.134 and 413.153 are effective for cost reporting periods beginning on or after October 1, 1994. Because the revisions to these sections involve changes to the cost payment rules rather than the prospective payment system rules, an effective date tied to the cost reporting period is more appropriate than an effective date tied to discharges.

We also agree with several of the commenter's recommendations, and have made the following changes in response to these comments:

- We are revising § 413.134(e)(1) to state that, in order for the investment income earned on the funded depreciation account to be exempt from offset against interest expense, the investment income must be deposited in, and become part of, the funded depreciation account at the time of receipt by the provider. This revision is consistent with section 226.2 of the Manual, and it also incorporates the requirement in section 226.3 of the Manual that the investment income must be deposited, by the provider, in the funded depreciation account at the time of receipt.
- As recommended, we are revising the regulations to state that when a provider invests or transfers assets of the fund to a related organization, these assets are treated as the provider's funds and are subject to all the provisions governing funded depreciation, notwithstanding the transfer. However, because we believe this is a pervasive principle of the funded depreciation rules, we are inserting this statement in the introductory material of § 413.134(e)(1), rather than in § 413.134(e)(4), as the commenter suggested.
- We are revising § 413.134(e)(4) to state that interest expense incurred on loans from the providers's funded depreciation account to purchase depreciable assets for that provider is not an allowable cost. We agree that, consistent with section 226.1 of the Manual, the provider's funded depreciation must be used, rather than loaned, for that purpose.
- We are adding the parenthetical phrase "principal and interest" after both uses of the word "loan" in § 413.153(d)(3) to clarify that any repayments must be applied to both the allowable principal and interest portions of the necessary portion of the loan before the repayments can be applied to the unallowable portion of the loan. However, we do not believe that it is appropriate to revise the regulations to add an example illustrating the application of the policy regarding repayments for the necessary and unnecessary portions of a loan. Instead. we intend to incorporate the example into a section 203.D of the Provider Reimbursement Manual as part of the upcoming revision of that manual.
- We are revising § 413.153(d)(3) to clarify that if any funds that are

generated from the provider's patient care activities are diverted to pay an unallowable borrowing, that diversion is considered an investment of the provider's patient care related funds, and any investment income generated must be used to reduce the provider's otherwise allowable interest expense.

We also adopted several of the commenter's editorial suggestions. However, as discussed below, we did not agree with two of the commenter's recommendations.

Since 1983, we have had several inquiries regarding whether a provider may lend its funded depreciation to a related organization for the purpose of acquiring depreciable assets to be used by the related organization. We have responded to these inquiries by stating that these loans are permissible as long as the funds remain available to the provider making the loan. Thus, if a provider lends its funded depreciation to a related organization, and subsequently borrows for a purpose for which its funded depreciation should have been used, the borrowing will be considered unnecessary to the extent of the funded depreciation that should have been available, but was not, due to the loan to the related organization. We are adding new § 413.134(e)(4)(iv) to incorporate this longstanding policy.

We do not believe that it would be appropriate to add a definition of investment income to § 413.153 in this final rule for the following reasons. First, since we did not propose to add a new definition of investment income to the regulations, there would be no opportunity for public comment. Moreover, we would prefer to continue to refine our definition of this term and propose it in a future rulemaking document. In developing any changes to this definition, we will fully consider the commenter's suggestions.

VI. 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 prospective payment systems are based on an averaging concept that 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 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 that 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. Because we believe such exclusions are contrary to the purpose and scheme of section 1886(d)(1)(B) of the Act, we proposed to revise the regulations to prevent inappropriate exclusions.

To avoid recognizing nominal hospitals, while allowing adequate flexibility for legitimate networking and sharing of services, we proposed additional criteria in 42 CFR part 412, subpart B for determining whether an entity qualifies for exclusion from the prospective payment systems as a long-term care hospital. Under the proposed rule, 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 proposed 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 considered "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 asked for 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 proposed to delete all references in the current prospective payment systems regulations to excluded units as "distinct part" facilities.

We received a number of comments on these proposals and our responses to them are as follows.

Comment: Some commenters expressed unqualified support for the new criteria, saying they would help to limit long-term care exclusions to only legitimately organized long-term care hospitals, and allow for more equitable treatment of facilities.

Response: We continue to believe new criteria, as proposed in § 412.23(e)(3), are needed and are adopting them, subject to the changes described below.

Comment: Several commenters questioned HCFA's authority to impose new criteria for exclusion of long-term care hospitals. The commenters stated that the term "hospital" is defined in section 1861(e) of the Act and section 1886(d)(1)(B) of the Act provides an exclusion from the prospective payment systems for a "hospital" having an average length of stay over 25 days.

Response: As discussed above and in the proposed rule, we are adding new criteria to prevent inappropriate exclusions from the prospective payment system. The purpose of excluding entities from the prospective payment system is to address situations in which the principles of prospective payment do not apply well. The considerations underlying exclusions may not apply to situations involving a "hospital within a hospital." If an entity is effectively part of another hospital and the principles of prospective payment do apply well to the organization as a whole, then it would not be appropriate to exclude part of that organization from the prospective payment system.

Moreover, we believe that granting exclusion to a "hospital within a hospital" may be contrary to the statutory scheme. The statute provides for exclusion of certain types of hospitals and certain types of hospital units. Significantly, the statute does not provide for exclusion of long-term care units. A "hospital within a hospital" may essentially be a long-term care unit of another hospital. We believe these distinctions are meaningful and that it would undermine the distinctions if we allowed exclusion of entities that are essentially long-term care units.

Thus, in order to prevent exclusions that are contrary to the purpose of the statute and to the statutory scheme, we proposed additional criteria for entities seeking exclusion. Sections 1102 and 1871 of the Act confer authority on the Secretary to establish rules and regulations as may be necessary to administer the Medicare program.

Comment: Some commenters indicated that the new criteria would not eliminate the possibility that some entities may be able to circumvent the prospective payment systems. Several commenters suggested that, instead of imposing structural criteria for determining when an entity qualifies as a bona fide separate hospital, we should develop criteria that, like those for rehabilitation hospitals and units, are specific to the types of care or services furnished. Another commenter recommended that we accept individual States' standards for long-term care hospitals instead of adopting the proposed requirements. Some commenters stated that a facility being operated as a long-term care unit rather than a separate hospital would be expected to receive most of its patients on referral from the host hospital. Thus, one commenter recommended that, in addition to meeting other criteria, a long-term care hospital must show that it has some admissions from hospitals other than the one with which it shares a building or campus. Another commenter recommended that requiring a minimum percentage of admissions from hospitals other than the one in which it is located be adopted as an alternative to the proposed criteria. Still another commenter recommended that a long-term care hospital be required to have at least 75 percent of its admissions from entities to which it is not related by common control, as defined in § 413.17(b)(3).

Response: Although we recognize that the proposed criteria may not prevent all attempts to circumvent the prospective payment systems, we do expect them to identify situations when exclusion is appropriate, and thus address the potential abuses of the exclusion provisions. We do not agree that the intended effect of the proposals could be achieved through service-specific criteria. The problem the

proposals were designed to deal with does not relate to the scope or types of services available in facilities, but to the organizational integrity of entities seeking exclusion from the prospective payment systems as separate hospitals. If a "hospital within a hospital" is really part of another hospital and the principles of the prospective payment system would apply to the organization as a whole, then the "hospital within a hospital" should not receive an exclusion.

Also, although long-term care hospitals are required to comply with licensure or other State laws affecting patient health and safety, we do not agree that it would be appropriate simply to adopt whatever requirements a particular State might impose on long-term care hospitals as the basis for exclusion from the prospective payment systems; on the contrary, we believe exclusion decisions should be made under a uniform national policy.

With regard to the suggestions that we adopt a standard related to the source of a hospital's patients, we agree that the extent to which a facility accepts patients from outside sources can be an important indicator of its status as a separate facility, not merely a unit of another hospital. In general, a facility's functional separateness should be reflected in its ability to attract patients from sources other than the hospital that serves as its host. For example, if a facility receives all (or nearly all) of its admissions independently (that is, from outside sources), it can reasonably be assumed to be functioning separately from the host hospital. In such a case, the fact that it shared services and facilities with the host hospital would not necessarily be an indication that exclusion is inappropriate. On the other hand, if a facility has no more than a bare majority (for example, 51 or 55 percent) of its admissions from other sources, and does not meet the other criteria for separateness, the facility may be dependent upon the host hospital for both services and patients. In such cases, we do not believe it can or should be seen as functionally or structurally separate from the host hospital; therefore, the payment considerations underlying exclusion do not apply and exclusion would be inappropriate.

On the other hand, the level of outside referrals required should not be set so high as to discourage use of the facility by the host facility as well as by others in the community. To balance these opposing concerns, we are revising § 412.23 to adopt a 75 percent referral standard as an alternative criterion to the proposed criteria. Under this approach, a hospital may obtain an exclusion either by meeting the criteria relating to organizational and functional separateness in § 412.23(e)(3)(i), or by meeting the organizational separateness criteria (that is, § 412.23(e)(3)(i) (A) through (D)) and by showing that, during the qualifying period used to establish compliance with the length of stay requirement, at least 75 percent of the hospital's inpatient population were referred to it from a source other than a hospital occupying space in the same building or on the same campus. We believe allowing a hospital to qualify under either of these alternatives will mitigate the concerns expressed by commenters about cost-effectiveness and the status of satellite facilities (discussed below), while still helping to avoid circumvention of the rules governing exclusion from the prospective payment systems.

We recognize that in determining the level of outside referrals needed to permit a long-term care exclusion for a hospital operating in the same building or on the same campus as another, we could have chosen a percentage higher or lower than 75 percent. We adopted this level of outside referrals as a qualifying level not only because it was recommended by a commenter but also because we believe it is indicative of situations when a hospital is sufficiently separate so that the reasons underlying exclusions do apply. At the same time, it prevents exclusion for a facility that is not a functionally separate hospital meeting community needs for long-term care, but may be a paper entity for which the reasons underlying exclusions do not apply.

In adopting this criterion, we are aware of the possibility that some facilities may attempt to adopt reciprocal referral arrangements under which one so-called "hospital within a hospital" would refer patients to another such entity, thus establishing "hospitals" that are not true community institutions but in effect operate as mutually supportive hospital units. We plan to monitor the referral patterns of facilities that obtain prospective payment system exclusion under the criterion based on their inpatient population, and may propose further changes to the regulations or take other actions as needed.

Comment: Two commenters stated that the new exclusion criteria for long-term care hospitals appear to have been designed to prevent inappropriate exclusion of long-stay units of prospective payment systems hospitals. As proposed, however, the criteria would also prevent a current long-term care hospital from keeping its long-term care exclusion if it sets up a separate rehabilitation hospital on its campus or in its facility, in order to avoid actual and potential problems. (One hospital apparently faces an actual problem in providing rehabilitation services at costs less than its TEFRA limits, since those limits reflect a base year during which it furnished virtually no rehabilitative care. The hospital also faces a potential problem, in that if it remains a single long-term care hospital it may not qualify for payment under whatever prospective payment system is finally adopted for rehabilitation hospitals and units.) To avoid this result, one commenter recommended that the proposed regulations be revised to apply only to applicant long-term care hospitals set up in the same building or on the same campus as prospective payment systems hospitals, or that existing long-term care hospitals be exempted from the new criteria. Another commenter suggested that the new criteria be applied more liberally in the case of applicant long-term care hospitals that obtain space from hospitals excluded from the prospective payment systems.

Response: The new exclusion criteria were developed in response to situations involving prospective payment systems hospitals rather than currently excluded hospitals. However, we recognize that there may be other situations in which a hospital may want to reconfigure itself solely to gain a reimbursement advantage, rather than to improve its quality of care or efficiency of operation. Under these circumstances, we believe it is appropriate to apply the revised long-term care exclusion criteria as needed to ensure that a facility is not able to circumvent the prospective payment systems or a TEFRA limitation simply through a nominal restructuring. In addition, § 413.40 contains several provisions that allow for adjustments to accommodate changes that occur after an excluded hospital's base year. For these reasons, we have not revised the exclusion criteria for long-term care hospitals as requested by these commenters.

Comment: Some commenters stated that the new exclusion criteria are not necessary to prevent inappropriate utilization of long-term care services, since PRO review of admissions already achieves this result.

Response: We recognize the importance of PRO activities in assuring appropriate utilization, but we do not believe PRO review of specific admissions can be effective in dealing with problems of inappropriate exclusion of certain types of facilities.

Comment: A commenter stated that in some cases, long-term care exclusions have been granted to hospitals that lease space from another company to which they are related by common ownership. The commenter recommended the final rules be clarified to state that long-term care exclusions are available to hospitals that are separately operated but are related through common ownership.

Response: A facility may qualify for exclusion as long as it meets the criteria, even if it is owned by the same entity as a hospital with which it shares a building or a campus. A separately operated hospital is not ineligible for exclusion solely because it and the host facility are under common ownership. We do not believe that it is necessary to revise the regulations to clarify this point.

Comment: Some commenters stated that the new exclusion criteria could adversely affect the quality of care patients receive, by limiting access to care and by requiring transfers that could be medically inappropriate. A commenter stated that the criteria could lead to a shortage of long-term care beds in rural areas, and suggested we either abandon the proposal or create an exception for rural facilities.

Response: We agree that it would not be desirable to limit patients' access to long-term care or to require medically inappropriate transfers. However, none of the commenters presented any data, studies, or other objective information to demonstrate that these results would occur. Moreover, all hospitals are obligated under the Medicare conditions of participation (§ 482.21(b)) to have an effective, ongoing discharge planning program that facilitates the provision of follow-up care. We believe this requirement is effective in preventing premature or inappropriate discharges, but will investigate fully any complaints we receive in this area. In this context, we note that the new criteria are designed only to make appropriate payments, not to affect medical practice.

We also considered the proposal to exempt rural facilities from the requirements; however, we believe that the exclusion provisions can be administered most efficiently and equitably if we use a single set of standards for both urban and rural facilities. In addition, we do not want to indirectly encourage the development of hospitals within hospitals in rural areas. Therefore, we are not adopting this suggestion.

Comment: A commenter expressed reservations about several of the specific proposed criteria, saying that having a separate governing body, chief medical officer, and chief executive officer could impede coordination of care.

Response: As noted above, all hospitals are responsible for discharge planning, and they typically develop referral and other relationships with other facilities to fulfill this responsibility. In general, there is no indication that the independence of these facilities impedes the coordination of hospital and post-hospital care. Thus, we do not believe that these criteria will impede the coordination of patient care.

Comment: A commenter opposed the use of the definition of "control" incorporated into the proposed criteria. The commenter stated that "control" is a reimbursement concept and that it is not appropriate to apply this concept for purposes of determining whether two facilities may be separately certified for Medicare participation.

Response: The purpose of the proposed criteria is not to determine whether a facility seeking to participate in Medicare as a hospital is qualified to do so under the conditions of participation. On the contrary, the goal of the criteria is to limit exclusions to situations when exclusion is warranted. We believe that it is appropriate to adopt the definition of control under § 413.17(b)(3), which currently applies for reimbursement purposes, because it is a long-established and well understood payment rule that can be readily applied to this new situation.

Comment: Several commenters stated that the proposals would increase costs by limiting hospitals' ability to share space and services. Even some commenters who generally favored the "core services" criteria (that is, the requirement under proposed § 412.23(e)(3)(v) that a hospital perform basic hospital functions through the use of its employees or under contract with an entity other than the hospital from which it obtains space) nevertheless suggested that long-term care hospitals be allowed to buy laboratory and radiology services from the host hospital.

Response: We understand the commenters' concerns, but also believe that the ability to provide certain core services, including laboratory and radiology services, needed by patients can be an important indicator of the separateness of a facility seeking exclusion as a long-term care hospital. Moreover, as noted elsewhere in this preamble, hospitals that receive a certain percentage of their patients from sources other than the hospital from which it obtains space are not required to meet the "core services" requirement. Therefore, we did not adopt the recommendation that laboratory and radiology be excluded from the list of core services.

Comment: A commenter asked for clarification of whether the additional criteria would apply only when an applicant long-term care hospital obtains space from another hospital, or whether they also would apply when the applicant long-term care hospital obtains space from a third entity that controls both hospitals.

Response: The new criteria apply whenever a hospital seeking long-term care exclusion occupies space in a building that is also used by another hospital, or in a building that is located on the same campus as one or more buildings used by another hospital. If these conditions exist, the exclusion request must be evaluated under the new criteria, regardless of whether the space occupied by the applicant long-term care hospital is furnished by another hospital or by a third entity. However, the criteria do not apply if the applicant long-term care hospital is the only hospital to occupy space in the building or on the campus.

The following examples illustrate this rule: if a hospital seeking long-term care exclusion and another hospital each occupy five floors of the same ten-story building, the new criteria apply. This is the case even if the applicant long-term care hospital does not lease its space from the other hospital, but from another source, such as a private realty company that acts only as a lessor and does not have any other association with the long-term care hospital. However, the criteria do not apply if the applicant long-term care hospital occupies the entire building, or if the other five floors are occupied by an entity other than a hospital, such as a health maintenance organization or physician professional corporation. Under these circumstances the criteria do not apply, even if the space is provided to the applicant long-term care hospital by a controlling third entity, such as a chain organization that owns or controls it as well as one or more other hospitals.

To clarify these points, we have revised § 412.23(e) to remove references to hospitals that provide or obtain space, and to refer instead to hospitals that occupy space in the same building or on the same campus.

Comment: A commenter asked whether a hospital seeking long-term care exclusion would be disqualified if it purchased therapy services and supplies, such as pharmaceuticals, from the hospital from which it obtains space.

Response: In general, exclusion or non-exclusion of individual facilities is

determined on a facility-by-facility basis by the HCFA regional office (RO), based on the facility's compliance with the exclusion criteria. We note that pharmaceutical services are among the core services that a hospital must provide directly, or obtain from an entity other than the one with which it shares space in a building or on a hospital campus. However, we also note that, if a hospital satisfies the 75 percent referral standard, it would not be disqualified simply because it purchased pharmaceutical services from the host hospital.

Comment: A commenter suggested that the term "campus" be defined more specifically as a continuous parcel of property owned by an applicant long-term care hospital. The commenter believes that "campus" should not include any property owned by an excluded hospital, even though it may adjoin the applicant hospital's property.

Response: We have not adopted an explicit definition of the term "campus," but intend that decisions about whether facilities are on the same campus be made by the ROs in the course of applying the new provisions. In making these assessments, RO staff will consider not only the ownership of a tract of land but its actual use. For example, if a hospital owns one tract of land but holds an adjacent tract under a long-term lease, and occupies and uses both tracts as if they were one, the two tracts might be considered the hospital's campus regardless of the ownership of the second tract. Thus, because of the possibility of arrangements such as this, we do not believe that ownership is the sole determinant of what constitutes a hospital's campus.

Comment: A commenter recommended that the regulations be revised to exclude situations in which a hospital has a majority of its beds located in a single site, and incurs most of its costs at that site, but has a satellite location at which some of its beds are located in the same building as another hospital.

Response: We believe the proposed criteria should be applied in all cases involving joint occupancy of a building or campus by an applicant long-term care hospital and another hospital, and have not adopted this comment. This means that if a hospital has established a satellite unit within another hospital and has most or all basic hospital functions for the unit performed by the host hospital or by a controlling third entity, the hospital would not be able to qualify for a long-term care exclusion under the criteria as proposed. However, the additional criterion related to the sources of a long-term care hospital's patients will be applied with respect to the total patient population a hospital treats at all locations, including both base and satellite facilities. A hospital which has a majority of its beds at a central location and maintains only a small number of satellite beds probably would attract patients from a variety of sources other than the hospital(s) in which its satellite facilities are located, and thus may be able to meet the alternative criterion related to the sources of its patients.

Comment: Several commenters noted that some long-term care hospitals have operated for many years by using space and services obtained from other hospitals, and that the TEFRA rates for these hospitals effectively prevent excess costs at these facilities. Because of this, the commenters recommended that we exempt currently excluded facilities from the new criteria, or provide a facility-by-facility exceptions process.

Response: We understand that some facilities that have been excluded under their current forms of organization for many years may not meet the new exclusion criteria. We agree that it might be inequitable to impose new criteria on them effective immediately. However, we believe that the exclusion provisions can be administered most efficiently and equitably if we use a single set of standards for both currently excluded hospitals and those requesting exclusion for the first time. We considered the suggestion that we adopt a case-by-case exceptions process, but we are concerned about the administrative burden involved in such a process, as well as the difficulty in setting criteria. Therefore, to allow for equitable treatment of currently excluded hospitals while ensuring that all similar hospitals eventually will be subject to the same standards, we are adding paragraph (e)(4) to § 412.23 to allow hospitals with long-term care exclusions in effect for cost reporting periods beginning on or after October 1, 1993, but before October 1, 1994, an additional 12 months before the new exclusion criteria will apply. Thus, the new exclusion criteria specified in § 412.23(e)(3) will not apply to those hospitals until the start of their first cost reporting period beginning on or after October 1, 1995.

B. Miscellaneous Comments

Comment: Some commenters recommended that we revise the regulations on exclusion of rehabilitation hospitals and units from the prospective payment systems. They suggested that four new medical conditions—oncology cases, pulmonary disorders, cardiac disorders, and chronic pain—be added to the list of medical conditions, under § 412.23(b)(2), that is used to identify hospitals and hospital units that are primarily engaged in intensive inpatient rehabilitation.

Response: Although this issue was not addressed in the May 27, 1994 proposed rule, we are interested in suggestions regarding changes in this provision and will take them into consideration in deciding what, if any, future changes are appropriate.

Comment: Some commenters stated that there is an increasing need for subacute care, which is not now recognized as a distinct level of care under Medicare. The commenters recommended that new coverage and payment policies specific to subacute care be adopted to respond to this need.

Response: These comments are similar to others we have recently received from providers involved in treating long-stay patients. These commenters suggested that a separate Medicare benefit, similar to the hospital and SNF care benefits, be developed for care that is variously described as "transitional" or "subacute." We are reviewing these suggestions carefully, and may propose new legislation or regulations on this type of care in the future. However, there is currently no Medicare benefit for subacute care, and we made no change in these regulations based on these comments.

C. Removal of the 1986 Malpractice Rule (§ 413.56)

We proposed to remove from the regulations "the 1986 malpractice rule", which is set forth at § 413.56. We also proposed to remove all cross-references to § 413.56. This technical change is designed to conform the regulations to the various authorities that have previously established that the 1986 malpractice rule is invalid. See the May 27, 1994 proposed rule for a detailed discussion of this proposed change (59 FR 27751). We received no comments and are adopting the proposal without change in this final rule. As a result, the amended Medicare rules 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.

D. 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 proposed 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 proposed 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 proposed 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.

We received no comments on the technical changes described above. Therefore, we are adopting those changes as proposed.

VII. ProPAC Recommendations

As required by law, we reviewed the March 1, 1994 report submitted by ProPAC to Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our response to that recommendation, we have not repeated the recommendation and response in the discussion below. Recommendations 9, 12, and 13 concerning the update factors for inpatient operating costs are discussed in Appendix D to this final rule. Recommendations 10 and 11 concerning the update factors for inpatient capital costs are 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 on which we received comments are discussed below.

A. 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 in the Proposed Rule: 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.

Comment: ProPAC believes that annual audits are necessary to develop the data needed to monitor dialysis costs over time and to ensure that payments for dialysis services are updated appropriately.

Response: We believe it is not feasible at this time to conduct annual audits of renal facilities. The selection of a representative sample of renal facilities nationally, the coordination of the audits with fiscal intermediaries, and the review and analysis of data are time consuming activities. The audit process takes about 12 months to complete. Moreover, audits impose burdens on renal facilities, who have limited staff resources. We believe that conducting audits on a 3-year basis is a reasonable alternative to annual audits. During the interval, unaudited data are available from HCRIS for ProPAC's analysis. In addition, prior audit results can be used to account for differences between reported and audited costs.

Comment: One commenter believes that the lack of a payment rate increase for dialysis services is unfair to hospital-based renal facilities, and claims that hospitals service a more resource-intensive and consequently costlier patient population.

Response: In its report to Congress, ProPAC addressed the issue of the cost differential between hospital-based renal facilities and independent facilities (see p. 85–86). ProPAC's analyses of various data failed to attribute the cost difference between hospital-based and independent renal facilities to factors, such as patient mix, for which the payment system should compensate. The data showed that higher costs for hospital-based renal facilities may be due, in part, to "richer employee skill mix" and the inclusion of inpatient dialysis service costs in the outpatient department. Furthermore, ProPAC found that audited cost data did not justify an increase and recommended no payment rate update.

To date, no study has clearly demonstrated that hospitals treat a more resource-intensive, and consequently costlier, ESRD patient population than independent renal facilities. Until an ESRD case mix index is developed to adjust payment rates, the exception process provides a mechanism for adjusting payment rates to account for differences in patient mix.

B. 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 in the Proposed Rule: 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.

Comment: In commenting on the proposed rule, ProPAC reiterated much of its original recommendation, stating again that the IME adjustment should be reduced to 7.0 in FY 1995. The Commission continues to argue that further reductions should be gradual and occur only after examination of the financial status of teaching hospitals. The Commission expressed its appreciation for HCFA's explanation of the methodology it uses to control for DSH when estimating indirect teaching costs. The Commission also indicated its intent to continue examining the level and the structure of the IME adjustment. Finally, ProPAC indicated support for the explicit recognition of IME by all payers under health care reform, and called for Medicare to retain the IME adjustment until an alternative system was operational.

Response: We appreciate ProPAC's past contributions to the understanding of the relationship between patient care costs and graduate medical education, and anticipate that the Commission will continue to be at the analytic forefront of this important issue.

C. 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 in the Proposed Rule: 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.

Comment: ProPAC continues to believe that the Secretary should not delay correcting beneficiary liability for outpatient services until the implementation of prospective payment.

Response: We understand the concern expressed by ProPAC. However, we continue to believe that a meaningful solution to the high level of beneficiary liability can most appropriately be achieved with the implementation of a prospective payment system for hospital outpatient services in the near future. The time and effort needed to develop an interim solution might detract from the development of the prospective payment system that would make possible an equitable solution for all parties, while minimizing the negative financial impact on the Medicare program.

VIII. Other Required Information

A. Paperwork Reduction Act

As discussed in detail in section III.F of this preamble, we proposed 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 proposed 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. In our May 27, 1994 proposed rule, we published a list of data sets that are available for purchase (59 FR 27756). We received no comments concerning this process.

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

We ordinarily publish a notice of proposed rulemaking for a rule to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest. We find good cause to implement this rule as a final rule with comment period because the delay involved in prior notice and comment procedures for the new provisions of this rule would be contrary to the public interest.

The only provisions of this rule that were not part of our May 27, 1994, proposed rule are those eliminating the requirement in 42 CFR 412.230 that an individual hospital be located in an area adjacent to the area to which it seeks geographic reclassification. As discussed in section III.F of this preamble, the MGCRB is required, by statute, to issue decisions on hospital applications no later than 180 days after October 1, the first day of the Federal fiscal year preceding the Federal fiscal year for which the hospital is seeking reclassification. To be considered for reclassification for FY 1996, a hospital must submit its application no later than October 1, 1994. In this rule, we are revising § 412.230 to eliminate the adjacency requirement for individual hospitals seeking geographic reclassification for prospective payment purposes. We believe that it is necessary to implement this revision as part of this final rule to allow hospitals that previously would not have qualified for reclassification an opportunity to submit timely applications for the next MGCRB adjudication period. We find that the delay involved in prior notice and comment would be contrary to the public interest in that it would diminish or eliminate some hospital's opportunities to file timely applications for reclassification for FY 1996 and to receive the potential benefits of reclassification.

Timely adjudication is essential not only to ensure that hospitals are not deprived of the statutory right, subject to specified criteria, to apply for reclassification for FY 1996, but also to ensure that the budget neutrality requirement imposed by Congress in section 1886(d)(8)(D) of the Act can be met for FY 1996 prospective payment system rates.

Therefore, we have concluded that it is appropriate to implement the revisions to § 412.230 as final in this instance. However, we are providing a 60-day period for public comment, as indicated at the beginning of this rule, on these changes to the reclassification criteria.

We also normally provide a delay of 30 days in the effective date of a regulation. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date. We may also waive the delay in the case of a rule that grants an exemption or relieves a restriction. We find good cause to waive the usual 30-day delay in this instance. As explained above, it is essential that these provisions have immediate effect, so that hospitals will be able to apply for reclassification under the revised criteria set forth in this final rule with comment period. A 30-day delay in the effective date could deprive some hospitals of the opportunity to file timely applications and to receive the potential benefits of reclassification. Moreover, the delay would jeopardize the budget neutrality requirement described above. Thus, a 30-day delay in the effective date would be contrary to the public interest. Therefore, we find good cause to waive the usual 30-day delay in the effective date.

D. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and we will respond to these comments in subsequent rulemaking document. Comments on changes to the criteria for geographic reclassification will be considered if we receive them by the date specified in the "DATES" section of this preamble. We will not consider comments concerning provisions that remain unchanged from the May 27, 1994 proposed rule or that were changed based on public comments.

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 466

Grant programs-health, Health care, Health facilities, Health professions, Peer Review Organizations (PRO), Reporting and recordkeeping requirements.

42 FR Part 482

Grant programs-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 FR 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 is amended as set forth below:

A. Part 412 is 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

§ 412.2 [Amended]

2. In paragraph (e)(4) of § 412.2, remove the words "and liver" and add, in their place, the words "liver, and lung".

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) Except as provided in paragraph (e)(4) of this section, 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 either the criteria in paragraph (e)(3)(i) or (e)(3)(ii) of this section.

(i) The hospital meets the following requirements:

(A) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(B) *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 occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(C) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. 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.

(D) *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 occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(E) *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 occupying space in the same building or on the same campus, 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 occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(ii) For the period of at least 6 months used to determine compliance with the length-of-stay criterion in paragraph (e)(2) of this section, the hospital meets the requirements of paragraphs (e)(3)(i)(A) through (e)(3)(i)(D) of this section and has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(4) If a hospital has been excluded from the prospective payment systems under this paragraph for any cost reporting period beginning on or after October 1, 1993, but before October 1, 1994, the criteria in paragraphs (e)(3) of this section do not apply to the hospital until the hospital's first cost reporting period beginning on or after October 1, 1995.

(5) 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 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)(i) HCFA makes a midyear correction to the wage index for an area only if a hospital can show that—

(A) The intermediary or HCFA made an error in tabulating the hospital's data; and

(B) 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.

(ii) 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" 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 nursery beds assigned to newborns that 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, including the time limits for filing requests for hearings as specified in §§ 405.1811(a) and 405.1841(a)(1) and (b) of this chapter.

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

§ 412.113 [Amended]

15. Section 412.113 is amended as follows:

a. In paragraph (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,".

b. In paragraph (d), remove the words "and liver" wherever they appear and add, in their place, the words "liver, and lung".

Subpart L—The Medicare Geographic Classification Review Board

16. Section 412.230 is amended as follows:

a. Paragraph (a)(2) is removed and paragraphs (a)(3) through (a)(5) are

redesignated as paragraphs (a)(2) through (a)(4).

b. In redesignated paragraph (a)(2), "(a)(4)" is removed and "(a)(3)" is added in its place, and the word "adjacent" is removed.

c. Redesignated paragraph (a)(3)(i) is removed, redesignated paragraphs (a)(3)(ii) through (a)(3)(v) are further redesignated as (a)(3)(i) through (a)(3)(iv), in redesignated paragraph (a)(3)(iii) remove "(a)(4)" and add, in its place, "(a)(3)", and redesignated paragraph (a)(3)(iv) is revised.

d. In paragraphs (b), (c), and (d), the word "adjacent" is removed wherever it appears.

e. In paragraph (e), the word "adjacent" is removed wherever it appears, the introductory text of paragraph (e)(2) is republished, and paragraphs (e)(2)(ii)(A) and (e)(2)(ii)(B) are revised.

The revisions read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General*— * * *

(3) *Special rules for sole community hospitals and rural referral centers*— * * *

(iv) A hospital that is redesignated under paragraph (a)(3) of this section may not be redesignated in the same fiscal year under paragraph (a)(2) of this section.

* * * * *

(e) *Use of urban or other rural area's wage index*— * * *

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate data as follows:

* * * * *

(ii) * * *

(A) The average hourly wage in the area in which the hospital is located and the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification and;

(B) If the hospital is requesting reclassification under §412.230(e)(1)(iv)(B), occupational-mix data to demonstrate the average occupational mix for each employment category in the area to which the hospital seeks reclassification. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

17. 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

18. 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 later of September 30, 1996 or 4 years from the date the certificate of need was approved.

* * * * *

§ 412.308 [Amended]

19. In paragraph (c)(3) of § 412.308, remove the phrase "For FY 1992 through FY 2001,".

20. Section 412.348 is revised to read as follows:

§ 412.348 Exception payments.

(a) *Definitions.* As used in this section—

Annual operating expenses. Annual operating expenses means the sum of net expenses for all reimbursable cost centers for a 12 month cost reporting period. Annual operating expenses are obtained from the Medicare cost report.

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.

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 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 a project need requirement, a project size requirement, and, in the case of certain 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.

(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).

(iii) Hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

(2) *Project need requirement.* A hospital must show that it has obtained any required approval from a State or local planning authority. If a hospital is not required to obtain approval from a planning authority, it must satisfy the age of asset test specified in paragraph (g)(3) of this section and, in the case of an urban hospital, the excess capacity test under paragraph (g)(4) of this section.

(3) *Age of assets test.* A hospital must show that 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.

(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) After completion of the project, its capacity is no more than 80 percent of its prior capacity (in terms of bed size).

(5) *Project size requirement.* A hospital must complete, during the period from the beginning of its first cost reporting period beginning on or after October 1, 1991 to the end of its last cost reporting period beginning before October 1, 2001, a project whose costs for replacement and/or renovation of fixed assets related to patient care are at least:

(i) $200 million; or

(ii) 100 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

(6) *Minimum payment level.* The minimum payment level for qualifying hospitals will be 70 percent.

(7) *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 completes a project for replacement or renovation of capital assets that meets project need and project size requirements (and, if applicable, excess capacity test), provided that it completes the project no later than the end of the hospital's last cost reporting period beginning before October 1, 2001. A project is considered to be completed when the assets are put into use for patient care.

(8) *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.* Offsetting amounts are applied in the following order—(A) 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.

(B) Any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding, if applicable, 75 percent of the hospital's operating prospective payment system disproportionate share 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. For purposes of calculating the offset, the costs and payments for services that are not subject to the hospital inpatient prospective payment system are excluded.

(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]

21. 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 is amended as follows:

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

1. The authority citation for part 413 continues 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, 1395l (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 paragraphs (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 allowable time worked 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 provided such investment income is deposited in, and becomes part of, the funded depreciation account at the time of receipt by the provider. 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. If a provider transfers assets of the funded depreciation account to a related organization (for example, pooling of several chain organization providers' funded depreciation accounts at the chain home office for investment purposes), these assets shall be treated as the provider's funds and are subject to all the requirements specified in paragraph (e) of this section.

(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 are 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). However, if the general fund of the provider borrows from the funded depreciation account to acquire depreciable assets used in furnishing patient care, or for other capital purposes related to patient care, interest expense paid by the general fund to the funded depreciation account is not an allowable cost. Providers are

expected to use the funded depreciation for these purposes.

(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.

(iv) A provider may loan its funded depreciation to a related organization for any purpose subject to the following conditions:

(A) Authorization for such a loan by the provider's appropriate managing body of the provider, such as Board of Trustees or Board of Directors, must be on file.

(B) The funded depreciation loaned must remain available, as specified in paragraph (e)(2) of this section, to the provider making the loan. Costs incurred for lines of credit to assure such availability are not allowable costs. During the period of time that the loan is outstanding, if the provider making the loan resorts to outside borrowing for a purpose for which its funded depreciation should have been used, interest expense on an amount of the outside borrowing up to the amount of the funded depreciation that should have been available would be disallowed as unnecessary.

(C) Such loans shall be considered investments of the provider's funded depreciation, but the requirement that funded depreciation be invested in readily marketable investments as required in paragraph (e) of this section is waived for such loans.

(D) The funded depreciation account must earn interest on such loans at a rate that does not exceed the rate that would be charged for a comparable loan from an independent lending institution. This investment income will not be used to reduce the provider's interest expense if all the other conditions in paragraph (e) of this section are met. If the entity borrowing the funds is another provider participating in the Medicare program, the interest expense incurred on such loans would be allowable if the loan meets all of the interest expense requirements specified in § 413.153. (For purposes of § 413.153(b)(3)(ii), such loans are not considered to be with a related lender.)

* * * * *

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 borrowing related to the tangible assets, then to the borrowing related to the intangible assets other than goodwill, and lastly to the borrowing related to the goodwill.

(3) When a provider borrows funds, but only some of the funds are necessary, repayments of the loan (principal and interest portions) are applied first to pay for the necessary portion of the loan. Only after all of the necessary portion of the loan (principal and interest) has been repaid are any repayments applied to the unnecessary portion of the loan. Repayments toward non-allowable borrowing pertaining to assets or activities not related to patient care are considered investments, and the provisions of paragraph (b)(2)(iii) of this section are applied.

* * * * *

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 466 is amended as follows:

PART 466—UTILIZATION AND QUALITY CONTROL REVIEW

1. The authority citation for part 466 continues to read as follows:

Authority: Secs. 1102, 1154, 1159, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1320c–3, 1320c–8, 1395cc, and 1395hh).

Subpart C—Review Responsibilities of Utilization and Quality Control Peer Review Organizations (PROs)

2. In § 466.71, paragraph (c)(2) is revised to read as follows:

§ 466.71 PRO review requirements.

* * * * *

(c) * * *

(2) As directed by HCFA, the PRO must review changes in DRG assignment made by the intermediary under the provisions of § 412.60(d) that result in the assignment of a higher-weighted DRG. The PRO's review must verify that the diagnostic and procedural information supplied by the hospital is substantiated by the information in the medical record.

* * * * *

3. In § 466.78, paragraph (a) is revised to read as follows:

§ 466.78 Responsibilities of health care facilities.

(a) Every hospital seeking payment for services furnished to Medicare beneficiaries must maintain a written agreement with a PRO operating in the area in which the hospital is located. These agreements must provide for the PRO review specified in § 466.71.

* * * * *

D. Part 482 is 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,

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.

* * * * *

E. Part 485 is 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.

* * * * *

F. Part 489 is 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: August 23, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 25, 1994.

Donna E. Shalala,

Secretary.

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

Addendum—Schedule of Standardized Amounts Effective with Discharges On or After October 1, 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 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 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, hospitals located in Puerto Rico, and hospitals subject to the regional floor, each hospital's payment per discharge under the prospective payment system is based on 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). Hospitals affected by the regional floor are paid on the basis of 85 percent of the Federal national rate and 15 percent of the Federal regional rate.

As discussed below in section II, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively, will affect the calculation of the Federal rates. In section III we discuss changes we are making in the determination of the prospective payment rates for Medicare inpatient capital-related costs. Section

IV sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the final rule are presented at the end of this addendum in section V.

II. Changes to Prospective Payment Rates For Inpatient Operating Costs for FY 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. The Federal and Puerto Rico rate changes will be effective with discharges occurring on or after October 1, 1994. Below, we discuss the manner in which we are changing some of the factors used for determining the prospective payment rates.

As discussed in section IV.C of this final 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 any 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. Since there will no longer be separate other urban and rural standardized amounts we will refer to the other 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 relative weights for discharges in FY 1995.

In summary, the 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 large 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 a "large urban area" as an urban area with a population of more than 1,000,000. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. 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 for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on 1992 population estimates published by the Bureau of the Census, 56 large urban areas meet the criteria to be defined as large urban areas for FY

1995. Since the publication of the proposed rule, the Bureau of the Census has published revised population estimates so that the Monmouth Ocean, NJ, MSA now meets the definition of a large urban area. Large urban areas are identified by an asterisk in Table 4a.

Table 1a contains the two national standardized amounts that are applicable to most hospitals. Table 1b sets forth the 18 regional standardized amounts that continue to be applicable for hospitals located in census areas subject to the regional floor. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national large urban standardized amount, and the national other urban standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is set forth in Table 1c. This table also includes the two standardized amounts that are applicable to most hospitals in Puerto Rico.

We note that on July 5, 1994, the Office of Management and Budget announced the designation of Hattiesburg, Mississippi as a Metropolitan Statistical Area (MSA).

3. Updating the Average Standardized Amounts. In accordance with section 1886(d)(3)(A) of the Act, we are updating the large urban, other urban, and rural average standardized amounts for FY 1995 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. Section 1886(b)(3)(B)(i)(X) of the Act (as amended by section 13501(a) of Pub. L. 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 establishing an update to the rural average standardized amount for FY 1995 of 8.4 percent.

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 FY 1995 standardized amounts reflect a single reduction for this factor of 0.6 percent.

With the phase-out of the separate rural standardized 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. As explained in the proposed rule, we are adjusting 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.) We are therefore adjusting 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 published the report to Congress as Appendix C to the proposed rule. This recommendation was based on an earlier forecast of the hospital market basket increase. Our final recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act), is set forth as Appendix D to this final 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 assures 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 assures 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 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 1993 and 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 proposed budget neutrality adjustment factor equal to 0.997647. The final budget neutrality adjustment factor is equal to 0.998050. 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 will continue to apply the same FY 1995 adjustment factor to the hospital-specific rates that are effective 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. In the proposed rule, we applied an adjustment of 0.993814 to ensure that the effects of reclassification are budget neutral. The final budget neutrality adjustment is 0.994055.

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 adjustment reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 14, 1994. The final budget neutrality adjustment factor reflects the effects of all reclassification decisions and changes in these decisions 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.

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 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 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 modifies 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 final 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 proposed 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 also proposed to reduce the marginal cost factor for each outlier day from 55 percent to 49 percent in FY 1995 in order to reduce the proportion of payments paid under the day outlier methodology. The thresholds that we are establishing in this final rule continue to be the geometric mean length of stay for each DRG plus the lesser of 22 days or 3.0 standard deviations. However, based on updated simulations we are establishing in this final rule a marginal cost factor for each outlier day of 47 percent in FY 1995.

Our policy will reduce the proportion of outlier payments paid to day outliers as required by section 1886(d)(5)(A) of the Act. We proposed to establish 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 proposed to increase the marginal cost factor for cost outliers from 75 to 80 percent. In this final rule, based on updated simulations, we are establishing a fixed loss cost outlier threshold in FY 1995 equal to the prospective payment rate for the DRG plus $20,500 ($18,800 for hospitals that have not yet entered the prospective payment system for capital-related costs). We are also establishing a marginal cost factor for cost outliers of 80 percent for FY 1995, as proposed.

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.

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 June 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), before FY 1994, we used a charge inflation factor to adjust charges to costs; beginning with FY 1994, we are 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 automatically adjust 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. In setting the final FY 1995 outlier thresholds, we used a cost inflation factor of 1.025. The difference is attributable to the use of the cost per case increase in PPS–9 (data from cost reporting periods beginning in FY 92) in setting the final FY 95 outlier thresholds instead of the average increase in cost per case between PPS–7 (data from cost reporting periods beginning in FY 1990) and PPS–9. This modification was introduced after a preliminary review of the cost per case increase of 2,500 hospitals in PPS–10 (data from cost reporting periods beginning in FY 93). The cost per case increase from PPS–9 to PPS–10 was much closer to the increase from PPS–8 to PPS–9 than from PPS–7 to PPS–9. Thus, for FY 1995, we are using a cost inflation factor based on the observed increase in hospital costs between PPS–8 and PPS–9. In the future, we still plan to use 2-year averages in computing the cost inflation factors, unless preliminary data from more recent years indicate that the 2-year average may be inaccurate.

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 final thresholds for FY 1995 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.9 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 are applying a reduction of approximately 5.1 percent to the FY 1995 standardized amounts to account for the proportion of prospective payments made 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 Amount—0.948772

Capital Federal Rate—0.9372

The final outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1995 are as follows:

Operating Standardized Amount—0.948940

Capital Federal Rate—0.9414

As in the proposed rule, we will apply the 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 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 will be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.275 or greater than 1.310 and capital cost-to-charge ratios lower than 0.013 or greater than 0.235. 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 will be applied to all hospital-specific cost-to-charge ratios based on cost report settlements occurring during FY 1995.

Comment: One commenter expressed concern over the use of statewide averages for those hospitals in which the intermediary computes operating cost-to-charge ratios lower than the

minimum acceptable ratio (that is, minus 3 standard deviations from the mean). The commenter stated that the minimum threshold created a clear incentive for hospitals to artificially inflate their gross charges, and circumvent the intent that hospitals only be paid marginal costs for outliers. The commenter recommended elimination of the minimum cost-to-charge ratios.

Response: We use the statewide average operating cost-to-charge ratios in cases where an intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Our current definition of reasonableness is based on a range of plus or minus 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals. We do not believe hospitals are setting their charges just to manipulate their cost-to-charge ratios. In fact, contrary to the commenter's contention, the incentives a hospital would have to maximize outlier payments, if any, would be to lower charges in order to increase its cost-to-charge ratio. Thus, we will continue to use statewide cost-to-charge ratios where the cost-to-charge ratio for any hospitals falls outside the prescribed ranges.

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. Our estimates of actual outlier 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 4.2 percent of total DRG payments. These estimates are based on simulations using the August 1993 update of the provider-specific file and the August 1993 update of the MedPAR file.

In the 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 Medicare cases 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 actual FY 1994 outlier payments will be 3.9 percent of actual FY 1994 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 (based on the best available data) used to estimate outlier payments in setting FY 1994 outlier thresholds appears to have been overstated. Based on more recent data, we are using a cost inflation factor of 2.5 percent to set outlier payments for FY 1995. Also, although we estimate that actual FY 1994 outlier payments will approximate 3.9 percent of actual FY 1994 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 estimate is 2.7 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.

Comment: Some commenters are concerned about our projection that the percentage of FY 1994 outlier payments will be lower than estimated when we set the FY 1994 outlier thresholds. These commenters urge that we establish a method of monitoring outlier payments during a fiscal year, so that we can prospectively change the outlier thresholds in the event that projected outlier payments are not between 5 and 6 percent of total DRG payments.

Response: We responded to similar comments in the final rules for FY 1993 (57 FR 39784) and FY 1994 (58 FR 46347). Section 1886(d)(5)(A)(iv) of the Social Security Act (the Act) requires that outlier payments be between 5 and 6 percent of the total payments "projected or estimated to be made" based on diagnosis-related group (DRG) prospective payment system rates for discharges in that year. Pursuant to this provision, we calculated the FY 1994 outlier thresholds so that estimated outlier payments were 5.1 percent of estimated total DRG payments. We used the most recent Medicare discharge and hospital-specific data available to estimate total payments and outlier payments. This is necessarily a prospective process, and the resulting estimate may prove to be inaccurate. We do not believe that Congress envisioned we would revise in midyear any of the estimates of factors used to set prospective payment amounts for a given Federal fiscal year. These factors include not only the outlier thresholds, but the market basket rate of increase used to establish the update factors, the recalibration of the DRG rates, and the various required budget neutrality provisions.

Our current estimate for FY 1994 outlier payments is 3.9 percent of total DRG payments. We note that this result is mainly due to the reduction in the cost inflation factor that we use to set the thresholds, from the 8.3 percent level used to set the FY 94 thresholds to the 2.5 percent level used to make this estimate. However, as discussed in section IV.D. of the preamble to this final rule, we are addressing this problem for FY 1995 as part of our continuing efforts to refine the outlier estimation methodology. Normally, we would use 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 in FY 1992) as the cost inflation factor in setting the FY 1995 outlier thresholds. However, after reviewing the preliminary data for 2500 hospitals from PPS–10 (data from cost reporting periods in FY 1993) we found the cost per case increase to be much closer to the PPS–9 data than the PPS–7 data, indicating a continued downward trend in the rate of increase in hospitals costs. Thus, for FY 95, we have decided to use

solely the PPS–9 cost per case increase of 2.5 percent.

B. Adjustments for Area Wage Levels and Cost of Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in 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 the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 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 will be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.225
County of Hawaii	1.15
County of Kauai	1.175
County of Maui	1.225
County of Kalawao	1.225

(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 DRG classification system for hospital inpatient discharges, and have developed relative weights for each DRG that reflect the resource utilization of cases in that DRG relative to Medicare cases in other DRGs. The intermediary calculates the prospective payment amount by multiplying the applicable 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 will 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, hospitals subject to the regional floor and hospitals in Puerto Rico, the hospital's rate is comprised exclusively of the Federal national rate. Section 1886(d)(1)(A)(iii) of the Act, as amended by section 13501(f) if Public Law 103–66, provides that the Federal rate is comprised of 100 percent of the Federal national rate except for those hospitals located in census regions that have a regional rate that is higher than the national rate. The Federal rate for hospitals located in census regions that have a regional rate that is higher than the national rate equals 85 percent of the Federal national rate plus 15 percent of the Federal regional rate. For discharges occurring on or after October 1, 1994, hospitals in regions I, IV, and VI are affected by the regional floor.

The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban 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 increasing 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 section 13501(a)(2) of Public Law 103–66, provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor under section 1886(b)(3)(B)(iv) 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). That section 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 that affected payment rates in FY 1994. However as discussed in our June 23, 1994 final rule (59 FR 32381), we have revised our interpretation 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.

b. Calculation of Hospital-Specific Rate. For sole community hospitals, the applicable FY 1995 hospital-specific rate will be calculated by multiplying a hospital's deemed hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 1.4 percent). In addition, the hospital-specific rate will be adjusted by the budget neutrality adjustment factor (that is, 0.99805) as discussed in section II.A.4.b. of this addendum. This resulting rate will be used in determining the 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. 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 used to determine the Federal rate and the hospital-specific rate for FY 1995. The rates will be effective for discharges occurring on or after October 1, 1994.

For FY 1992, we computed the 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 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.

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 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. In the proposed rule, we stated that the proposed FY 1995 Federal rate was $353.87. In this final rule, we are establishing an FY 1995 Federal rate of $376.83.

In the discussion that follows, we explain the factors that were used to determine the FY 1995 Federal rate. In particular, we explain why the FY 1995 Federal rate has decreased 0.40 percent compared to the FY 1994 Federal rate, and why the rate has increased 6.49 percent compared to the proposed FY 1995 Federal rate. We also explain that aggregate payments for capital in FY 1995 are estimated to increase by 5.32 percent.

The major factor contributing to the decrease in the FY 1995 rate in comparison to FY 1994 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. Accordingly, based on the most recent estimate of FY 1995 costs, the rate must be reduced somewhat to assure that system-wide payments will equal 90 percent of cost.

Based on the most recent data, we now estimate that capital payments for FY 1992 equalled 93.14 percent of reasonable costs, that capital payments for FY 1993 equal 96.45 percent of reasonable costs, and that capital payments for FY 1994 will equal 90.32 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 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.

Two factors account for the 6.49 percent increase in the Federal rate since the proposed rule. One factor is the 2.05 percent increase in the budget neutrality target for FY 1995 over the target in the proposed rule. As we describe in section III.A.4 below, this increase is due to more recent cost report data on capital cost per case in FY 1992, partially offset by a very small decline in the actuarial projections that we employ to project the FY 1995 capital cost per case.

Another factor that has contributed to the increase in the Federal rate since the proposed rule is a revision in our projection of the rate of increase in case mix. As we discuss in Appendix B, we have reduced our projected increase in case mix from 1.5 percent to .85 percent. The estimate of case-mix increase does not affect the cost-per-case increase estimates that are used to set the budget neutrality target. It does, however, affect the payment rate level necessary to assure that estimated payments equal 90 percent of estimated reasonable costs. All other things being equal, the Federal rate must be reduced when case-mix increase projections accelerate to avoid exceeding the budget neutrality target. Conversely, a reduction of case-mix increase projections requires an increase in the Federal rate to assure that estimated payments do not fall short of the target. The reduction in our case-mix increase projections since the proposed rule thus requires an increase in the Federal rate relative to the level in the proposed rule.

Although the Federal rate for FY 1995 is 0.40 percent lower than the FY 1994 Federal rate, we estimate that total capital payments per case will increase 5.32 percent in FY 1995. The estimated 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 (5.32 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 0.36 percent higher than the FY 1994 budget neutrality target. As a result, payments must increase slightly 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, 1.0570/1.0036=1.0532, an increase of 5.32 percent). We discuss the determination of the budget neutrality target in section III.A.4 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.

In the proposed rule, we stated that the proposed FY 1995 update factor for the Federal rate would be 2.22 percent. In this final rule, based on the most recent data, we are providing that the final FY 1995 update factor for the Federal rate is 3.44 percent. The following chart, based on the June 1994 update of HCRIS, shows how this figure was computed:

CAPITAL COSTS PER CASE INCREASE FROM COST REPORT DATA

FY	Number hospitals 1st HCR (1)	Number hospitals 2nd HCR[1] (2)	Unadj. capital cost per case (3)	Increase in cost per case (percent) (4)	Audit adjusted capital cost per case[2] (5)	Increase in adjusted cost per case (percent) (6)	Average 2-year increase in adjusted cost per case (percent) (7)	Observed CMI (percent) (8)	CMI adjusted increase (percent) (9)	Update (average two year increase of CMI adjusted rate of increase) (percent) (10)
1990	4229	5413	$541.60	.....	$539.88	.....	.....	.....	.....	.....
1991	4170	5332	580.43	7.17	570.35	5.64	.....	2.52	3.04	.....
1992	4112	4953	631.86	8.86	601.40	5.44	5.54	1.55	3.83	3.44

[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 June 1994 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 0.9268
FY 1991 0.9220
FY 1992 0.9494

Audit Adjustment Applied to Settled Cost Reports

All years 1.0045

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.

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 3.44 percent, the FY 1995 Federal rate is slightly 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.

Comment: One commenter stated that the proposed decreases of 6.47 percent for the Federal rate and the 5.76 percent for the hospital-specific rate are not tolerable. The commenter argued that the 1.0222 update factor does not match the market basket increases, even though HCFA had predicted that these factors would be well above that proposed for FY 1995. The commenter recommended that the update factor be revisited to reflect a more appropriate increase in actual capital costs to which the 90 percent goal could then be applied via the budget neutrality factor.

Response: It is not clear what market basket increases the commenter is referring to. The market basket used to develop the update recommendation for the operating prospective payment system is not applicable to the capital rate. As we discuss in Appendix E, a market basket is under development for the capital prospective payment system. A capital input price index will be part of the update framework that will take effect in FY 1996. In the meantime, the regulations require the use of a lagged two-year average of actual cost per case increases, as shown in the table above. As we also noted above, the update factor of 2.22 percent is not used to set the budget neutrality target. The procedure that we follow in setting the budget neutrality target is described in section IV.D below. This procedure involves developing a budget neutrality target on the basis of an actuarial projection of increases in Medicare capital costs per case. The FY 1995 budget neutrality target reflects a projected 5.70 percent increase in Medicare capital costs per case for FY 1995.

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

Response: The present update factor is based on a 2-year moving average of actual increases in Medicare inpatient capital-related costs per discharge. Since the actual costs include spending for new technology, the cost of new technology is already accounted for in the update factor. A separate adjustment for new technology would constitute double-counting and is therefore not appropriate, as long as the update is determined by the average of actual cost increases in recent years. However, we do believe that the cost of new technology is a factor that should be accounted for in the capital analytical update framework that will be used beginning in FY 1996. We discuss the methodology for incorporating appropriate changes in cost for new technology into the update framework in Appendix E.

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 capital in 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 5.86 percent of inpatient capital-related payments based on the Federal rate in FY 1995. We are therefore applying an outlier adjustment factor of 0.9414 to the Federal rate. Thus, 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 .9958 (.9414/.9454). Thus, the outlier adjustment reduces the FY 1995 Federal rate by 0.42 percent (.9958–1) compared with the FY 1994 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classification and 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 the proposed rule for FY 1995, we proposed a GAF/DRG budget neutrality factor of 1.00115. In this final rule, based on calculations using updated data, we are applying a factor of 0.9998 to meet this requirement. 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 0.9998. The cumulative change in the rate due to this adjustment is 1.0031 (the product of the factors for FY 1993, FY 1994, and FY 1995: $.9980 \times 1.0053 \times .9998 = 1.0031$).

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 adjustment is made if aggregate payments are greater than or less than 90 percent of actual Medicare inpatient capital-related costs for that year. Section 412.352 of the regulations provides that HCFA determines an adjustment to the hospital-specific rate and the Federal rate proportionately, so that the estimated payments for capital in each year from FY 1992 through FY 1995 will equal 90 percent of what would have been payable that year on a reasonable cost basis. The effect of this provision is that the 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. In the proposed rule for FY 1995, we proposed a budget neutrality factor of 0.7986. In this final rule, we are establishing a budget neutrality factor of 0.8432. The budget neutrality adjustment factor for FY 1995 is 5.76 percent lower than the FY 1994 budget neutrality adjustment (.8947), and 5.58 percent higher than the budget neutrality factory in the proposed rule (.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 had actual data for FY 1992 from the December 1993 HCRIS update. For this final rule, we have actual data for FY 1992 from the June 1994 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 30.52 percent increase in Medicare inpatient capital cost per case between FY 1992 and FY 1995. In the proposed rule for FY 1995, we estimated that there would be a 12.83 percent increase in Medicare inpatient capital cost per case between FY 1992 and FY

1995, a decline of 13.56 percent (1.1283/1.3052=.8644, or −13.56 percent) in the estimated rate of increase since the final rule for FY 1994. In this final rule for FY 1995, we are estimating that there will be a 12.49 percent increase in Medicare inpatient capital cost per case between FY 1992 and FY 1995, a decline of 13.81 percent in the estimated rate of increase since the final rule for FY 1994 (1.1249/1.3052=.8619, or 13.81 percent), and a decrease of 0.30 percent since the proposed rule for FY 1995 (1.1249/1.1283=−0.30 percent). The following chart shows how the rate-of-increase estimates for FY 1992 through FY 1995 were calculated in the proposed rule and in this final rule for FY 1995.

COMPARISON OF FACTORS FOR MEDICARE INPATIENT CAPITAL COST PER CASE INCREASES: FY 1995 PROPOSED RULE (PR) AND FY 1995 FINAL RULE (PR)

[In percentages]

Estimate for FY	(1) Total inpatient capital			(2) Medicare share			(1)×(2)=(3) Medicare inpatient capital			(4) Medicare enrollment			(5) Admissions incidence			(4)×(5)=(6) Medicare admissions			(3)/(6)=(7) Estimated increase in Medicare inpatient capital cost per case		
	FY95 PR	FY95 FR	Percent change	FY95 PR	FY95 FR	Percent change	FY95 PR	FY95 FR	Percent change	FY95 PR	FY95 FR	Percent change	FY95 PR	FY95 FR	Percent change	FY95 PR	FY95 FR	Percent change	FY95 PR	FY95 FR	Percent change
1993	5.23	5.23	0.00	0.52	0.23	−0.30	5.78	5.46	−0.30	2.67	2.67	0.00	1.00	1.00	0.00	3.70	3.70	0.00	2.00	1.70	−0.30
1994	7.00	7.00	0.00	1.00	1.00	0.00	8.07	8.07	0.00	2.13	2.13	0.00	1.11	1.11	0.00	3.26	3.26	0.00	4.65	4.65	0.00
1995	8.00	8.00	0.00	1.00	1.00	0.00	9.08	9.08	0.00	1.83	1.83	0.00	1.34	1.34	0.00	3.19	3.19	0.00	5.70	5.70	0.00

The chart shows the causes of the decline in the rate of increase projections since the proposed rule. As the chart shows, the small decline in the rate of increase projection is due entirely to a decline in the rate of increase projections for Medicare share in FY 1993. (As the chart also shows, the rate of increase projections for all other factors are unchanged.)

In addition to the slight decline in the rate of increase estimates since the proposed rule, there has been a 2.36 percent increase in the FY 1992 cost per case in the June 1994 HCRIS data, compared to the December 1993 HCRIS data, that we used in the proposed rule. 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 proposed rule and in this final rule for FY 1994:

EFFECT OF REVISED RATE OF INCREASE ESTIMATES ON CALCULATION OF FY 1995 BUDGET NEUTRALITY TARGET

	Capital cost per case	Percent change in rate of increase	Percent change in capital cost per case
FY 1992 cost per case:			
Proposed FY 95: 12/93 HCRIS	[1] $590.87	N/A	2.36
Final FY 95: 6/94 HCRIS	[2] $604.83	.....	.....
FY 1993 adjusted cost:			
Proposed FY 95: 2.00%	$602.72	−0.30	2.05
Final FY 95: 1.70%	615.10	.....	.....
FY 1994 adjusted cost:			
Proposed FY 95: 4.65%	$630.78	0.00	2.05
Final FY 95: 4.65%	$643.75	.....	.....
FY 1995 adjusted cost:			
Proposed FY 95: 5.70%	$666.75	0.00	2.05
Final FY 95: 5.70%	$680.43	.....	.....
Cumulative:		−0.30	

[1] FY 1992 cost per case based on December 1993 HCRIS data, audit-adjusted, excluding waiver hospitals and PPS-excluded hospitals.
[2] FY 1992 cost per case based on June 1994 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 1995 budget neutrality target by 0.30 percent. Together with the 2.36 percent increase due to updated HCRIS data, this accounts for the 2.05 percent increase in the FY 1995 final rule capital cost per case budget neutrality target compared to the proposed rule for FY 1995.

We received several comments on the budget neutrality estimates presented in the proposed rule.

Comment: Several commenters noted that the proposed regulation included the effect of reductions in FY 1992, FY 1993 and FY 1994 capital costs per case estimates from previously published amounts. The commenters contended that, to protect the prospective nature of the system, HCFA should not be making retroactive changes over previously published amounts.

Response: The prospective nature of the system is not threatened by revising previous estimates of costs per case, since we use the revised estimates only to set the budget neutrality factor and the rate for the current year, not to revise the rates for the prior years. We make no retroactive changes in rates or payment amounts for prior years. However, it is necessary to revise our prior estimates of capital cost per case increases as new information becomes available. Otherwise, we would base the budget neutrality target for the current year on information that we know to be inaccurate.

Comment: One commenter expressed concern about data in the proposed regulations indicating that payments may be well below 90 percent of costs in order to offset the estimated effects of payments in excess of the 90 percent budget neutrality target in FY 1993 and FY 1994. The commenter noted that many issues remain unresolved with the

1992 base year audits and a number of providers have significant obligated capital effects to be considered. The commenter asserted that HCFA's forecasting methodologies do not properly reflect the capital cost payments anticipated by Congress in their legislative approval.

Response: Contrary to the commenter's belief, we did not propose to set the level of payments lower than 90 percent of costs in order to offset payments greater than 90 percent of costs in previous years. Rather, we stated that because we estimated that payments in FY 1994 exceeded the budget neutrality target, the increase in payments from FY 1994 to FY 1995 would have to be less than the full increase in estimated costs. Otherwise, estimated payments in FY 1995 would exceed the budget neutrality target. Both in the proposed rule and in this final rule, we estimate that payments in FY 1995 will equal 90 percent of estimated costs. The statutory language and regulations governing the budget neutrality requirement do not mandate a dollar level of capital cost payments, as the commenter seems to imply. Rather, payments are tied to a percentage of estimated capital costs. We estimate capital costs on the basis of the best information available, and we revise our estimates regularly in order to account for new data. The capital acquisition model, which is used to determine the appropriate budget neutrality adjustment factor, does consider the effects of obligated capital. The model also contains audit adjustments which account for unaudited HCRIS provider data. The model and its application are described more fully in appendix B.

Comment: Two commenters expressed concern over the unpredictability of the Federal capital rate. One commenter expressed concern over the accuracy of the budget neutrality estimates, asserting that HCFA's inability to accurately estimate budget neutrality adjustments exposes them to financial distress. This commenter also noted that this situation will become more and more critical as the Federal rate assumes a larger and larger proportion of the payment rate for hospitals paid under the fully prospective payment method. Another commenter expressed concern over the accuracy of HCFA's capital projection model, stating that uncertainty regarding future capital payments affects their ability to obtain capital funding, and at a reasonable cost.

Response: We are sensitive to hospitals' need for predictability in the levels of their capital payments. We recognize that uncertainty regarding future capital payments affects planning for capital purchases and obtaining capital funding. We therefore continually seek to improve the accuracy and reliability of our estimates. The budget neutrality estimates in this final rule have changed very little in relation to the estimates in the proposed rule. However, we are required by statute and regulations to set the rates according to our best estimate of capital costs, and we change those estimates as the data at our disposal warrants. We note that this budget neutrality requirement expires in FY 1996.

Comment: One hospital questioned why the budget neutrality adjustment resulted in a decrease in its payments. The commenter stated the belief that, if the budget was actually neutral, then payments would be identical to those in the previous year. The commenter contended that HCFA is using funds allocated to capital payments to providers for some other purpose.

Response: The commenter has mischaracterized the budget neutrality requirement: the regulations do not require that payments in one year should be identical to payments in the preceding year, either in the aggregate or for individual hospitals. The regulations require 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. Thus, aggregate payments will increase or decrease in any given year depending on the increase or decrease in estimated Medicare inpatient capital-related costs.

As discussed above, we estimate that aggregate payments this year will increase 5.32 percent. This increase in payments is less than the estimated increase in costs (5.7 percent) because we estimate that payments in FY 1994 exceeded the budget neutrality target by 0.32 percent. Although aggregate capital payments may increase in a particular year, payments to an individual hospital may increase or decrease for that same year. The way individual hospitals are affected will vary, depending upon their current capital payment method. It is possible that an individual hospital, especially a hospital paid based on 100 percent of the Federal rate, could experience a decrease in capital payment due to the reduction in the Federal rate. We have set the capital rates at the level necessary to pay the full amount required by the law and the regulations.

For FY 1995, we proposed a budget neutrality factor of 0.7986. In this final rule, the budget neutrality adjustment factor is 0.8432. 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 FY 1994 budget neutrality factor was .8947. The net adjustment to the FY 1994 Federal rate will therefore be .8432/.8947 or 0.9424.

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 estimated in the May 27, 1994, proposed rule that exceptions payments would equal 2.03 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed to apply an exceptions reduction factor of 0.9797 (1–.0203) to determine the FY 1995 Federal rate. For the final rule, we estimate that exceptions payments for FY 1995 will equal 2.66 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are therefore applying an exceptions payment reduction factor of 0.9734 to the Federal rate for FY 1995.

The final exceptions reduction factor for FY 1995 is thus 2.63 percent higher than the factor for FY 1994, and 0.64 percent lower than the factor in the FY 1995 proposed rule. We have generally expected exceptions payments to increase during the transition period as payments are based increasingly on the Federal rate. However, it is also to be expected that the general tendency for exceptions payments to increase could be reversed by lower rates of increase in capital cost per case. In other words, as capital costs per case increase more slowly, fewer hospitals than we previously estimated will qualify for exceptions payments by falling below their minimum payment levels, and those that still do qualify may receive somewhat smaller payments. We believe

that this explains the lower level of exceptions payments for FY 1995 as compared to FY 1994.

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 .9734/.9485, or 1.0263.

6. Standard Federal Rate for FY 1995. For FY 1994, the Federal rate was $378.34. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1995 Federal rate would be $353.87. In this final rule, we are establishing an FY 1995 Federal rate of $376.83. The final Federal rate for FY 1995 was calculated as follows:

- The FY 1995 update factor is 1.0344.
- The FY 1995 outlier adjustment factor is 0.9414.
- 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 is 0.9998.
- 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 is 0.8432.
- The FY 1995 exceptions payments adjustment factor is 0.9734.

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.

Comment: Several commenters expressed concern about a proposed reduction in capital payments. One commenter noted a decline of 6.47 percent in the proposed capital payment rate, and an overall decline of 14.9 percent from the inception of PPS capital rules.

Response: We are required to adjust the Federal rate and the hospital-specific rate so that aggregate payments under the prospective payment system for capital-related costs equal 90 percent of what it is estimated would have been paid on the basis of reasonable costs. While we did propose a reduction in the Federal rate to meet that requirement, we did not propose a reduction in payments, as the commenter states. In this final rule, we estimate that aggregate payments will increase 5.32 percent despite a 0.40 percent decrease in the Federal rate.

As for the overall decline in the Federal rate since FY 1992, Public Law 103–66 required that, for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent. Therefore, a large portion of the reduction to the Federal rate was the result of a Congressional action. Congress took this action on the basis of data that capital cost per case estimates used in setting the rate were too high.

We are providing a chart that shows how each of the factors and adjustments for FY 1995 affected the computation of the final FY 1995 Federal rate in comparison to the FY 1994 Federal rate. The FY final 1995 update factor has the effect of increasing the Federal rate 3.44 percent compared to the rate in FY 1994, while the final geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.42 percent. The final FY 1995 exceptions reduction factor has the effect of increasing the final Federal rate by 2.63 percent compared to the exceptions reduction for FY 1994. The final FY 1995 budget neutrality adjustment factor has the effect of reducing the final FY 1994 rate by 5.76 percent compared to the budget neutrality reduction in FY 1994. The combined effect of all the changes is to decrease the FY 1995 Federal rate by 0.40 percent compared to the Federal rate for FY 1994.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1994 FEDERAL RATE AND FY 1995 FEDERAL RATE

		Change	Percent change
Update factor: [1]			
FY 1994	1.0304	.....	.....
FY 1995	1.0344	1.0344	3.44
GAF/DRG adjustment factor: [1]			
FY 1994	1.0053	.....	.....
FY 1995	0.9998	0.9998	−0.02
Outlier adjustment factor: [2]			
FY 1994	0.9454	.....	.....
FY 1995	0.9414	0.9958	−0.42
Exceptions adjustment factor: FY 1994 [2]	0.9485	.....	.....
FY 1995	0.9734	1.0263	2.63
Budget neutrality adjustment factor: [2]			
FY 1994	0.8947	.....	.....
FY 1995	0.8432	0.9424	−5.76
Federal Rate:			
FY 1994	$378.34	.....	.....
FY 1995	$376.83	0.9960	−0.40

[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 0.9998 GAF/DRG budget neutrality factor for FY 1995 is 0.9998.

[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 0.9734/0.9485, or 1.0263.

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.

We are also providing a chart that shows how the final FY 1995 Federal rate differs from the proposed FY 1995 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 1995 FEDERAL RATE AND FINAL FY 1995 FEDERAL RATE

		Change	Percent change
Update factor:			
Proposed FY 1995	1.0222	.....	.....
Final FY 1995	1.0344	1.0119	1.19
GAF/DRG adjustment factor:			
Proposed FY 1995	1.0012	.....	.....
Final FY 1995	0.9998	0.9987	−0.13

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 1995 FEDERAL RATE AND FINAL FY 1995 FEDERAL RATE—Continued

		Change	Percent change
Outlier adjustment factor:			
Proposed FY 1995	0.9372	.....	.....
Final FY 1995	0.9414	1.0045	0.45
Exceptions adjustment factor:			
Proposed FY 1995	0.9797	.....	.....
Final FY 1995	0.9734	0.9936	−0.64
Budget neutrality adjustment factor:			
Proposed FY 1995	0.7986	.....	.....
Final FY 1995	0.8432	1.0558	5.58
Federal Rate:			
Proposed FY 1995	$353.87	.....	.....
Final FY 1995	$376.83	1.0649	6.49

This chart shows that the major factor in the 6.49 percent increase in the rate since the proposed rule is the 5.58 percent increase in the budget neutrality factor. The other significant factor contributing to the increase in the rate was the 1.19 percent increase in the update factor.

6. Special Rate for Puerto Rico Hospitals. For FY 1994, the special rate for Puerto Rico hospitals was $291.03. With the changes we proposed making to the factors used to determine the rate, the proposed FY 1995 special rate for Puerto Rico was $272.20. In this final rule, the standard rate for Puerto Rico is $289.87.

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 proposed that the hospital-specific rate be updated by a factor of 1.0222. In this final rule, we are updating the hospital- specific rate by a factor of 1.0344.

2. Exceptions Payment Adjustment Factor. For FY 1992 through FY 2001, the updated hospital-specific rate is multiplied by an adjustment factor to account for estimated exceptions payments for capital-related costs 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 estimated in the proposed rule that exceptions payments would be 2.03 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore proposed that the updated hospital-specific rate be reduced by a factor of 0.9797. In this final rule, we are applying an exceptions reduction factor of 0.9734 to the hospital-specific rate. The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1995 hospital-specific rate is therefore .9734/.9485, or 1.0263.

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 1994, the budget neutrality adjustment was 0.8947. For FY 1995, we proposed a budget neutrality factor of 0.7986. In this final rule, we are applying a budget neutrality factor of 0.8432 to the hospital-specific rate. The budget neutrality factor is not built permanently into the rates; that is, the factor is not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1995 hospital-specific rate is therefore .8432/.8947, or 0.9424.

4. Net Change to Hospital-Specific Rate. We are providing a chart below to show the net change to the hospital-specific rate. The chart shows the factors for FY 1994 and FY 1995 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 1994 to FY 1995 is 1.0005, which represents an increase of 0.05 percent to the hospital-specific rate, as opposed to the 5.76 percent decrease to the hospital-specific rate in the proposed rule. The FY 1995 hospital-specific rate for each hospital is determined by multiplying the FY 1994 hospital-specific rate by the cumulative net adjustment of 1.0005.

FY 1995 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net-adjustment	Percent change
Update factor:			
FY 94 ...	1.0304	.....	.....
FY 95 ...	1.0344	1.0344	3.44
Exceptions payment adjustment factor:			
FY 94 ...	0.9485	.....	.....
FY 95 ...	0.9734	1.0263	2.63
Budget neutrality factor:			
FY 94 ...	0.8947	.....	.....
FY 95 ...	0.8432	0.9424	−5.76
Cumulative adjustments:			
FY 94 ...	0.8744	.....	.....
FY 95 ...	0.8748	1.0005	0.05

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 FY 1994 to FY 1995 is 1.0344. 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 FY 1994 to FY 1995 is .8432/.8947, or .9424.

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 was 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 to 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 or 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 portion is 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 outlier thresholds for FY 1995 are published in section II.A.4.c of the Addendum to this final rule. For FY 1995, 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 $20,500. 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. Changes for Excluded Hospitals and Units

A. Rate-of-Increase Percentages for Excluded Hospitals and Units

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 allowable 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. Section 13502 of Public Law 103–66 amended section 1886(b)(3)(B) of the Act to provide that for cost reporting periods beginning on or after October 1, 1993 and before October 1, 1994, 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 operating 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 rate of increase 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.

B. Wage Index Exceptions for Excluded Hospitals and Units

In the August 30, 1991 final rule (56 FR 43232), we set forth our policy for target amount adjustments for significant wage increases. Effective with cost reporting periods beginning on or after April 1, 1990, significant increases in wages since the base period are recognized as a basis for an adjustment in the target amount under § 413.40(g).

To qualify for an adjustment, the excluded hospital or hospital unit must be located in a labor market area for which the average hourly wage increased significantly more than the national average hourly wage between the hospital's base period and the period subject to the ceiling. We use the hospital wage index for prospective payment hospitals to determine the rate of increase in the average hourly wage in the labor market area. For a hospital to qualify for an adjustment, the wage index value for the cost reporting period subject to the ceiling must be at least 8 percent higher than the wage index based on wage survey data collected for the base year cost reporting period. If survey data are not available for one (or both) of the cost reporting periods used in the comparison, the wage index based on the latest available survey data collected prior to that cost reporting period will be used. For example, to make the comparison between a 1983 base period and a hospital's cost reporting period beginning in FY 1992, we would use the rate of increase between the wage index based on 1982 wage data and the wage index based on the FY 1991 data, since the FY 1991 data are the most recent data that are currently available. Further, the comparison is made without regard to geographic reclassifications made by the MGCRB under sections 1886(d)(8) and (10) of the Act. Therefore, the comparison is made based on the wage index value of the labor market area in which the hospital is actually located.

We determine the amount of the adjustment for wage increases by considering three factors for the time between the base period and the period for which an adjustment is requested: the rate of increase in the hospital's average hourly wage; the rate of increase in the average hourly wage in the labor market area in which the hospital is located; and, the rate of increase in the national average hourly wage for hospital workers. The adjustment is limited to the amount by which the lower of the hospital's or the labor market area's rate of increase in average hourly wages significantly exceeds the national increase (that is, exceeds the national rate of increase by more than 8 percent). For purposes of computing the adjustment, the relative rate of increase in the average hourly wage for the labor market area is assumed to have been the same over each of the intervening years between the wage surveys.

To determine the rate of increase in the national average hourly wage, we use the average hourly earnings (AHE) component of the wages and salaries portion of the market basket. This measure is derived from the 1982-based market basket since the 1987-based market basket uses the employment cost index (ECI) for hospital workers as the price proxy for this component. Unlike the AHE, the ECI for hospital workers can be measured historically only back to 1986. In addition, the ECI does not adjust for skill-mix shifts and, therefore, measures only the change in wage rates per hour.

The average hourly earnings for hospital workers as measured by the market basket show the following increases:

1992=4.8 percent
1993=3.7 percent
1994=2.8 percent
1995=3.4 percent
1996=4.3 percent

We note that this section merely provides updated information with respect to areas that would qualify for the wage index adjustment under § 413.30(g). This information was calculated in accordance with established policy and does not reflect any change in that policy. The geographic areas in which the percentage difference in wage indexes was sufficient to qualify for a wage index adjustment are listed in Table 10 of section V of the addendum to this final rule. The table is constructed with old MSAs instead of the revised MSAs effective October 1, 1993 because current adjustment requests are for years prior to FY 1995.

V. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 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, 9 and 10 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 6/94 GROUPER V11.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 93 MEDPAR Update 6/94 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 10—Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

TABLE 1a.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,709.42	$1,085.29	$2,666.52	$1,068.10

TABLE 1b.—REGIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

	Large urban areas		Other urban areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
1. New England (CT, ME, MA, NH, RI, VT)	$2,840.62	$1,137.84	$2,795.63	$1,119.82
2. Middle Atlantic (PA, NJ, NY)	2,592.46	1,038.44	2,551.42	1,022.00
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,654.29	1,063.21	2,612.28	1,046.38
4. East North Central (IL, IN, MI, OH, WI)	2,892.31	1,158.55	2,846.52	1,140.20
5. East South Central (AL, KY, MS, TN)	2,508.24	1,004.71	2,468.53	988.80
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	2,711.20	1,085.99	2,668.26	1,068.80
7. West South Central (AR, LA, OK, TX)	2,638.83	1,057.01	2,597.06	1,040.27
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,621.88	1,050.22	2,580.37	1,033.59
9. Pacific (AK, CA, HI, OR, WA)	2,680.57	1,073.72	2,638.13	1,056.73

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	$2,682.96	$1,074.69	$2,682.96	1,074.69
Puerto Rico	2,416.27	503.53	2,378.02	495.56

TABLE 1d.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$376.83
Puerto Rico	289.87

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	01.3442	15.05	010095	01.0795	09.76	020027	00.9878	.....	030095	01.1917	.....	040091	01.3720	19.00
010004	01.0487	10.14	010096	01.0307	.....	030001	01.3699	18.78	040001	01.1281	11.01	040093	00.9699	10.69
010005	01.1176	13.17	010097	00.9084	11.13	030002	01.7746	19.83	040002	01.1992	13.30	040095	00.8490	10.35
010006	01.3877	13.78	010098	00.9527	12.29	030003	01.3832	19.56	040003	00.9791	12.33	040100	01.1199	12.90
010007	01.0801	11.93	010099	01.0409	11.87	030004	01.0299	11.84	040004	01.2828	13.41	040105	01.0224	11.67
010008	00.9889	09.72	010100	01.2265	13.10	030006	01.5786	16.65	040005	00.9403	10.85	040106	01.1860	09.69
010009	01.0719	14.87	010101	01.0924	13.51	030007	01.2290	14.86	040007	01.6632	16.45	040107	01.1690	15.19
010010	01.1136	11.37	010102	00.8912	11.19	030008	01.9726	19.55	040008	01.0916	10.26	040109	01.0815	12.01
010011	01.4690	17.34	010103	01.6306	14.92	030009	01.2212	14.70	040010	01.2155	12.51	040114	01.7801	15.12
010012	01.3013	13.75	010104	01.5986	15.37	030010	01.3714	17.87	040011	00.9928	10.69	040116	01.3712	17.33
010015	01.0329	12.67	010108	01.2436	12.94	030011	01.4628	18.72	040013	00.9538	10.97	040118	01.1420	12.62
010016	01.1882	12.69	010109	01.0737	12.62	030012	01.2287	15.25	040014	01.2059	14.37	040119	01.1531	12.60
010018	00.8766	14.94	010110	00.9976	10.56	030013	01.2275	16.12	040015	01.1102	11.30	040124	01.2008	12.65
010019	01.2446	12.48	010112	01.1606	12.89	030014	01.4712	18.10	040016	01.6978	14.44	040126	00.9931	10.09
010021	01.2841	13.82	010113	01.6227	12.67	030016	01.3398	21.17	040017	01.3329	11.19	040132	00.9040	11.45
010022	00.9852	14.35	010114	01.2586	14.30	030017	01.4213	16.52	040018	01.2816	15.40	050002	01.3599	24.36
010023	01.3996	14.63	010115	00.8731	13.94	030018	01.7379	19.49	040019	01.1973	11.70	050006	01.3569	18.76
010024	01.3249	14.19	010117	00.9039	17.92	030019	01.2374	19.51	040020	01.4992	12.86	050007	01.5315	24.12
010025	01.2163	11.22	010118	01.2144	14.55	030022	01.4990	17.29	040021	01.2777	13.19	050008	01.5683	24.13
010027	00.8697	12.83	010119	01.1022	14.41	030023	01.2779	15.17	040022	01.8439	12.85	050009	01.5121	22.22
010029	01.4519	13.86	010120	00.9922	13.31	030024	01.6768	18.15	040024	01.0193	10.84	050013	01.9683	21.58
010031	01.2731	12.35	010121	01.1798	12.93	030025	01.1273	13.58	040025	00.9299	10.28	050014	01.0992	19.15
010032	00.9123	13.01	010122	00.8442	.....	030027	01.1398	14.27	040026	01.5777	14.46	050015	01.3294	20.74
010033	01.9003	17.10	010123	01.2698	15.56	030030	01.6884	21.32	040027	01.3022	12.52	050016	01.1475	19.69
010034	01.0490	12.98	010124	01.2786	14.78	030033	01.2464	14.70	040028	01.0200	08.78	050017	02.0513	22.70
010035	01.1935	13.35	010125	01.0379	11.83	030034	01.1126	15.82	040029	01.1562	12.86	050018	01.3054	16.74
010036	01.1318	14.33	010126	01.0647	11.19	030035	01.2953	18.75	040030	00.9105	11.23	050019	00.8715	.....
010038	01.2377	14.62	010127	01.5497	15.59	030036	01.1799	17.67	040031	00.7835	10.74	050021	01.3033	20.12
010039	01.6341	14.65	010128	00.9501	11.41	030037	01.9356	20.11	040032	00.9923	09.75	050022	01.4793	21.23
010040	01.4331	16.04	010129	01.0839	10.44	030038	01.5349	18.27	040035	00.9432	09.29	050024	01.4202	22.43
010043	01.0160	12.49	010130	01.0853	13.73	030040	01.0462	16.22	040036	01.3635	14.75	050025	01.6421	21.40
010044	01.0348	14.66	010131	01.2386	16.21	030041	00.9318	16.66	040037	01.1669	10.55	050026	01.4946	20.53
010045	01.1137	11.53	010134	00.8782	10.46	030043	01.1886	19.23	040039	01.2310	11.05	050028	01.3231	15.49
010046	01.3961	12.45	010136	00.9052	13.02	030044	01.0476	13.44	040040	01.1237	14.85	050029	01.2641	24.70
010047	00.9961	08.62	010137	01.2852	14.66	030046	00.9869	17.75	040041	01.3496	12.90	050030	01.3478	17.25
010049	01.0940	13.92	010138	00.9632	11.08	030047	00.9416	16.97	040042	01.2528	12.86	050032	01.2633	20.61
010050	00.9552	10.19	010139	01.6336	19.91	030049	00.9762	14.22	040044	00.9057	09.86	050033	01.4526	24.20
010051	00.9138	07.25	010143	01.1697	14.49	030054	00.8935	12.19	040045	01.0376	13.11	050036	01.7666	21.61
010052	00.9459	12.78	010144	01.3177	15.51	030055	01.2529	15.39	040047	00.9968	13.53	050038	01.4599	27.19
010053	01.0626	12.36	010145	01.2434	16.15	030059	01.3055	18.17	040048	01.2032	12.62	050039	01.6355	20.21
010054	01.1953	14.52	010146	01.1189	15.02	030060	01.0566	13.68	040050	01.1328	10.29	050040	01.2599	22.53
010055	01.3849	14.09	010148	00.9529	11.17	030061	01.5825	15.57	040051	01.0572	11.86	050041	01.2850	21.60
010056	01.3838	16.34	010149	01.4278	15.65	030062	01.3479	14.98	040053	01.1474	12.16	050042	01.2659	17.98
010058	01.0082	07.49	010150	01.0415	13.50	030064	01.5514	16.64	040054	01.0580	10.02	050043	01.5036	25.84
010059	01.0573	13.64	010152	01.3663	14.13	030065	01.5217	18.30	040055	01.3727	14.19	050045	01.2478	17.59
010061	01.0061	14.30	010153	02.6152	18.16	030067	01.0966	14.05	040058	01.1501	12.39	050046	01.1631	21.80
010062	00.9862	10.43	010155	00.9962	09.32	030068	00.9652	13.73	040060	00.9518	12.62	050047	01.7720	27.86
010064	01.8517	14.55	020001	01.4507	24.33	030069	01.3114	18.16	040062	01.5168	14.54	050051	01.1122	15.76
010065	01.4385	13.58	020002	00.9558	23.02	030071	00.8850	.....	040063	01.5633	14.49	050052	01.8867	.....
010066	00.9149	08.90	020004	01.0660	23.25	030072	00.8597	.....	040064	00.8951	09.17	050054	01.2695	19.42
010068	01.2877	17.41	020005	00.8704	22.74	030073	01.1453	.....	040066	01.1042	12.97	050055	01.2753	24.47
010069	01.1427	12.42	020006	01.0780	22.50	030074	01.0022	.....	040067	01.0697	10.71	050056	01.4260	21.51
010072	01.1757	11.43	020007	00.8969	18.20	030075	00.9370	.....	040069	01.0133	11.34	050057	01.4685	18.64
010073	00.9111	08.91	020008	01.0533	25.53	030076	00.9436	.....	040070	00.9906	10.66	050058	01.4153	21.51
010078	01.2300	14.44	020009	01.0441	19.58	030077	00.9796	.....	040071	01.3836	15.71	050060	01.4793	17.85
010079	01.1397	13.10	020010	01.0273	26.51	030078	01.0876	.....	040072	01.1038	13.20	050061	01.2803	19.57
010080	00.9877	11.70	020011	01.0005	21.11	030079	00.6249	.....	040074	01.2103	13.36	050063	01.3995	19.94
010081	01.8414	16.28	020012	01.2962	22.42	030080	01.6470	18.80	040075	01.1241	10.83	050065	01.5226	22.66
010083	01.0473	15.00	020013	01.0087	28.18	030083	01.2863	19.53	040076	01.0883	12.49	050066	01.2416	22.96
010084	01.3966	16.55	020014	01.0943	24.09	030084	01.1358	.....	040077	00.9164	09.81	050067	01.3641	21.76
010085	01.2000	14.98	020017	01.3855	23.44	030085	01.4462	17.81	040078	01.2703	14.53	050068	01.0990	16.87
010086	01.0091	11.41	020018	00.9915	.....	030086	01.1453	17.91	040080	01.0472	14.19	050069	01.6099	22.39
010087	01.8168	14.94	020019	00.8136	.....	030087	01.6386	16.84	040081	00.8861	09.28	050070	01.2333	27.81
010089	01.1454	14.71	020020	00.8059	.....	030088	01.3584	17.48	040082	01.2292	13.01	050071	01.2930	27.45
010090	01.5670	15.24	020021	00.8018	.....	030089	01.4014	17.92	040084	01.0813	14.12	050072	01.3285	27.78
010091	00.9593	11.17	020024	01.1141	21.11	030092	01.4750	16.73	040085	01.2332	13.61	050073	01.2469	27.89
010092	01.3576	14.56	020025	00.9507	21.76	030093	01.3592	17.22	040088	01.3066	13.30	050074	01.1070	26.44
010094	01.1695	16.12	020026	01.3131	.....	030094	01.2928	17.50	040090	00.9106	11.44	050075	01.3692	27.54

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
050076	01.5776	28.16	050170	01.4521	20.26	050277	01.4532	21.98	050390	01.3119	20.96	050502	01.6487	21.81
050077	01.5930	21.33	050172	01.3210	19.50	050278	01.4107	20.59	050391	01.3476	18.94	050503	01.2835	21.76
050078	01.3470	22.80	050173	01.2847	21.21	050279	01.2274	18.52	050392	00.9931	14.75	050506	01.4420	24.55
050079	01.4682	29.24	050174	01.6642	25.19	050280	01.5553	20.61	050393	01.4125	22.60	050510	01.3252	27.75
050080	01.3034	23.23	050175	01.3383	22.08	050281	01.4131	19.38	050394	01.4869	19.55	050512	01.3107	28.18
050081	01.6246	20.20	050177	01.2267	17.98	050282	01.3133	21.41	050396	01.5501	22.84	050515	01.2995	28.20
050082	01.5054	22.06	050179	01.2476	17.01	050283	01.2397	25.87	050397	01.0645	18.46	050516	01.6464	22.49
050084	01.5680	20.91	050180	01.5080	28.43	050286	00.9279	18.66	050401	01.2104	16.24	050517	01.2745	19.39
050088	01.1145	22.27	050181	01.2415	.....	050289	01.7627	25.03	050404	01.2039	15.52	050522	01.3938	26.52
050089	01.3872	17.98	050183	01.1897	18.72	050290	01.6142	24.11	050406	01.1165	14.52	050523	01.2318	24.38
050090	01.2813	20.35	050186	01.5127	22.72	050291	01.2160	23.08	050407	01.2695	23.69	050526	01.3671	23.21
050091	01.2017	24.16	050188	01.4071	24.07	050292	01.0735	20.59	050410	01.0177	24.20	050528	01.2370	15.19
050092	00.9137	17.43	050189	00.9795	22.42	050293	01.1061	19.45	050411	01.3103	27.43	050531	01.3607	20.08
050093	01.5357	19.94	050191	01.4420	22.19	050295	01.4509	19.24	050414	01.2934	23.33	050534	01.4946	22.69
050095	01.2160	27.91	050192	01.2147	17.92	050296	01.2147	23.31	050417	01.2306	20.44	050535	01.3500	22.44
050096	01.2440	20.89	050193	01.3646	20.72	050298	01.1859	18.06	050418	01.3333	22.55	050537	01.3186	20.44
050097	01.4662	16.38	050194	01.2188	23.01	050299	01.2983	22.08	050419	01.3452	16.62	050539	01.1746	21.36
050099	01.5708	21.78	050195	01.5851	28.28	050300	01.2986	17.35	050420	01.4434	21.82	050541	01.5384	27.82
050100	01.8030	23.83	050196	01.3440	17.36	050301	01.3566	19.83	050421	01.4219	22.42	050542	01.1215	13.71
050101	01.3963	22.78	050197	01.9400	25.14	050302	01.3663	23.01	050423	00.9846	16.65	050543	00.9021	21.03
050102	01.3789	19.71	050199	01.3116	18.65	050305	01.5671	27.33	050424	01.7237	21.45	050545	00.8660	20.90
050103	01.6468	19.35	050204	01.3606	21.05	050307	01.4322	18.55	050425	01.2778	27.22	050546	00.8558	21.22
050104	01.3977	20.54	050205	01.3899	17.92	050308	01.5293	30.29	050426	01.3348	22.74	050547	00.9794	22.15
050107	01.2990	19.86	050207	01.2836	18.15	050309	01.3540	22.97	050427	00.8394	22.94	050549	01.7505	24.00
050108	01.4855	22.51	050208	01.2846	23.14	050310	01.2492	19.13	050430	01.0333	14.73	050550	02.3726	21.19
050109	02.1062	23.09	050211	01.3040	26.33	050312	01.8368	21.49	050431	01.1447	21.80	050551	01.3671	22.74
050110	01.2281	17.08	050213	01.3469	18.97	050313	01.1901	20.49	050432	01.5721	22.46	050552	01.2496	19.17
050111	01.3370	18.50	050214	01.5529	20.85	050315	01.3152	20.06	050433	01.2059	13.93	050557	01.6026	20.11
050112	01.4534	22.04	050215	01.5408	24.70	050317	01.2514	22.00	050434	01.0838	18.98	050559	01.3589	23.50
050113	01.1366	26.39	050217	01.2468	15.90	050320	01.3667	27.40	050435	01.2227	16.54	050560	01.4455	22.18
050114	01.4076	27.65	050219	01.3061	19.43	050324	01.8356	22.28	050436	01.0234	15.88	050561	01.1557	27.90
050115	01.5730	20.93	050220	01.6373	18.06	050325	01.2801	20.26	050438	01.5716	22.52	050564	01.2890	26.82
050116	01.4942	21.77	050222	01.5396	19.26	050327	01.5964	20.30	050440	01.3087	17.95	050565	01.2111	19.30
050117	01.2910	18.00	050224	01.5765	20.63	050328	01.4340	25.87	050441	01.8342	25.65	050566	00.9535	15.29
050118	01.2118	22.47	050225	01.3925	19.07	050329	01.2255	20.16	050443	00.9414	11.92	050567	01.6064	20.07
050121	01.4266	18.50	050226	01.3679	19.25	050331	01.3796	28.94	050444	01.2679	19.12	050568	01.3186	19.87
050122	01.5397	22.28	050228	01.3688	28.38	050333	00.9543	17.59	050446	00.9065	17.49	050569	01.2307	21.62
050124	01.1945	22.67	050230	01.3926	23.56	050334	01.5594	27.46	050447	01.0648	19.33	050570	01.7251	24.72
050125	01.3539	23.19	050231	01.4909	21.30	050335	01.2475	18.97	050448	01.1669	21.09	050571	01.4621	22.91
050126	01.3932	22.84	050232	01.8392	24.76	050336	01.3209	18.34	050449	01.3206	20.39	050573	01.6799	23.79
050127	01.3040	22.13	050233	01.2560	26.78	050337	01.3957	24.13	050451	00.8860	16.91	050575	01.2474	21.28
050128	01.5366	20.09	050234	01.2776	18.69	050342	01.4356	15.53	050454	01.8386	24.99	050577	01.2369	20.65
050129	01.4989	20.29	050235	01.4845	24.01	050343	01.0621	15.51	050455	01.8514	21.40	050578	01.3849	23.24
050131	01.2653	23.99	050236	01.5310	22.42	050345	01.4979	19.74	050456	01.3067	22.43	050579	01.3958	24.99
050132	01.3951	21.23	050238	01.5006	23.50	050348	01.5499	24.59	050457	01.9263	27.09	050580	01.4041	21.12
050133	01.3153	19.07	050239	01.4937	21.81	050349	00.9544	14.35	050458	00.8655	22.37	050581	01.4769	23.13
050135	01.2053	24.37	050240	01.4862	25.19	050350	01.3974	22.44	050459	01.2453	29.05	050583	01.6869	21.15
050136	01.3889	21.51	050241	01.3090	27.24	050351	01.5032	26.10	050464	01.8760	22.66	050584	01.3054	21.70
050137	01.2685	28.56	050242	01.3945	25.47	050352	01.3369	21.27	050468	01.4202	13.23	050585	01.3352	25.78
050138	01.7804	29.95	050243	01.5383	21.44	050353	01.5303	21.82	050469	01.1137	17.38	050586	01.3266	22.31
050139	01.3319	28.23	050245	01.4438	23.48	050355	00.9418	16.56	050470	01.1269	16.91	050587	01.2924	19.72
050140	01.3389	28.60	050248	01.1319	22.92	050357	01.9564	21.24	050471	01.7713	23.28	050588	01.2579	26.65
050144	01.5704	21.85	050251	01.0990	15.38	050359	01.0659	18.20	050475	01.2763	17.98	050589	01.3272	23.05
050145	01.3500	24.11	050253	00.9026	17.17	050360	01.4472	27.20	050477	01.4095	24.42	050590	01.2896	20.88
050146	01.3122	.....	050254	01.1845	18.88	050363	02.1935	.....	050478	01.0136	20.41	050591	01.2187	19.81
050147	00.6839	16.46	050256	01.7794	20.44	050366	01.3048	18.50	050481	01.4398	23.28	050592	01.2434	19.32
050148	01.0998	14.81	050257	01.0771	15.23	050367	01.2720	24.59	050482	00.9592	14.95	050593	01.4479	24.80
050149	01.3528	21.03	050258	01.3430	24.73	050369	01.2920	22.10	050483	01.1747	19.39	050594	02.0951	22.24
050150	01.2998	21.08	050260	00.9806	18.54	050373	01.3093	22.31	050485	01.6350	21.08	050597	01.2757	22.04
050152	01.3982	24.04	050261	01.1832	16.58	050376	01.3922	23.30	050486	01.3920	22.96	050598	01.4694	27.45
050153	01.6323	26.54	050262	01.7839	24.23	050377	00.8663	13.19	050488	01.3350	24.20	050599	01.6475	21.12
050154	01.3034	24.75	050263	01.3142	23.85	050378	01.0663	24.65	050489	01.0532	23.76	050601	01.3037	27.93
050155	01.1483	22.21	050264	01.4298	25.01	050379	01.1521	16.12	050491	01.3653	22.42	050603	01.4440	20.02
050158	01.5304	27.04	050267	01.5606	23.58	050380	01.6401	25.01	050492	01.1869	19.34	050604	01.4176	26.67
050159	01.3400	18.86	050270	01.3549	21.83	050382	01.4205	21.08	050494	01.0785	21.35	050607	01.2392	19.43
050167	01.3883	20.29	050272	01.3900	17.78	050385	01.3911	23.35	050496	01.7895	27.22	050608	01.1508	16.21
050168	01.5795	22.94	050274	01.1350	20.00	050387	00.9095	12.76	050497	00.9428	11.97	050609	01.3274	29.05
050169	01.5338	22.37	050276	01.2436	25.76	050388	00.8618	15.42	050498	01.3050	20.50	050613	01.0186	22.54

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
050615	01.4446	21.07	060016	01.1675	10.83	070017	01.3674	22.45	100043	01.4152	19.25	100128	02.1689	18.89
050616	01.2691	20.04	060018	01.2497	14.35	070018	01.3498	25.96	100044	01.4413	17.72	100129	01.3602	17.02
050618	01.2205	15.89	060020	01.5142	14.61	070019	01.2567	21.49	100045	01.4554	14.39	100130	01.1726	17.79
050619	01.3454	19.03	060022	01.6484	17.08	070020	01.4074	22.22	100046	01.3482	16.46	100131	01.3011	18.69
050622	01.2594	21.36	060023	01.4622	16.23	070021	01.1805	22.73	100047	01.7883	17.88	100132	01.4788	14.76
050623	01.2563	21.16	060024	01.6640	22.87	070022	01.6437	22.82	100048	00.9927	11.41	100135	01.5000	14.95
050624	01.2605	23.39	060026	01.4335	18.36	070023	01.2106	20.41	100049	01.2748	16.51	100137	01.2387	15.05
050625	01.5236	22.82	060027	01.4674	18.10	070024	01.3163	20.12	100050	01.1771	14.96	100138	00.9841	10.25
050630	01.2823	23.63	060028	01.4158	18.91	070025	01.6942	22.92	100051	01.2647	15.10	100139	01.0428	16.00
050633	01.3236	20.93	060029	00.9748	13.15	070026	01.1741	22.90	100052	01.4138	14.18	100140	01.1929	16.26
050635	01.3019	27.91	060030	01.3480	16.98	070027	01.2085	22.98	100053	01.3034	17.73	100142	01.1733	15.12
050636	01.3894	21.83	060031	01.5082	16.61	070028	01.4692	21.94	100054	01.3318	16.83	100143	02.0565	.....
050637	01.1270	21.41	060032	01.4296	19.33	070029	01.2270	19.29	100055	01.3834	15.81	100144	01.3439	12.10
050638	00.9629	24.33	060033	01.0703	11.58	070030	01.2073	22.70	100056	01.4688	21.01	100145	01.3697	13.57
050641	01.1681	12.65	060034	01.4752	17.73	070031	01.2867	18.49	100057	01.3219	15.19	100146	01.1272	15.35
050643	00.9472	.....	060036	01.1796	13.52	070033	01.2692	22.64	100059	01.6344	16.57	100147	01.1204	12.08
050644	00.9873	21.63	060037	01.0028	12.14	070034	01.3310	23.40	100060	01.6863	17.02	100150	01.3132	15.58
050660	01.1327	.....	060038	01.0135	11.55	070035	01.3544	21.55	100061	01.5765	20.45	100151	01.8136	17.59
050661	00.9004	17.84	060041	00.9717	12.34	070036	01.2987	25.17	100062	01.7336	15.56	100154	01.6023	16.55
050662	00.8235	20.98	060042	00.9336	13.29	080001	01.6109	20.42	100063	01.2711	14.64	100156	01.1634	17.85
050663	01.1100	20.81	060043	01.0267	10.83	080002	01.2228	15.45	100067	01.4248	15.63	100157	01.5938	17.06
050666	00.9589	23.34	060044	01.2595	14.53	080003	01.3183	18.22	100068	01.4430	15.32	100159	01.0448	15.59
050667	01.0549	23.63	060046	01.0830	14.51	080004	01.3342	16.62	100069	01.3356	15.97	100160	01.2094	16.10
050668	01.1445	23.59	060047	00.9097	12.30	080005	01.3846	15.58	100070	01.4113	16.41	100161	01.4469	18.23
050671	01.1408	25.26	060049	01.0418	16.46	080006	01.2297	14.99	100071	01.2555	14.91	100162	01.4028	16.66
050672	00.6524	19.59	060050	01.2021	12.70	080007	01.2438	15.70	100072	01.2262	14.14	100165	01.2106	16.85
050674	01.1892	26.59	060052	01.1062	12.20	090001	01.4395	18.92	100073	01.7760	18.60	100166	01.4555	18.62
050675	01.5392	13.30	060053	00.9926	12.72	090002	01.1472	16.35	100074	01.2348	17.34	100167	01.3508	20.22
050676	01.0310	12.91	060054	01.2663	14.73	090003	01.3310	22.14	100075	01.6621	16.96	100168	01.3308	17.37
050677	01.3055	29.76	060056	00.9409	12.78	090004	01.5533	22.28	100076	01.4766	18.32	100169	01.8235	17.12
050678	01.1027	24.06	060057	00.9469	20.55	090005	01.2755	25.99	100077	01.3315	15.89	100170	01.4798	15.72
050680	01.2191	22.47	060058	00.9388	10.75	090006	01.3501	19.60	100078	01.1794	16.23	100172	01.3794	13.20
050682	00.9483	13.47	060060	01.0555	11.16	090007	01.3341	19.75	100079	01.1962	14.43	100173	01.6383	15.42
050684	01.2056	22.36	060062	00.9858	11.79	090008	01.5342	23.18	100080	01.5553	17.32	100174	01.4204	18.07
050685	01.1501	24.19	060063	01.1506	10.58	090010	00.9711	24.67	100081	01.1435	11.05	100175	00.9514	15.25
050686	01.3532	27.79	060064	01.4264	18.46	090011	01.9533	23.85	100082	01.5118	16.80	100176	01.9256	22.43
050688	01.2086	25.13	060065	01.3955	18.91	100001	01.4715	16.11	100083	01.2875	15.26	100177	01.3233	16.58
050689	01.4362	26.91	060066	00.9326	11.17	100002	01.4467	17.78	100084	01.4891	15.78	100179	01.6528	17.36
050690	01.3427	27.92	060068	01.2181	14.20	100004	01.0434	11.37	100085	01.3179	18.81	100180	01.4301	17.00
050693	01.2812	28.69	060070	01.0160	15.33	100005	01.1603	17.02	100086	01.4018	20.75	100181	01.6762	15.78
050694	01.3197	21.34	060071	01.2362	14.78	100006	01.5877	17.22	100087	01.7514	19.08	100183	01.3690	17.97
050695	01.2481	25.38	060072	00.9051	.....	100007	01.8613	17.80	100088	01.6046	16.52	100186	01.3876	15.09
050696	02.1328	26.16	060073	01.0079	15.52	100008	01.6759	18.69	100089	01.2412	15.39	100187	01.3692	20.52
050697	01.1797	.....	060075	01.2514	16.15	100009	01.5780	19.14	100090	01.3504	15.49	100189	01.2857	20.80
050698	01.0467	23.39	060076	01.4150	14.58	100010	01.3896	18.78	100092	01.5232	15.54	100191	01.3367	17.44
050699	00.8430	.....	060085	00.9715	08.89	100012	01.5379	17.53	100093	01.4666	13.19	100196	01.5217	15.84
050700	01.3655	.....	060087	01.6122	18.10	100014	01.2838	16.40	100098	01.2607	16.57	100199	01.2090	18.69
050701	01.2568	.....	060088	01.0287	13.60	100015	01.2993	17.02	100099	01.2480	14.53	100200	01.3809	21.17
050702	01.2043	.....	060090	00.9595	11.72	100017	01.6635	15.75	100100	01.4521	16.89	100203	01.1543	18.05
050703	00.8419	.....	060096	01.0133	18.00	100018	01.3505	17.76	100102	01.0643	15.90	100204	01.5526	16.81
050704	01.2199	.....	060100	01.3701	20.82	100019	01.4542	17.17	100103	01.0168	15.39	100206	01.3807	21.64
050705	02.6844	.....	060103	01.2616	18.94	100020	01.3562	17.23	100105	01.4016	16.60	100207	01.3841	19.04
050706	00.9304	.....	060104	01.3367	18.78	100022	01.6958	21.32	100106	01.0273	13.60	100208	01.7382	18.61
050707	00.8547	.....	070001	01.7512	22.43	100023	01.3278	14.40	100107	01.2655	18.74	100209	01.5364	19.87
050708	00.8707	.....	070002	01.8075	23.72	100024	01.3790	19.06	100108	01.0529	15.10	100210	01.7008	15.97
060001	01.4814	16.98	070003	01.1472	21.97	100025	01.5776	14.76	100109	01.3352	14.91	100211	01.2772	17.32
060003	01.2909	17.31	070004	01.1580	21.82	100026	01.4999	13.26	100110	01.4365	16.61	100212	01.6223	16.73
060004	01.0772	17.37	070005	01.3270	23.96	100027	00.8554	11.90	100112	00.9797	10.90	100213	01.6396	17.36
060006	01.2666	14.82	070006	01.3116	25.81	100028	01.2739	15.02	100113	02.0746	15.79	100217	01.1845	18.25
060007	01.2602	12.50	070007	01.3828	22.86	100029	01.4444	18.08	100114	01.4922	17.48	100220	01.8048	17.82
060008	01.0109	13.26	070008	01.2456	20.66	100030	01.2716	16.73	100117	01.2930	16.44	100221	01.4532	17.82
060009	01.4468	18.59	070009	01.2617	21.54	100032	01.8861	16.48	100118	01.1775	15.44	100222	01.2511	17.00
060010	01.5638	18.49	070010	01.4539	21.55	100034	01.6934	17.25	100121	01.2293	13.62	100223	01.4441	16.55
060011	01.2279	20.96	070011	01.2100	21.19	100035	01.5604	15.92	100122	01.3603	14.84	100224	01.4403	18.78
060012	01.4319	14.65	070012	01.1714	22.67	100038	01.6547	18.93	100124	01.3583	16.70	100225	01.3935	19.07
060013	01.2983	16.63	070013	01.3347	22.91	100039	01.7027	20.12	100125	01.1502	17.51	100226	01.3666	17.08
060014	01.7025	20.85	070015	01.3016	22.72	100040	01.6908	16.07	100126	01.4582	18.35	100227	00.9534	17.48
060015	01.5538	17.85	070016	01.2499	23.08	100042	01.2008	20.82	100127	01.6127	17.26	100228	01.2295	18.55

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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
100229	01.3901	16.30	110029	01.3254	16.69	110114	01.0580	14.00	120001	01.7391	22.04	140008	01.4359	19.25
100230	01.3248	18.30	110030	01.2625	16.96	110115	01.6496	17.83	120002	01.2222	15.87	140010	01.3097	18.77
100231	01.7130	17.42	110031	01.2891	20.89	110117	00.9252	11.64	120003	00.9710	20.59	140011	01.1181	12.97
100232	01.2677	16.44	110032	01.1310	13.22	110118	01.0457	10.01	120004	01.2989	18.29	140012	01.2090	15.31
100234	01.3614	17.94	110033	01.4208	18.34	110120	01.0429	10.51	120005	01.2810	17.03	140013	01.5980	14.68
100235	01.3840	15.58	110034	01.4850	15.64	110121	01.1443	11.37	120006	01.1593	21.83	140014	01.0954	15.12
100236	01.4900	15.80	110035	01.3122	17.12	110122	01.2835	14.70	120007	01.6419	20.22	140015	01.2270	12.74
100237	02.1488	22.04	110036	01.6987	21.09	110124	01.0984	14.20	120009	00.9961	18.32	140016	00.9807	10.62
100238	01.3722	17.27	110037	01.0639	09.10	110125	01.1837	14.60	120010	01.7249	20.04	140018	01.4002	17.67
100239	01.4978	17.74	110038	01.3929	13.02	110127	00.9029	09.56	120011	01.2501	26.59	140019	00.9330	11.96
100240	00.8035	14.20	110039	01.3486	16.87	110128	01.1452	15.46	120012	00.8968	16.54	140024	01.0131	12.34
100241	00.9441	11.33	110040	01.0619	12.16	110129	01.5352	12.01	120014	01.2149	19.14	140025	01.1016	15.27
100242	01.3146	14.92	110041	01.1457	14.35	110130	01.0852	09.68	120015	00.8178	19.23	140026	01.1248	13.43
100243	01.4250	16.65	110042	01.0553	13.66	110132	01.1520	12.20	120016	00.9973	18.55	140027	01.2020	14.63
100244	01.3618	16.40	110043	01.5773	13.73	110134	00.8595	10.02	120018	00.9138	17.94	140029	01.3188	16.19
100246	01.3454	19.50	110044	01.1391	12.22	110135	01.1043	13.78	120019	01.2339	17.90	140030	01.5404	19.79
100248	01.6667	17.89	110045	01.1241	19.62	110136	01.1588	13.15	120021	00.8779	19.14	140031	01.0291	11.46
100249	01.2751	18.23	110046	01.2134	14.30	110140	00.8302	13.51	120022	01.6633	20.55	140032	01.2865	14.20
100252	01.1996	17.43	110048	01.1013	13.14	110141	00.8972	09.72	120024	01.0150	15.72	140033	01.2494	17.22
100253	01.3614	16.33	110049	01.0591	14.55	110142	01.0137	10.29	120026	01.2954	20.12	140034	01.1750	14.60
100254	01.6057	17.14	110050	01.0847	11.33	110143	01.2846	17.24	120027	01.3545	19.59	140035	01.1514	09.85
100255	01.3267	20.57	110051	00.9783	15.64	110144	01.1668	12.74	130001	01.0107	13.17	140036	01.1215	14.22
100256	01.8444	18.38	110052	00.9264	14.74	110146	00.9328	11.89	130002	01.3774	14.35	140037	01.0236	11.74
100258	01.7091	20.22	110054	01.2700	15.38	110149	01.0750	11.01	130003	01.2226	16.62	140038	01.1485	13.82
100259	01.4444	16.66	110056	00.8911	12.63	110150	01.2960	14.47	130005	01.3631	16.13	140039	01.0245	11.51
100260	01.3833	17.08	110059	01.3090	12.94	110152	01.1662	11.82	130006	01.7653	16.81	140040	01.2453	13.79
100262	01.3941	18.96	110061	01.0249	09.64	110153	00.9816	15.92	130007	01.5368	16.33	140041	01.1555	14.31
100263	01.3547	17.78	110062	00.9617	10.81	110154	00.9816	11.86	130008	00.9304	12.71	140042	01.1036	12.72
100264	01.3743	15.50	110063	01.0882	11.47	110155	01.0525	12.55	130009	00.9629	13.18	140043	01.2452	15.68
100265	01.3079	17.19	110064	01.2610	15.82	110156	00.9647	11.50	130010	00.9419	15.53	140045	01.0059	12.10
100266	01.3021	15.42	110065	00.9751	11.47	110157	01.1009	15.28	130011	01.3533	13.99	140046	01.2829	14.33
100267	01.3063	18.95	110066	01.3019	15.59	110161	01.2406	18.47	130012	00.9944	16.65	140047	01.2223	11.40
100268	01.2433	21.55	110069	01.1801	14.92	110162	00.8663	.....	130013	01.2643	15.99	140048	01.3062	20.15
100269	01.3512	21.42	110070	00.9980	11.76	110163	01.4225	16.50	130014	01.3488	16.35	140049	01.3569	17.97
100270	00.8838	12.30	110071	01.0242	09.41	110164	01.3716	17.39	130015	00.8742	11.45	140051	01.3482	18.90
100271	01.6050	16.88	110072	01.0023	12.37	110165	01.2885	15.93	130016	00.8542	15.89	140052	01.2810	14.67
100273	01.0658	16.70	110073	01.2810	12.22	110166	01.4933	15.76	130017	01.0252	12.65	140053	01.7729	16.02
100275	01.3386	20.17	110074	01.4423	16.63	110168	01.6691	17.53	130018	01.5822	19.65	140054	01.3051	22.11
100276	01.3219	20.62	110075	01.1310	13.64	110169	00.7618	17.87	130019	01.1747	14.07	140055	00.9338	11.82
100277	01.0833	12.90	110076	01.3234	17.00	110171	01.3476	19.39	130021	00.9281	10.63	140058	01.1583	14.34
100278	00.8698	16.01	110078	01.5676	21.62	110172	01.2397	25.10	130022	01.1197	15.42	140059	01.0725	11.39
100279	01.4270	21.86	110079	01.3888	19.60	110174	01.0088	12.79	130024	01.1015	14.66	140061	01.1007	15.08
100280	01.4172	.....	110080	01.1829	14.65	110176	01.1887	18.24	130025	01.1046	15.36	140062	01.2341	20.99
100281	01.2160	.....	110082	02.0224	23.13	110177	01.3894	18.41	130026	01.1117	16.17	140063	01.3445	19.00
110001	01.2551	15.81	110083	01.6451	20.82	110178	01.4829	17.06	130027	00.8922	16.13	140064	01.1811	15.11
110002	01.2498	14.41	110086	01.0560	14.40	110179	01.1702	19.22	130028	01.1847	15.29	140065	01.4134	21.65
110003	01.3337	12.00	110087	01.2666	17.61	110181	01.0288	08.35	130029	01.0231	14.26	140066	01.1794	13.05
110004	01.2191	15.29	110088	00.8786	12.27	110183	01.2913	18.26	130030	01.0340	12.46	140067	01.7228	16.34
110005	01.1700	15.96	110089	01.2055	14.65	110184	01.0926	18.57	130031	01.0143	11.69	140068	01.4052	15.66
110006	01.2843	16.38	110091	01.3772	19.15	110185	01.1298	12.31	130034	01.0457	14.13	140069	01.0744	13.61
110007	01.4503	15.97	110092	01.0709	11.21	110186	01.3356	15.53	130035	01.0182	13.66	140070	01.3038	14.49
110008	01.1066	14.16	110093	00.9715	08.54	110187	01.1761	16.81	130036	01.2487	08.52	140074	01.0194	14.20
110009	01.0204	14.23	110094	01.0205	11.02	110188	01.4360	17.33	130037	01.1166	14.67	140075	01.4119	17.78
110010	02.0046	20.95	110095	01.2505	13.02	110189	01.0934	19.00	130043	01.0399	13.65	140077	01.2636	13.35
110011	01.1827	14.97	110096	01.0978	12.76	110190	01.0854	12.93	130044	00.9745	12.73	140079	01.2695	21.34
110013	01.1083	13.50	110097	01.1016	16.29	110191	01.2392	17.33	130045	00.9056	11.43	140080	01.7887	17.20
110014	01.1894	11.75	110098	01.0361	13.41	110192	01.3442	19.58	130048	01.1050	10.87	140081	01.1079	10.92
110015	01.1355	15.78	110100	01.0988	11.22	110193	01.1408	16.99	130049	01.2245	15.55	140082	01.4045	19.71
110016	01.2952	13.84	110101	01.0715	09.49	110194	00.9760	12.31	130054	00.9113	14.10	140083	01.2841	15.35
110017	00.9323	10.40	110103	00.9611	08.82	110195	01.2032	10.66	130056	00.9454	11.94	140084	01.2110	17.72
110018	01.1766	15.88	110104	01.1479	12.86	110198	01.3701	21.77	130058	00.9163	11.59	140086	01.1083	11.72
110020	01.1997	16.55	110105	01.1353	13.47	110200	01.9905	14.43	130060	01.1885	.....	140087	01.4133	16.09
110023	01.2550	17.17	110107	01.6433	17.26	110201	01.4001	14.99	140001	01.2552	13.67	140088	01.5044	21.90
110024	01.3830	15.58	110108	01.0233	10.19	110203	00.9939	15.78	140002	01.2491	15.22	140089	01.2464	13.84
110025	01.3117	15.02	110109	01.1199	11.30	110204	00.8075	13.88	140003	01.0438	13.21	140090	01.4523	26.53
110026	01.1566	12.82	110111	01.1285	12.71	110205	01.0542	11.10	140004	00.9859	13.64	140091	01.6824	15.96
110027	01.0355	15.43	110112	00.9922	15.95	110207	01.1390	.....	140005	00.9652	09.64	140093	01.1922	14.60
110028	01.6334	15.10	110113	01.0259	13.67	110208	00.9490	12.61	140007	01.4615	19.18	140094	01.3158	15.80

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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
140095	01.2211	17.48	140182	01.2646	18.80	150006	01.2471	14.67	150082	01.4663	16.73	160033	01.4585	14.99
140097	00.9794	13.23	140184	01.1702	12.95	150007	01.2317	16.00	150084	01.8366	20.84	160034	00.9809	12.26
140098	01.2721	18.87	140185	01.4019	14.80	150008	01.3191	17.15	150085	00.9551	10.27	160035	00.9182	10.60
140100	01.4498	18.43	140186	01.1921	17.96	150009	01.2891	16.47	150086	01.2684	14.97	160036	01.0980	12.62
140101	01.1882	16.70	140187	01.4101	14.44	150010	01.1613	16.91	150088	01.1618	16.44	160037	01.0995	13.20
140102	01.0163	13.47	140188	00.9952	10.46	150011	01.2230	16.35	150089	01.3856	17.35	160039	01.0908	13.56
140103	01.3476	15.26	140189	01.1432	14.82	150012	01.6245	17.37	150090	01.2972	18.44	160040	01.2992	14.92
140105	01.3373	18.62	140190	01.1571	12.46	150013	01.1935	12.66	150091	01.0796	14.68	160041	01.1270	11.51
140107	01.1306	11.58	140191	01.4016	22.19	150014	01.3786	17.11	150092	01.0338	13.77	160043	01.0127	11.81
140108	01.3348	19.18	140192	01.0745	16.18	150015	01.2586	15.48	150094	01.0088	15.63	160044	01.1760	11.94
140109	01.0492	11.80	140193	01.0180	12.88	150017	01.7796	16.19	150095	01.0817	13.62	160045	01.6674	15.84
140110	01.2880	12.82	140197	01.3042	18.59	150018	01.3134	15.81	150096	01.0511	17.17	160046	01.0096	11.17
140112	01.0816	12.81	140199	01.0372	13.34	150019	01.0796	14.92	150097	01.0928	15.62	160047	01.3670	14.34
140113	01.4290	16.37	140200	01.4005	20.01	150020	01.0947	11.59	150098	01.1526	11.43	160048	01.0676	12.01
140114	01.2761	17.35	140202	01.2643	18.76	150021	01.6030	16.43	150099	01.2561	15.68	160049	00.9581	11.45
140115	01.1712	16.67	140203	01.2244	15.95	150022	01.1271	17.24	150100	01.7072	17.00	160050	01.0211	12.47
140116	01.2900	17.61	140205	00.8422	11.22	150023	01.4118	15.56	150101	01.1155	13.32	160051	01.2040	12.25
140117	01.2999	18.69	140206	01.0654	17.10	150024	01.2106	14.95	150102	01.0577	13.18	160052	01.0436	11.95
140118	01.6004	20.68	140207	01.3948	18.78	150025	01.5388	16.21	150103	01.0226	13.14	160054	01.1022	12.01
140119	01.6661	20.07	140208	01.4898	22.91	150026	01.1923	16.04	150104	01.0812	13.64	160055	00.9485	11.27
140120	01.4141	13.85	140209	01.6445	14.99	150027	01.0126	14.08	150105	01.1628	15.14	160056	01.0806	12.76
140121	01.5539	08.74	140210	01.0433	11.29	150029	01.2511	17.48	150106	01.0463	17.80	160057	01.3502	13.92
140122	01.4768	20.02	140211	01.1982	17.90	150030	01.0812	15.16	150109	01.3691	14.70	160058	01.6992	16.69
140123	01.2294	15.10	140212	01.1656	20.42	150031	01.0957	14.78	150110	00.9296	13.42	160059	01.2630	16.34
140124	01.1358	19.42	140213	01.2009	19.50	150032	01.7588	17.72	150111	01.0950	12.33	160060	01.0284	12.62
140125	01.2390	13.29	140215	01.1446	10.48	150033	01.5943	18.01	150112	01.2111	16.18	160061	00.9538	13.54
140127	01.2956	15.35	140217	01.2374	19.16	150034	01.2863	17.20	150113	01.1478	15.45	160062	00.9618	10.99
140128	01.0433	15.50	140218	00.9567	13.96	150035	01.4080	17.05	150114	00.9924	12.31	160063	01.1404	10.67
140129	01.0693	12.58	140220	01.1752	13.57	150036	01.0229	16.08	150115	01.3247	13.92	160064	01.5931	15.57
140130	01.1602	19.25	140223	01.5029	22.80	150037	01.1956	17.77	150122	01.1148	17.31	160065	01.0733	13.93
140132	01.5272	17.61	140224	01.3267	19.20	150038	01.1995	15.85	150123	01.0958	12.57	160066	01.0801	13.35
140133	01.3502	19.24	140228	01.6053	16.14	150039	00.9143	13.42	150124	01.1234	14.04	160067	01.3105	15.77
140135	01.2358	14.27	140229	00.9303	09.86	150042	01.1893	14.72	150125	01.3773	16.98	160068	01.0005	13.07
140137	01.0291	12.24	140230	00.9506	13.17	150043	01.0846	15.00	150126	01.5079	18.30	160069	01.3793	14.35
140138	01.0241	11.15	140231	01.5410	19.84	150044	01.2714	15.75	150127	01.2053	11.94	160070	01.0399	11.90
140139	01.0516	12.47	140233	01.7208	14.89	150045	01.1633	15.40	150128	01.2212	17.22	160072	01.1162	11.93
140140	01.1237	11.90	140234	01.2047	14.44	150046	01.5484	16.63	150129	01.2144	18.69	160073	01.0381	11.15
140141	00.9810	12.26	140236	01.0041	12.56	150047	01.6831	17.65	150130	01.1198	13.18	160074	01.0271	14.05
140143	01.0728	14.63	140239	01.5754	16.58	150048	01.1715	15.11	150132	01.3672	19.75	160075	01.0535	13.37
140144	00.9953	13.14	140240	01.4164	20.64	150049	01.1211	12.76	150133	01.1774	14.00	160076	01.0077	13.71
140145	01.1475	14.17	140242	01.5346	19.78	150050	01.1464	13.85	150134	01.1496	15.65	160077	00.9877	09.72
140146	00.9720	14.22	140245	01.0564	12.26	150051	01.3409	15.58	150136	00.8373	18.39	160079	01.3225	14.87
140147	01.1895	12.55	140246	01.0439	11.22	150052	01.0935	10.31	150137	02.8509	.....	160080	01.1510	14.09
140148	01.6515	16.06	140250	01.2052	19.71	150053	01.0023	16.74	150897	04.9451	.....	160081	01.1054	13.36
140150	01.4651	20.76	140251	01.3108	16.26	150054	01.0899	12.38	160001	01.1864	15.08	160082	01.6745	15.91
140151	01.1004	15.02	140252	01.3458	20.39	150056	01.7050	19.00	160002	01.1621	12.09	160083	01.5104	16.07
140152	01.0787	21.93	140253	01.3767	24.54	150057	02.3820	13.49	160003	01.0524	11.50	160085	01.0059	11.42
140155	01.1690	15.83	140258	01.3969	19.92	150058	01.6361	18.17	160005	01.0831	12.28	160086	00.9935	11.97
140158	01.4060	19.65	140271	00.9808	12.27	150059	01.1919	17.50	160007	00.9597	11.53	160088	01.1130	12.79
140159	01.2401	12.04	140275	01.2724	14.62	150060	01.1308	15.24	160008	01.1460	12.99	160089	01.2177	13.80
140160	01.1835	14.34	140276	02.0686	18.92	150061	01.1952	12.43	160009	01.2384	13.34	160090	01.0499	13.51
140161	01.1023	15.66	140280	01.2391	15.41	150062	01.0335	12.77	160012	01.1231	12.70	160091	01.0972	11.91
140162	01.6816	15.64	140281	01.5966	19.47	150063	01.0813	13.91	160013	01.2444	13.60	160092	00.9851	13.58
140164	01.2770	13.78	140285	01.3018	14.03	150064	01.0620	15.32	160014	00.9484	11.72	160093	01.1425	11.52
140165	01.0512	12.51	140286	01.1246	15.68	150065	01.0845	15.64	160016	01.2702	14.43	160094	01.1061	14.65
140166	01.2083	14.64	140288	01.6329	20.42	150066	01.0441	12.68	160018	00.8938	11.90	160095	01.1343	14.50
140167	01.1178	12.82	140289	01.2651	14.49	150067	01.0953	13.31	160020	01.0997	11.81	160097	01.1379	12.57
140168	01.1806	14.17	140290	01.3067	19.27	150069	01.2292	14.39	160021	01.0801	12.04	160098	00.9995	12.47
140170	01.0176	10.98	140291	01.3069	20.16	150070	01.0214	13.03	160023	01.0701	12.61	160099	01.0430	10.99
140171	00.9245	12.22	140292	01.1650	19.76	150071	01.1226	12.39	160024	01.5224	15.43	160101	01.1531	15.89
140172	01.4928	18.33	140294	01.1308	14.61	150072	01.2197	14.26	160025	01.8445	15.04	160102	01.4203	15.23
140173	01.0401	13.57	140297	01.2286	20.74	150073	00.9898	16.29	160026	01.1258	13.21	160103	00.9634	12.62
140174	01.4898	16.75	140299	00.8525	22.50	150074	01.5553	19.36	160027	01.1424	12.49	160104	01.2134	15.40
140176	01.2854	18.62	150001	01.0566	15.39	150075	01.1997	12.67	160028	01.2118	16.69	160106	01.0802	12.86
140177	01.5125	15.14	150002	01.3662	16.67	150076	01.0762	15.74	160029	01.5235	15.57	160107	01.2048	12.64
140179	01.2492	18.13	150003	01.6898	15.65	150077	01.2331	14.59	160030	01.3238	14.98	160108	01.0918	12.98
140180	01.5100	19.11	150004	01.4962	18.06	150078	01.1045	15.23	160031	01.1537	12.06	160109	00.9703	11.06
140181	01.2782	17.32	150005	01.1848	17.30	150079	01.1034	12.83	160032	01.1884	13.93	160110	01.4776	16.07

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160111	01.0495	09.59	170050	00.7731	10.65	170133	01.1786	13.81	180047	01.0461	12.20	190008	01.5397	17.01
160112	01.4123	13.17	170051	00.9991	13.38	170134	01.0123	11.44	180048	01.1437	14.45	190009	01.2947	13.88
160113	01.0150	11.03	170052	01.0909	10.94	170137	01.1535	15.62	180049	01.3972	13.11	190010	01.0785	14.19
160114	01.0347	13.68	170053	00.8682	10.41	170139	01.0526	11.31	180050	01.2714	14.68	190011	01.1190	12.19
160115	01.0569	12.36	170054	01.0889	11.90	170140	01.0504	11.09	180051	01.3043	12.81	190013	01.2339	13.20
160116	01.1453	13.89	170055	00.9637	13.55	170142	01.3014	15.41	180053	01.2849	13.26	190014	01.0865	12.69
160117	01.2772	14.07	170056	00.9755	10.54	170143	01.1407	11.86	180054	01.0041	12.50	190015	01.1628	16.58
160118	01.0383	12.14	170057	01.0697	13.53	170144	01.4728	14.00	180055	01.0469	12.65	190017	01.2199	12.10
160120	00.9891	08.34	170058	01.0783	13.89	170145	01.1856	13.04	180056	01.0706	15.74	190018	01.2787	14.25
160122	01.1631	13.40	170060	01.0531	11.99	170146	01.3620	16.72	180058	00.8915	12.36	190019	01.4660	15.85
160123	01.0309	13.08	170061	01.1160	11.60	170147	01.1301	16.42	180059	00.8664	12.17	190020	01.1850	14.53
160124	01.2481	13.81	170062	00.9459	11.58	170148	01.4025	17.53	180063	01.0511	09.78	190025	01.2406	11.69
160126	01.0561	11.21	170063	00.9046	10.73	170150	01.0814	13.01	180064	01.1018	10.97	190026	01.3918	15.09
160129	01.0282	12.08	170064	00.9869	11.33	170151	01.0014	10.99	180065	00.9641	09.28	190027	01.4597	15.99
160130	01.0416	11.62	170066	00.9301	11.45	170152	00.9702	12.21	180066	01.2906	16.62	190029	01.1671	13.12
160131	01.1439	11.67	170067	00.8591	12.46	170159	00.9310	.....	180067	01.8613	15.59	190033	00.9131	07.96
160133	01.0955	16.39	170068	01.2507	14.20	170160	00.9833	10.63	180069	01.0154	14.41	190034	01.2126	13.01
160134	01.0727	10.74	170069	01.0333	12.27	170164	00.9554	13.38	180070	01.0481	12.77	190035	01.4086	17.47
160135	00.9890	10.91	170070	00.9728	12.23	170166	01.0157	13.45	180072	01.0799	14.38	190036	01.6500	17.28
160138	01.1163	12.46	170072	00.9173	10.58	170168	00.9043	08.28	180075	00.9842	10.68	190037	01.0946	17.85
160140	01.0654	13.24	170073	01.1027	12.78	170171	01.1033	10.91	180078	01.0783	15.71	190039	01.4727	16.44
160141	00.8389	10.05	170074	01.0959	11.30	170172	00.9711	.....	180079	00.9817	12.61	190040	01.4197	17.30
160142	01.0835	11.71	170075	00.8432	09.47	170174	00.8355	10.81	180080	01.1021	12.85	190041	01.5259	16.54
160143	01.0648	11.92	170076	01.1061	10.14	170175	01.2782	15.18	180081	01.5080	17.66	190043	01.1080	10.44
160145	01.0547	11.04	170077	00.9343	11.31	170176	01.4954	18.34	180085	01.3121	16.18	190044	01.0842	15.51
160146	01.3578	14.81	170079	01.0716	09.81	170180	00.9497	.....	180087	01.0822	12.45	190045	01.2847	17.63
160147	01.1855	13.17	170080	01.0304	11.67	180001	01.2063	15.10	180088	01.6461	18.61	190046	01.5088	16.18
160151	01.1023	12.32	170081	01.0304	10.30	180002	01.0558	14.95	180092	01.1080	13.45	190047	01.1529	16.09
160152	00.9970	12.73	170082	01.0350	10.91	180004	01.1744	12.90	180093	01.3853	14.17	190048	01.0973	13.35
160153	01.6502	16.13	170084	00.8777	10.03	180005	01.0444	14.66	180094	00.9476	11.59	190049	01.0513	13.59
170001	01.2083	14.25	170085	00.9636	11.57	180006	00.9029	11.80	180095	01.1229	11.81	190050	01.0974	13.67
170004	01.0582	12.68	170086	01.7041	17.38	180007	01.4577	13.73	180099	01.0774	10.13	190053	01.0886	11.08
170006	01.1785	13.00	170087	01.3942	18.90	180009	01.2790	16.51	180101	01.2180	19.86	190054	01.4390	12.13
170008	01.0815	11.61	170088	00.8810	08.09	180010	01.8120	15.34	180102	01.4457	12.80	190059	00.9479	17.29
170009	01.2522	15.16	170089	01.0458	13.83	180011	01.2072	14.69	180103	01.9661	16.39	190060	01.4131	14.77
170010	01.2129	14.80	170090	01.0756	09.53	180012	01.3677	15.91	180104	01.4486	14.71	190064	01.5065	16.13
170011	01.4374	14.07	170092	00.7989	11.32	180013	01.3280	14.46	180105	00.9262	15.54	190065	01.4844	15.65
170012	01.3724	15.42	170093	00.9273	11.25	180014	01.5173	17.45	180106	00.8984	11.57	190071	00.8849	11.25
170013	01.3311	14.02	170094	01.0821	13.06	180015	01.1320	14.27	180108	00.8906	12.67	190075	01.4392	19.38
170014	01.0487	14.36	170095	01.1131	12.46	180016	01.2634	12.65	180115	01.0927	13.33	190077	00.9533	10.49
170015	01.0035	12.48	170097	00.9929	12.19	180017	01.3036	12.52	180116	01.3607	14.88	190078	01.2408	10.47
170016	01.5938	18.86	170098	01.0691	13.99	180018	01.1528	12.70	180117	01.1918	12.53	190079	01.2546	14.38
170017	01.1818	15.65	170099	01.2498	10.05	180019	01.3022	15.60	180118	01.0380	10.98	190081	00.8933	09.79
170018	01.0376	11.86	170100	00.9250	13.52	180020	01.0535	14.18	180120	00.9600	11.55	190083	00.9095	11.31
170019	01.1664	14.86	170101	00.9580	12.56	180021	01.2222	12.05	180121	01.1330	12.12	190086	01.2984	13.80
170020	01.2784	14.70	170102	01.0011	12.58	180023	00.8308	10.45	180122	01.0106	12.03	190088	01.2471	15.55
170022	01.2502	11.71	170103	01.2714	14.43	180024	01.3172	15.71	180123	01.4815	17.52	190089	01.0474	09.57
170023	01.3885	15.44	170104	01.4228	18.83	180025	01.1247	13.86	180124	01.3514	14.80	190090	01.2103	14.47
170024	01.1843	11.73	170105	00.9739	14.10	180026	01.1969	10.47	180125	01.0206	14.88	190092	01.2826	16.62
170025	01.2580	13.63	170106	00.9198	12.06	180027	01.1226	12.56	180126	01.0168	10.88	190095	01.0350	12.77
170026	01.0138	14.25	170108	00.9078	10.27	180028	01.0368	15.42	180127	01.2145	16.76	190098	01.4469	16.69
170027	01.1818	15.09	170109	01.0837	13.77	180029	01.2896	14.10	180128	01.1231	14.91	190099	01.1067	14.71
170030	00.9610	13.61	170110	00.9268	12.68	180030	01.1350	11.60	180129	01.1193	11.56	190102	01.5102	14.99
170031	00.9031	11.54	170112	00.8931	11.15	180031	00.9966	11.68	180130	01.4243	16.58	190103	00.8671	09.80
170032	01.0399	13.75	170113	01.1280	13.45	180032	01.0592	14.39	180132	01.1994	15.26	190106	01.1645	15.56
170033	01.2512	14.38	170114	01.0939	12.12	180033	01.0621	10.03	180133	01.2492	17.98	190109	01.2001	13.91
170034	00.9660	13.54	170115	01.0547	11.25	180034	00.9930	13.98	180134	00.9826	11.38	190110	00.9443	10.81
170035	00.9068	12.55	170116	01.0986	12.83	180035	01.5185	16.43	180136	01.3870	15.97	190111	01.5657	15.92
170036	00.8756	11.84	170117	01.0083	11.90	180036	01.1639	16.11	180137	01.6460	17.11	190112	01.4060	16.41
170037	01.1331	15.60	170119	00.9699	10.40	180037	01.2596	17.97	180138	01.2598	17.78	190113	01.3192	16.22
170038	00.9494	11.73	170120	01.3050	14.99	180038	01.3422	14.34	180139	01.0589	13.66	190114	00.9470	12.67
170039	01.0575	12.85	170121	00.9078	10.42	180040	01.9499	18.25	190001	00.9125	14.98	190115	01.3549	21.52
170040	01.4677	16.84	170122	01.8166	19.22	180041	01.0425	13.18	190002	01.5680	14.50	190116	01.2132	12.23
170041	01.0475	10.30	170123	01.7327	18.31	180042	01.0821	11.66	190003	01.4246	17.42	190118	01.0429	11.05
170043	00.9951	12.13	170124	00.9317	12.74	180043	01.1262	13.52	190004	01.3241	13.12	190120	00.9278	14.66
170044	01.1531	14.13	170126	00.9136	10.31	180044	01.0420	12.66	190005	01.4454	14.98	190122	01.2075	13.84
170045	01.0097	12.52	170128	00.9733	12.97	180045	01.1996	15.05	190006	01.1903	13.93	190124	01.4624	18.09
170049	01.3253	17.19	170131	01.1254	10.65	180046	01.0795	16.50	190007	01.0336	12.14	190125	01.3726	13.88

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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
190127	01.4274	16.72	190222	01.7805	.....	210030	01.0946	18.05	220064	01.1949	19.68	230017	01.5141	19.59
190128	00.9131	15.49	190223	00.4818	.....	210031	01.7275	21.38	220065	01.2456	18.46	230019	01.5005	20.62
190130	00.9991	11.19	190227	00.7574	.....	210032	01.2560	17.31	220066	01.3009	18.54	230020	01.6541	18.94
190131	01.2762	13.59	200001	01.2705	15.09	210033	01.1890	16.07	220067	01.2473	21.25	230021	01.5791	15.00
190133	01.0452	09.24	200002	01.0955	15.46	210034	01.3026	18.66	220068	00.5926	17.13	230022	01.2981	17.19
190134	00.9913	09.28	200003	01.0709	15.05	210035	01.1827	15.47	220070	01.1592	18.14	230024	01.5296	22.55
190135	01.3911	16.54	200006	01.1645	14.04	210036	01.2939	16.68	220071	01.8216	23.03	230027	01.0751	15.36
190136	01.0604	12.04	200007	01.0246	15.37	210037	01.2424	15.64	220073	01.3094	22.57	230029	01.5333	20.32
190138	00.7195	19.68	200008	01.2632	17.11	210038	01.4191	17.39	220074	01.2435	20.16	230030	01.2368	16.73
190140	00.9943	11.25	200009	01.6699	17.96	210039	01.1670	16.17	220075	01.1897	20.08	230031	01.4714	17.50
190142	00.9868	12.54	200012	01.1409	14.30	210040	01.3355	21.10	220076	01.2095	22.33	230032	01.7001	17.85
190144	01.1611	13.35	200013	01.0904	14.12	210043	01.2501	20.01	220077	01.6494	20.98	230034	01.1781	14.38
190145	00.9378	14.48	200015	01.2427	16.17	210044	01.2676	19.24	220079	01.1475	20.12	230035	01.1032	14.84
190146	01.5485	16.85	200016	00.9868	14.92	210045	01.0235	10.65	220080	01.2286	17.63	230036	01.2686	17.94
190147	00.9870	12.33	200017	01.2677	16.81	210046	01.1370	09.48	220081	00.9674	20.33	230037	01.2047	15.86
190148	00.9289	11.58	200018	01.1593	13.98	210048	01.1729	20.49	220082	01.2124	19.86	230038	01.5837	18.78
190149	00.9770	10.49	200019	01.2620	16.59	210049	01.1487	15.63	220083	01.1157	18.96	230040	01.2391	15.59
190151	01.0919	11.17	200020	01.1415	18.32	210051	01.2959	12.97	220084	01.2116	21.89	230041	01.1843	17.06
190152	01.3446	19.19	200021	01.1375	16.13	210054	01.2291	19.77	220086	01.5700	22.71	230042	01.1267	16.80
190155	00.9687	10.29	200023	00.8693	15.15	210055	01.2349	20.46	220088	01.5463	20.83	230043	00.5585	.....
190156	00.8916	11.29	200024	01.1926	17.76	210056	01.4390	16.01	220089	01.2495	21.22	230046	01.8416	26.35
190158	01.2679	20.55	200025	01.1723	17.84	210057	01.3107	21.17	220090	01.1872	20.89	230047	01.2979	18.15
190160	01.1622	14.70	200026	01.0477	14.44	210058	01.7975	17.16	220092	01.2679	20.27	230053	01.4890	23.31
190161	00.8950	13.49	200027	01.2545	15.42	210059	01.3193	20.43	220094	01.2229	18.24	230054	01.7235	17.38
190162	01.2743	15.63	200028	00.9644	13.99	210060	01.0661	19.25	220095	01.1984	18.77	230055	01.1856	15.21
190164	01.1577	14.42	200031	01.2783	14.04	210061	00.8608	.....	220097	01.0484	21.81	230056	00.9564	13.41
190165	01.0022	10.72	200032	01.2729	16.82	220001	01.1826	19.14	220098	01.2234	17.36	230058	01.0954	15.65
190166	01.0293	11.98	200033	01.6732	18.43	220002	01.4334	19.70	220099	01.1610	19.90	230059	01.5458	18.06
190167	01.2778	15.44	200034	01.2070	17.64	220003	01.0778	15.29	220100	01.2409	21.09	230060	01.2794	15.46
190170	01.0716	12.52	200037	01.1799	15.05	220004	01.2325	21.14	220101	01.3956	22.89	230062	01.1726	13.45
190173	01.4217	18.02	200038	01.0132	17.44	220006	01.3029	21.22	220102	00.6305	19.91	230063	01.3822	17.52
190175	01.4664	.....	200039	01.2818	15.86	220008	01.1498	18.22	220104	01.2399	22.48	230065	01.4862	17.15
190176	01.5426	17.76	200040	01.1008	14.71	220010	01.2172	19.75	220105	01.1431	19.59	230066	01.3530	17.66
190177	01.5260	19.77	200041	01.1588	17.08	220011	01.1527	25.18	220106	01.1359	21.34	230068	01.3995	18.55
190178	00.9755	10.27	200043	00.6462	15.00	220012	01.3065	26.56	220107	01.1159	16.97	230069	01.1139	16.62
190182	00.9997	20.51	200050	01.1422	15.39	220015	01.1847	18.96	220108	01.1537	19.66	230070	01.4871	18.10
190183	01.2016	11.91	200051	00.9967	17.08	220016	01.2550	19.03	220110	01.9834	28.62	230071	00.6183	19.34
190184	00.9813	12.28	200052	01.0217	13.98	220017	01.2595	22.56	220111	01.1929	18.46	230072	01.2474	17.07
190185	01.2328	22.78	200055	01.0672	13.86	220019	01.0809	18.15	220114	01.0022	18.76	230075	01.4793	17.70
190186	00.9005	10.73	200062	00.9717	14.41	220020	01.1734	17.95	220116	01.8026	22.66	230076	01.2750	19.48
190187	00.7986	14.06	200063	01.2053	16.48	220021	01.2662	20.51	220118	02.0761	24.00	230077	01.9986	17.18
190189	00.4825	15.10	200066	01.1911	14.22	220023	01.1628	16.29	220119	01.3309	22.40	230078	01.1509	14.20
190190	00.9967	19.64	210001	01.3273	16.34	220024	01.1753	18.21	220120	01.1833	18.85	230080	01.1782	16.44
190191	01.2357	18.16	210002	02.0004	14.40	220025	01.1050	17.54	220123	01.0262	21.84	230081	01.2181	15.62
190193	01.2706	21.05	210003	01.5187	20.58	220026	01.3873	20.26	220126	01.2273	19.55	230082	01.1409	14.70
190194	01.1226	17.88	210004	01.3029	23.87	220028	01.3997	19.75	220128	01.0828	21.45	230085	01.1124	16.73
190196	00.8076	16.52	210005	01.2274	15.89	220029	01.1470	20.21	220131	01.1501	17.81	230086	01.0042	12.96
190197	01.2720	16.76	210006	01.1113	15.52	220030	01.0906	18.23	220133	00.8081	32.44	230087	01.0384	14.20
190198	01.1347	19.92	210007	01.5132	17.96	220031	01.6471	24.26	220135	01.1540	22.28	230089	01.3553	21.44
190199	01.2829	13.69	210008	01.3475	19.28	220033	01.3333	19.31	220153	01.0148	16.24	230092	01.2759	17.05
190200	01.5353	18.48	210009	01.6717	17.62	220035	01.2157	18.93	220154	00.9165	18.82	230093	01.2451	16.96
190201	01.4081	17.53	210010	01.2345	14.61	220036	01.5922	21.53	220156	01.3009	19.03	230095	01.2168	15.30
190202	01.4911	18.80	210011	01.2678	18.56	220038	01.2361	23.00	220162	01.4283	.....	230096	01.2423	16.62
190203	01.5344	19.81	210012	01.5499	19.80	220041	01.1752	20.17	220163	01.8447	25.11	230097	01.5436	17.27
190204	01.5003	19.33	210013	01.2857	20.56	220042	01.2688	22.59	220171	01.6792	20.19	230099	01.2443	17.18
190205	01.7944	16.25	210015	01.1955	18.69	220045	01.2560	19.58	220173	00.6336	.....	230100	01.2151	14.53
190206	01.4383	22.87	210016	01.8141	17.94	220046	01.3821	22.07	220897	04.7812	.....	230101	01.1090	16.09
190207	01.1983	19.24	210017	01.1032	13.97	220049	01.2323	21.24	230001	01.1909	16.33	230103	01.0248	14.39
190208	00.8194	09.75	210018	01.2806	19.36	220050	00.9707	15.98	230002	01.2722	18.31	230104	01.6288	20.01
190211	00.5866	11.07	210019	01.4061	16.06	220051	01.1964	19.14	230003	01.1367	16.51	230105	01.5479	17.41
190212	00.7212	09.55	210022	01.4209	18.96	220052	01.2009	20.82	230004	01.6989	18.57	230106	01.0959	16.74
190213	02.6746	10.83	210023	01.3472	22.27	220053	01.2833	20.22	230005	01.3315	16.98	230107	00.8939	10.39
190214	00.4476	11.33	210024	01.3347	19.84	220055	01.1986	17.51	230006	01.0618	14.61	230108	01.1695	14.76
190216	00.7615	.....	210025	01.3064	15.79	220057	01.2906	18.41	230007	01.0773	16.37	230110	01.2680	14.49
190217	00.9100	.....	210026	01.3091	18.97	220058	01.1247	19.41	230012	00.7031	14.26	230111	00.9760	14.53
190218	00.9222	.....	210027	01.2370	14.83	220060	01.1423	22.58	230013	01.3012	20.34	230113	01.0293	17.37
190219	00.4818	.....	210028	01.0904	14.70	220062	00.7219	18.20	230014	01.2674	13.29	230114	00.6562	20.94
190220	01.9831	.....	210029	01.3166	16.25	220063	01.2105	17.96	230015	01.2351	17.21	230115	00.9721	14.26

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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
230116	00.9313	13.79	230222	01.3030	16.28	240058	01.0092	09.62	240141	00.9930	18.54	250040	01.3036	14.79
230117	01.9236	20.87	230223	01.3443	18.13	240059	01.2100	17.26	240142	01.0475	13.23	250042	01.1639	13.22
230118	01.2684	15.27	230227	01.4180	18.92	240061	01.5649	20.05	240143	00.9200	09.58	250043	00.8793	11.24
230119	01.2374	20.41	230228	01.3346	17.04	240063	01.5312	19.77	240144	00.9469	14.36	250044	01.0257	11.99
230120	01.1310	16.19	230230	01.3499	18.21	240064	01.1862	17.45	240145	01.0236	10.16	250045	01.1858	14.86
230121	01.2738	17.52	230232	01.0269	15.35	240065	00.9615	11.40	240146	00.9792	13.78	250047	00.9690	09.06
230122	01.2966	17.18	230235	00.9287	12.87	240066	01.3761	17.16	240148	00.9367	10.13	250048	01.4260	13.20
230124	01.1212	15.55	230236	01.3267	18.37	240069	01.1315	16.35	240150	00.9295	10.19	250049	00.9223	10.78
230125	01.4034	13.28	230237	01.1209	18.78	240071	01.1252	16.43	240152	00.9629	15.64	250050	01.2364	10.90
230128	01.3674	20.20	230239	01.1815	15.59	240072	01.0470	14.61	240153	01.0283	13.43	250051	00.9053	09.10
230129	01.9337	19.47	230241	01.1452	15.34	240073	00.9857	11.34	240154	00.9850	14.51	250057	01.1384	11.55
230130	01.6192	20.80	230244	01.4473	19.18	240075	01.2235	17.19	240155	00.9704	13.26	250058	01.1748	11.42
230132	01.4471	19.39	230253	01.2209	16.09	240076	01.0812	17.80	240157	01.0271	13.38	250059	01.0249	10.92
230133	01.2099	14.69	230254	01.2119	20.53	240077	00.9540	12.78	240160	01.0223	13.44	250060	00.8086	10.54
230134	01.2065	14.24	230257	01.0308	16.29	240078	01.3986	20.24	240161	00.9919	12.77	250061	00.8723	09.07
230135	01.2848	17.71	230259	01.2056	18.24	240079	01.0466	12.37	240162	01.0410	14.61	250063	00.8607	10.84
230137	01.1498	16.37	230264	01.2863	17.31	240080	01.4245	19.24	240163	00.9238	12.90	250065	00.9000	10.30
230141	01.6104	19.10	230269	01.2254	19.90	240082	01.1766	13.75	240166	01.1521	14.56	250066	00.9710	09.70
230142	01.1810	23.19	230270	01.2495	18.39	240083	01.3174	15.80	240169	00.9629	13.10	250067	00.9668	11.74
230143	01.1721	13.64	230273	01.6929	18.16	240084	01.3441	15.28	240170	01.0631	13.78	250068	00.8967	12.25
230144	01.1897	19.77	230275	00.8457	15.29	240085	00.8935	12.80	240171	00.9851	13.00	250069	01.2085	12.00
230145	01.1687	14.34	230276	00.9634	14.84	240086	01.1767	14.11	240172	01.1034	14.02	250071	01.0495	10.98
230146	01.2787	18.56	230277	01.2058	18.72	240087	01.0594	13.50	240173	00.9808	14.21	250072	01.3428	14.40
230147	01.5731	18.29	230278	01.9299	17.95	240088	01.4614	16.70	240176	00.9959	11.09	250073	00.9818	09.92
230149	01.2363	14.09	240001	01.5709	19.57	240089	01.0424	14.41	240179	00.9910	13.73	250076	00.9532	09.20
230150	01.5558	19.01	240002	01.6583	18.05	240090	01.0898	13.05	240180	00.9751	10.20	250077	00.9312	10.22
230151	01.3819	18.80	240003	01.2260	22.55	240091	01.0285	10.83	240184	01.0000	10.98	250078	01.3952	13.14
230153	01.0545	14.86	240004	01.4565	19.95	240093	01.2745	15.33	240187	01.2855	17.00	250079	00.8711	12.23
230154	01.0145	12.31	240005	00.9226	12.75	240094	00.9733	15.34	240192	01.0414	12.40	250081	01.2179	14.37
230155	01.1301	12.02	240006	01.1607	18.19	240096	01.1233	13.37	240193	01.1285	14.01	250082	01.2194	11.07
230156	01.6572	20.20	240007	01.0727	14.10	240097	01.1103	16.27	240196	00.6073	18.87	250083	00.9415	11.25
230157	01.3264	18.63	240008	01.0423	13.25	240098	01.0163	13.46	240200	00.8775	12.53	250084	01.1268	13.13
230159	01.3241	17.40	240009	01.1501	12.81	240099	01.0446	11.38	240205	00.9269	.....	250085	01.0493	11.04
230162	00.9761	13.97	240010	01.9877	18.88	240100	01.2773	16.95	240206	00.8339	.....	250086	00.9820	12.08
230165	01.7408	18.96	240011	01.1026	14.63	240101	01.2198	15.26	240207	01.1892	21.20	250088	00.9881	13.26
230167	01.2063	18.27	240013	01.2265	15.49	240102	01.0632	12.97	240210	01.3002	21.21	250089	01.0398	10.86
230169	01.3445	19.72	240014	01.0877	16.06	240103	01.1255	14.27	250001	01.5597	13.55	250091	00.9638	10.48
230171	01.0360	12.36	240016	01.3843	14.67	240104	01.1698	19.04	250002	00.8108	11.80	250093	01.1476	11.22
230172	01.2642	17.17	240017	01.1252	14.24	240105	00.9307	13.40	250003	00.9261	12.12	250094	01.2731	13.27
230173	01.2653	17.18	240018	01.2112	15.09	240106	01.2288	21.48	250004	01.4355	13.66	250095	01.0352	11.59
230174	01.2966	16.15	240019	01.3072	18.63	240107	00.9027	13.16	250005	00.9909	08.78	250096	01.1186	14.83
230175	02.6575	14.97	240020	01.1766	16.41	240108	01.0205	10.01	250006	00.9784	12.45	250097	01.2120	12.30
230176	01.2103	20.13	240021	01.1289	13.70	240109	00.9590	13.51	250007	01.2263	15.01	250098	00.8689	09.46
230178	01.0454	14.99	240022	01.0734	15.34	240110	00.9611	15.47	250008	00.9896	11.21	250099	01.2528	11.75
230180	01.0835	14.16	240023	01.1016	15.19	240111	01.0310	11.74	250009	01.1394	12.14	250100	01.2444	11.80
230184	01.1304	14.57	240025	01.1440	14.38	240112	00.9869	12.95	250010	01.0681	10.06	250101	00.8813	08.70
230186	01.0962	14.08	240027	01.0252	11.62	240114	01.0385	10.60	250012	00.9557	12.30	250102	01.4950	13.33
230188	01.1138	15.94	240028	01.0995	15.09	240115	01.6058	21.44	250015	01.0527	09.37	250104	01.3329	14.08
230189	00.9189	13.54	240029	01.2110	14.23	240116	00.9244	12.14	250017	00.9473	13.08	250105	00.8949	11.28
230190	01.3785	18.04	240030	01.3289	15.33	240117	01.1189	15.35	250018	00.9046	10.20	250107	00.9558	13.72
230191	00.8881	13.06	240031	01.0538	13.01	240119	00.8879	14.25	250019	01.3901	14.82	250109	00.9646	10.30
230193	01.2619	16.40	240036	01.4910	17.88	240121	00.9040	16.37	250020	00.9777	08.74	250112	00.9603	11.79
230194	01.1983	13.91	240037	01.1014	15.67	240122	01.0987	15.27	250021	00.9506	07.83	250117	01.0673	12.06
230195	01.2973	19.72	240038	01.4942	21.20	240123	01.0561	13.47	250023	00.8516	09.86	250119	01.0942	10.32
230197	01.2661	17.75	240040	01.2590	16.06	240124	01.0496	14.28	250024	01.0275	07.74	250120	00.9973	10.44
230199	01.1337	15.53	240041	01.2707	13.37	240125	00.9045	10.46	250025	01.0231	12.94	250122	01.2232	15.54
230201	01.0707	12.87	240043	01.2186	15.65	240127	01.0109	11.10	250027	01.0461	10.39	250123	01.2141	18.71
230204	01.2813	19.02	240044	01.1936	15.06	240128	01.1627	15.73	250029	00.9638	10.16	250124	00.9091	10.51
230205	01.0786	14.68	240045	01.0165	16.58	240129	01.0178	12.94	250030	00.9948	10.01	250125	01.3004	14.95
230207	01.2236	18.62	240047	01.4158	15.84	240130	00.9797	13.39	250031	01.2574	16.18	250126	01.0603	11.53
230208	01.2154	13.74	240048	01.3229	20.23	240132	01.1820	22.17	250032	01.2336	14.64	250127	00.7931	.....
230211	00.9649	12.38	240049	01.7181	19.30	240133	01.1219	15.04	250033	00.9734	11.82	250128	00.9379	10.79
230212	01.0570	18.73	240050	01.1358	18.32	240135	00.9489	11.11	250034	01.4985	11.58	250131	01.0129	09.78
230213	01.0874	11.66	240051	00.9262	15.59	240136	00.8433	12.11	250035	00.8653	12.15	250134	01.0001	11.82
230216	01.3301	15.22	240052	01.2101	15.63	240137	01.1848	14.41	250036	00.9998	10.69	250136	00.8317	14.79
230217	01.1531	16.72	240053	01.4947	18.22	240138	00.8944	09.63	250037	00.9016	08.35	250138	01.2894	15.41
230219	01.0251	11.59	240056	01.2468	19.37	240139	00.9726	14.31	250038	00.9956	09.69	250140	00.9057	08.90
230221 ..	01.3034	20.08	240057	01.7397	20.10	240140	00.9074	11.48	250039	00.9782	08.23	250141	01.2843	14.93

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
250144	00.9087	.....	260086	01.0276	12.04	270003	01.1922	16.85	280021	01.1320	13.17	280108	01.0898	12.16
250145	00.7431	.....	260089	01.0034	12.53	270004	01.6473	16.14	280022	00.9379	10.81	280109	00.8498	11.14
250146	01.0147	.....	260091	01.6277	18.26	270006	00.9936	10.56	280023	01.3529	13.27	280110	00.9955	10.65
260001	01.6604	14.89	260092	01.0280	13.62	270007	00.9529	11.48	280024	00.9818	11.66	280111	01.2937	14.82
260002	01.3724	19.21	260094	01.0726	12.66	270009	01.0682	18.52	280025	01.0212	10.04	280114	01.0081	10.45
260003	01.0283	12.20	260095	01.3812	15.45	270011	01.1014	14.76	280026	01.0488	12.16	280115	01.0183	12.67
260004	01.0563	12.94	260096	01.4996	19.36	270012	01.4686	16.27	280028	01.0088	11.92	280117	01.0867	13.19
260005	01.5562	17.00	260097	01.1369	14.13	270013	01.2710	15.04	280029	00.8925	09.58	280118	01.0471	14.77
260006	01.5091	15.71	260100	01.0538	12.23	270014	01.6127	14.95	280030	01.8580	21.75	280119	00.8597	.....
260007	01.3660	15.19	260102	01.0829	14.83	270016	00.8137	09.83	280031	01.0559	12.06	280123	00.8035	13.91
260008	01.2489	14.14	260103	01.3961	16.34	270017	01.2385	15.69	280032	01.2486	14.22	290001	01.6545	20.33
260009	01.2556	14.91	260104	01.6527	17.76	270019	00.9621	10.82	280033	01.1060	13.61	290002	00.9094	16.20
260011	01.5675	16.81	260105	01.8628	17.57	270021	01.1288	13.12	280034	01.1970	13.53	290003	01.6628	20.74
260012	01.0755	10.76	260107	01.4005	16.71	270023	01.3333	16.04	280035	00.9221	11.06	290005	01.2576	18.60
260013	01.1777	13.00	260108	01.7809	17.07	270024	00.9949	12.25	280037	00.9970	10.57	290006	01.0379	17.56
260014	01.7042	17.03	260109	01.0304	10.83	270026	00.9248	14.52	280038	01.0946	12.32	290007	01.8706	22.26
260015	01.1455	13.06	260110	01.6218	13.93	270027	01.0069	11.19	280039	01.1507	11.46	290008	01.2910	19.77
260017	01.2244	13.75	260111	00.9167	10.33	270028	01.0198	14.70	280040	01.5951	17.67	290009	01.5071	20.23
260018	00.9461	08.71	260112	01.4058	17.17	270029	01.0302	14.41	280041	01.0360	10.18	290010	01.1549	16.04
260019	01.0189	12.36	260113	01.1613	11.99	270030	00.7612	.....	280042	01.0397	12.52	290011	00.8724	11.94
260020	01.6648	18.00	260115	01.1921	13.38	270031	00.9294	10.86	280043	01.1304	13.48	290012	01.3601	18.32
260021	01.4508	16.18	260116	01.1508	12.40	270032	01.0819	15.20	280045	01.1224	12.49	290013	00.9998	15.06
260022	01.3952	14.44	260119	01.2581	13.25	270033	00.9108	14.51	280046	00.9991	10.16	290014	01.0364	15.84
260023	01.2376	14.14	260120	01.2378	14.81	270035	01.0176	13.97	280047	01.0890	14.84	290015	00.9368	14.63
260024	01.0546	11.04	260122	01.1796	12.00	270036	00.9100	11.20	280048	01.0516	10.70	290016	01.2040	13.62
260025	01.2444	13.10	260123	01.0269	10.37	270039	00.9364	17.94	280049	01.0245	12.20	290018	01.2698	17.15
260027	01.5773	17.97	260127	00.9726	13.39	270040	01.0843	15.30	280050	00.9501	11.55	290019	01.2290	17.04
260029	01.1914	16.89	260128	00.9655	08.66	270041	00.9648	10.47	280051	00.9747	12.15	290020	01.2552	16.81
260030	01.1698	10.05	260129	01.0658	12.87	270044	01.2502	12.55	280052	01.0428	10.45	290021	01.5764	20.70
260031	01.4920	17.49	260131	01.2902	15.02	270046	00.9153	13.91	280054	01.2385	15.23	290022	01.5911	20.10
260032	01.6988	18.87	260134	01.2830	13.25	270047	01.1693	09.98	280055	00.9076	11.10	290027	01.0014	16.54
260033	01.3199	14.53	260137	01.1775	13.64	270048	01.1046	13.59	280056	01.0467	09.44	290029	00.9610	.....
260034	01.0194	13.13	260138	01.8670	18.90	270049	01.7178	15.71	280057	01.0131	13.50	290032	01.3945	19.64
260035	01.1391	11.06	260141	01.9337	15.87	270050	01.0085	15.42	280058	01.2654	12.49	300001	01.3455	19.02
260036	01.0811	14.55	260142	01.2046	13.51	270051	01.3094	18.46	280060	01.5755	17.64	300003	01.7463	19.71
260037	01.2491	13.74	260143	01.0419	10.03	270052	01.0278	19.34	280061	01.3448	14.94	300005	01.2754	17.05
260039	01.2075	10.70	260146	01.5253	14.81	270053	01.1036	08.14	280062	01.1994	11.55	300006	01.1294	15.08
260040	01.4936	14.03	260147	01.0244	11.64	270055	00.7054	.....	280064	01.0401	11.38	300007	01.1469	19.46
260042	01.1864	15.65	260148	00.9992	14.12	270057	01.1718	15.06	280065	01.2338	15.65	300008	01.2678	15.50
260044	01.0661	13.62	260158	01.0821	10.90	270058	00.9589	10.74	280066	01.0733	10.40	300009	01.1594	16.54
260047	01.2906	13.11	260159	01.1853	18.22	270059	00.8646	12.91	280068	00.9019	08.61	300010	01.2414	16.90
260048	01.2887	16.57	260160	01.1296	12.91	270060	00.9063	11.63	280070	01.0299	11.22	300011	01.2946	20.39
260050	01.0970	12.97	260162	01.1279	16.85	270063	00.8744	13.29	280073	01.0037	13.90	300012	01.2902	20.73
260051	01.0865	13.22	260163	01.1758	12.84	270067	01.1181	.....	280074	01.0922	10.62	300013	01.2111	15.98
260052	01.2556	15.53	260164	01.0759	11.11	270068	00.8709	11.69	280075	01.2277	11.19	300014	01.2533	16.93
260053	01.1325	09.80	260166	01.2139	17.16	270072	00.8859	15.52	280076	01.1028	13.66	300015	01.1504	16.71
260054	01.2860	15.62	260172	00.9927	11.99	270073	01.1496	10.27	280077	01.2979	16.26	300016	01.2402	17.23
260055	01.0641	12.73	260173	00.9866	10.22	270074	00.8792	.....	280079	00.9470	09.48	300017	01.1839	18.41
260057	01.2108	13.64	260175	01.1904	13.15	270075	00.9339	.....	280080	01.2358	10.27	300018	01.2222	18.26
260059	01.1143	11.93	260176	01.5577	15.91	270076	00.7820	.....	280081	01.4820	16.98	300019	01.2465	17.09
260061	01.1439	09.82	260177	01.2963	18.12	270079	00.9326	12.66	280082	01.2966	10.41	300020	01.2355	18.13
260062	01.1626	15.45	260178	01.5044	19.22	270080	01.1012	13.18	280083	01.0266	11.97	300021	01.1580	14.84
260063	01.1442	13.06	260179	01.5327	20.18	270081	00.9722	10.11	280084	01.0412	09.83	300022	01.1177	15.00
260064	01.3888	15.64	260180	01.5530	17.26	270082	00.9105	14.85	280085	00.8963	13.22	300023	01.2379	19.05
260065	01.6791	14.32	260183	01.6381	15.05	270083	01.0383	12.97	280088	01.6715	17.29	300024	01.2305	15.72
260066	01.1340	12.15	260186	01.1666	14.14	270084	00.9200	13.03	280089	01.0477	12.85	300028	01.2066	16.12
260067	00.9175	12.05	260188	01.3803	15.00	280001	01.0424	12.18	280090	00.9980	11.70	300029	01.3288	20.57
260068	01.7843	17.91	260189	00.8964	09.49	280003	01.8996	16.43	280091	01.0891	13.13	300033	01.0766	13.25
260070	01.2308	10.32	260190	01.2074	20.62	280005	01.4389	16.26	280092	00.9183	11.14	300034	01.7985	21.02
260073	01.0281	10.98	260191	01.2290	17.70	280009	01.5319	15.40	280094	01.1517	12.59	310001	01.6513	22.19
260074	01.2161	13.00	260193	01.2593	16.35	280011	00.9727	10.71	280097	00.9670	12.09	310002	01.7937	22.69
260077	01.5220	15.46	260195	01.1421	14.93	280012	01.2184	12.69	280098	00.9679	10.10	310003	01.2115	20.93
260078	01.1278	13.62	260197	01.2162	20.81	280013	02.0045	20.17	280101	01.1395	12.16	310005	01.1880	19.16
260079	01.0065	10.71	260198	01.2144	14.62	280014	01.0475	10.76	280102	00.9671	10.22	310006	01.2265	19.94
260080	01.0818	09.00	260200	01.2021	19.15	280015	01.1021	13.75	280104	01.0008	10.12	310008	01.2993	20.15
260081	01.4117	17.40	260202	01.2971	16.81	280017	01.1136	12.92	280105	01.2978	14.83	310009	01.1537	19.28
260082	01.1213	13.27	260204	00.8039	.....	280018	00.9982	11.78	280106	01.0662	12.09	310010	01.2724	19.78
260085	01.5139	17.37	270002	01.1955	12.64	280020	01.4322	16.53	280107	01.0346	10.56	310011	01.2389	18.15

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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
310012	01.5465	21.51	310105	01.3448	19.91	330012	01.5891	26.43	330115	01.2289	13.79	330221	01.2913	25.37
310013	01.3011	17.62	310108	01.3071	19.81	330013	01.9898	16.97	330116	00.9711	16.94	330222	01.2085	14.02
310014	01.6025	22.63	310110	01.1805	18.46	330014	01.4094	25.19	330118	01.5992	16.45	330223	01.0718	13.45
310015	01.6967	23.19	310111	01.2890	17.97	330016	01.0313	14.50	330119	01.7324	27.28	330224	01.2545	19.36
310016	01.2159	20.92	310112	01.2782	18.62	330019	01.2647	22.80	330121	01.0075	14.55	330225	01.1934	23.33
310017	01.3456	20.37	310113	01.2519	18.56	330020	01.0852	14.84	330122	01.2317	20.97	330226	01.2692	17.69
310018	01.2401	24.06	310115	01.1827	18.93	330023	01.2029	20.62	330125	01.6989	18.97	330229	01.3227	13.56
310019	01.6525	20.28	310116	01.2871	19.92	330024	01.8238	26.75	330126	01.2026	18.36	330230	01.5327	24.70
310020	01.2383	18.05	310118	01.2884	23.38	330025	01.1054	14.30	330127	01.3874	24.83	330231	01.1566	25.13
310021	01.3406	18.25	310119	01.5707	29.97	330027	01.5406	28.98	330128	01.4001	25.66	330232	01.2524	14.83
310022	01.2341	18.31	310120	01.0934	17.21	330028	01.3486	22.68	330132	01.1440	12.27	330233	01.5282	27.14
310024	01.2391	20.74	310121	01.1299	18.72	330029	01.1455	15.76	330133	01.3714	26.33	330234	02.0317	25.92
310025	01.1982	19.63	310898	00.4649	.....	330030	01.1803	14.98	330135	01.2404	16.49	330235	01.1443	16.14
310026	01.3190	20.21	320001	01.4446	16.86	330033	01.1764	13.16	330136	01.2613	21.77	330236	01.3346	25.41
310027	01.3101	18.35	320002	01.3067	20.26	330034	01.0194	28.07	330140	01.6566	16.38	330238	01.1253	14.95
310028	01.1788	18.28	320003	01.2587	13.22	330036	01.2568	20.09	330141	01.3119	22.33	330239	01.2376	13.84
310029	01.7881	19.95	320004	01.1565	15.58	330037	01.0934	13.75	330144	01.0820	12.78	330240	01.3190	26.44
310031	02.5338	22.82	320005	01.2264	16.12	330038	01.1641	14.14	330148	00.9909	13.44	330241	01.8452	20.10
310032	01.2716	19.09	320006	01.3782	13.69	330039	00.8406	13.46	330151	01.0970	12.90	330242	01.3650	19.96
310034	01.2258	19.42	320009	01.5065	15.54	330041	01.3283	24.26	330152	01.4065	26.08	330245	01.2193	15.62
310036	01.2240	17.75	320011	00.9910	15.41	330043	01.2503	24.13	330153	01.6335	16.75	330246	01.2161	22.72
310037	01.2157	23.45	320012	01.0253	14.52	330044	01.1694	16.27	330154	01.4930	.....	330247	00.6932	24.34
310038	01.7602	21.93	320013	01.0733	15.84	330045	01.4054	22.13	330157	01.2605	15.89	330249	01.2319	15.40
310039	01.2973	18.74	320014	00.9531	13.73	330046	01.5348	26.37	330158	01.3217	21.63	330250	01.2727	16.08
310040	01.2386	20.49	320016	01.1396	14.59	330047	01.2736	15.31	330159	01.3201	17.51	330252	00.9592	14.59
310041	01.2754	20.49	320017	01.1751	17.22	330048	01.2376	15.07	330160	01.4209	24.63	330254	01.0004	16.38
310042	01.1754	21.01	320018	01.4546	16.07	330049	01.2842	17.67	330161	00.9498	15.29	330258	01.3313	23.94
310043	01.2230	19.18	320019	01.3944	17.39	330053	01.1371	13.82	330162	01.3010	22.13	330259	01.4230	21.97
310044	01.3075	18.63	320021	01.6940	17.70	330055	01.4247	27.10	330163	01.1475	15.59	330261	01.2832	21.92
310045	01.2990	23.02	320022	01.2537	16.29	330056	01.4228	24.73	330164	01.3340	17.75	330263	01.0461	15.05
310047	01.2841	20.46	320023	01.0782	11.67	330057	01.6252	16.38	330166	00.9789	13.39	330264	01.1798	17.85
310048	01.2223	15.96	320030	01.0494	15.83	330058	01.2703	14.94	330167	01.5602	26.57	330265	01.2976	15.23
310049	01.3084	19.63	320031	00.9369	12.53	330059	01.5555	26.37	330169	01.4141	28.56	330267	01.3104	21.14
310050	01.1861	20.08	320032	00.9493	15.92	330061	01.3455	21.49	330171	01.2994	22.03	330268	01.1163	14.37
310051	01.2773	21.27	320033	01.1006	17.04	330062	01.0580	14.93	330175	01.0770	13.20	330270	01.9165	28.16
310052	01.2164	20.20	320035	01.3206	13.24	330064	01.4068	25.74	330177	01.0088	13.24	330273	01.3526	20.62
310054	01.2774	21.28	320037	01.1547	13.11	330065	01.1936	16.20	330179	00.8930	12.97	330275	01.2280	16.62
310056	01.1793	17.95	320038	01.2495	14.38	330066	01.2270	17.39	330180	01.1887	14.90	330276	01.2188	16.70
310057	01.2752	18.24	320046	01.0773	15.91	330067	01.3194	18.82	330181	01.2338	27.69	330277	01.1783	15.22
310058	01.1306	20.45	320048	01.2160	12.91	330072	01.3403	26.08	330182	02.3720	25.91	330279	01.2887	16.77
310060	01.1744	15.89	320056	00.9240	.....	330073	01.2108	12.91	330183	01.3597	17.43	330281	00.5697	20.00
310061	01.1668	18.39	320057	01.0162	.....	330074	01.2561	15.83	330184	01.3567	22.64	330285	01.7416	20.83
310062	01.3150	24.72	320058	00.7242	.....	330075	01.0777	15.06	330185	01.1982	22.90	330286	01.3414	21.78
310063	01.3385	20.38	320059	01.0386	.....	330078	01.3801	15.94	330186	01.0663	19.57	330288	01.0498	15.73
310064	01.2553	20.41	320060	00.9193	.....	330079	01.2608	14.89	330188	01.2357	16.63	330290	01.7045	26.56
310067	01.2814	19.21	320061	01.3108	.....	330080	01.3188	23.40	330189	00.7685	13.00	330293	01.1864	13.94
310069	01.1751	18.53	320062	00.8670	.....	330082	01.2573	16.58	330191	01.2977	16.96	330304	01.2689	24.14
310070	01.3224	20.67	320063	01.2952	15.07	330084	00.9780	15.00	330193	01.3655	24.94	330306	01.4100	23.49
310071	00.7721	.....	320065	01.1964	15.47	330085	01.3582	17.69	330194	01.8291	25.78	330307	01.2206	16.06
310072	01.2463	19.27	320067	00.9066	10.33	330086	01.2397	22.49	330195	01.5607	26.38	330308	01.2850	24.28
310073	01.4738	20.47	320068	01.0028	15.10	330088	01.1084	22.93	330196	01.3817	24.47	330309	01.2115	22.70
310074	01.2517	19.30	320069	01.0237	12.54	330090	01.6385	15.36	330197	01.0509	14.66	330314	01.2907	21.13
310075	01.3036	20.76	320070	00.9179	.....	330091	01.3756	17.28	330198	01.3557	26.09	330315	01.1665	21.49
310076	01.3534	25.44	320074	01.1338	17.10	330092	01.0293	13.86	330199	01.2843	23.00	330316	01.2991	23.18
310077	01.5680	20.76	320076	01.2003	14.58	330094	01.1784	14.68	330201	01.4500	24.55	330327	00.9253	14.93
310078	01.2714	22.01	320079	01.1346	18.51	330095	01.1935	15.53	330202	01.4040	25.07	330331	01.2039	24.80
310081	01.2509	18.24	320080	00.5832	12.07	330096	01.0573	13.82	330203	01.3484	18.97	330332	01.2506	22.24
310083	01.2392	20.23	330001	01.1722	19.91	330097	01.1720	14.78	330204	01.3382	23.41	330333	01.3116	23.30
310084	01.1994	18.74	330002	01.4547	22.56	330100	00.7032	22.60	330205	01.2042	17.97	330336	01.3679	26.05
310085	01.1133	.....	330003	01.2847	17.15	330101	01.7173	30.13	330208	01.2029	21.83	330338	01.1671	20.43
310086	01.1944	19.53	330004	01.3090	17.83	330102	01.3050	15.74	330209	01.2328	18.89	330339	00.7973	17.43
310087	01.2491	18.41	330005	01.7496	18.22	330103	01.1862	15.52	330211	01.1984	15.21	330340	01.1787	24.08
310088	01.1610	19.42	330006	01.3397	22.16	330104	01.3474	24.45	330212	01.2156	18.85	330350	01.8045	26.28
310090	01.2276	20.34	330007	01.3752	15.51	330106	01.5766	29.39	330213	01.1346	15.33	330353	01.3027	24.98
310091	01.2150	18.76	330008	01.1600	15.29	330107	01.1823	22.28	330214	01.7349	27.58	330354	01.4060	.....
310092	01.3769	18.31	330009	01.2687	26.03	330108	01.2065	16.53	330215	01.1490	15.94	330357	01.3696	29.57
310093	01.1876	18.84	330010	01.2305	14.08	330111	01.1373	13.22	330218	01.2150	16.58	330359	00.9253	19.30
310096	01.8968	22.27	330011	01.2148	16.40	330114	00.9949	15.08	330219	01.6147	18.45	330372	01.2703	21.37

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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
330381	01.2440	23.70	340065	01.1402	13.03	340160	01.1146	12.75	360015	01.4740	17.62	360091	01.2664	17.38
330383	01.5047	.....	340067	01.1674	12.63	340162	01.1558	16.49	360016	01.5341	17.05	360092	01.1787	16.42
330385	01.4091	29.11	340068	01.3530	12.17	340164	01.3548	17.07	360017	01.7224	18.91	360093	01.2189	15.15
330386	01.1674	17.11	340069	01.7583	17.39	340166	01.3222	17.47	360018	01.5058	17.63	360094	01.1798	18.37
330387	00.8496	23.22	340070	01.2688	15.12	340168	00.5447	14.80	360019	01.2310	17.21	360095	01.2746	15.08
330389	01.8827	27.58	340071	01.0358	13.49	350001	01.0315	11.25	360020	01.4312	16.47	360096	01.0991	14.95
330390	01.3011	24.47	340072	01.1025	13.40	350002	01.6951	16.15	360021	01.2185	16.31	360098	01.3837	17.84
330393	01.6207	22.84	340073	01.4664	18.47	350003	01.1489	14.21	360024	01.2366	16.75	360099	01.0624	15.49
330394	01.4091	16.96	340075	01.1532	14.80	350004	01.8730	17.07	360025	01.1899	17.00	360100	01.2993	15.02
330395	01.3622	25.96	340080	01.1422	09.88	350005	01.1089	11.21	360026	01.1855	15.01	360101	01.7474	19.63
330396	01.2287	26.91	340084	01.0553	13.62	350006	01.2745	17.95	360027	01.5371	17.37	360102	01.2642	17.18
330397	01.5173	26.69	340085	01.1922	14.33	350007	01.0060	09.21	360028	01.3748	15.02	360103	01.3969	18.47
330398	01.2377	24.94	340087	01.1725	14.86	350008	01.0659	13.30	360029	01.1187	14.74	360104	00.9491	16.76
330399	01.3658	28.62	340088	01.1225	14.92	350009	01.1443	14.36	360030	01.1943	14.51	360106	01.1455	12.63
340001	01.3618	17.90	340089	00.9771	10.77	350010	01.0952	11.07	360031	01.2736	16.00	360107	01.1824	15.07
340002	01.8293	16.29	340090	01.0764	14.15	350011	01.7258	16.96	360032	01.0786	15.27	360108	01.0347	13.97
340003	01.1755	14.86	340091	01.6452	17.60	350012	01.0654	11.31	360034	01.1979	12.84	360109	01.0463	16.12
340004	01.4936	15.33	340093	01.1216	11.99	350013	01.1237	13.52	360035	01.4871	18.47	360112	01.7808	19.41
340005	01.1924	12.35	340094	01.3282	15.81	350014	01.1283	10.67	360036	01.1922	16.47	360113	01.3411	17.59
340006	01.2405	13.41	340096	01.2409	14.57	350015	01.6098	15.71	360037	02.1054	18.67	360114	01.0986	14.97
340007	01.1630	13.78	340097	01.1145	11.48	350016	00.9575	11.10	360038	01.4843	16.89	360115	01.1640	16.96
340008	01.1836	15.73	340098	01.6380	16.25	350017	01.3376	15.09	360039	01.2818	14.64	360116	01.0704	14.50
340009	01.5128	18.76	340099	01.1377	11.89	350018	01.1527	09.40	360040	01.2237	16.01	360118	01.2778	15.25
340010	01.3133	14.82	340100	01.2221	.....	350019	01.5855	17.49	360041	01.3449	16.68	360119	01.2596	17.14
340011	01.0666	12.63	340101	01.0389	09.36	350020	01.3945	16.19	360042	01.1135	14.26	360120	00.7469	17.54
340012	01.1413	14.03	340104	01.0198	07.49	350021	01.0494	10.29	360044	01.0728	14.26	360121	01.2395	16.08
340013	01.2006	14.24	340105	01.3469	17.54	350023	01.0025	11.13	360045	01.4747	19.21	360122	01.3784	16.72
340014	01.6068	18.81	340106	01.1325	15.13	350024	01.1555	09.39	360046	01.1337	16.35	360123	01.2396	16.88
340015	01.2374	14.74	340107	01.2480	15.74	350025	00.9831	11.59	360047	01.0766	12.46	360124	01.2023	16.36
340016	01.1048	13.82	340109	01.3004	14.37	350027	00.9928	12.22	360048	01.8291	20.28	360125	01.1405	14.91
340017	01.2631	13.87	340111	01.1326	12.76	350029	00.8768	09.62	360049	01.3148	17.96	360126	01.3140	15.84
340018	01.1928	13.17	340112	01.0464	13.95	350030	01.0239	14.92	360050	01.1785	12.14	360127	01.0833	14.17
340019	01.1077	13.33	340113	01.9082	18.50	350033	00.9352	13.57	360051	01.5018	18.53	360128	01.1316	13.72
340020	01.1827	18.53	340114	01.4397	18.30	350034	00.9722	12.92	360052	01.7050	16.61	360129	01.0195	13.03
340021	01.3166	13.89	340115	01.5014	16.58	350035	00.9150	09.26	360054	01.2823	14.56	360130	01.0625	13.04
340022	01.0900	13.65	340116	01.7657	19.73	350036	00.9025	09.81	360055	01.1928	16.86	360131	01.2097	15.01
340023	01.3151	16.32	340119	01.2890	13.80	350038	01.0215	15.62	360056	01.3100	15.51	360132	01.2467	16.73
340024	01.2484	13.00	340120	01.1005	12.06	350039	01.0200	12.62	360057	01.0723	12.52	360133	01.4538	16.50
340025	01.1576	13.18	340121	01.0702	12.96	350041	01.0704	12.85	360058	01.1505	15.01	360134	01.5573	17.39
340027	01.2165	13.68	340122	01.0063	10.85	350042	01.0638	12.64	360059	01.4957	18.80	360135	01.2170	14.57
340028	01.4178	15.42	340123	01.1582	13.69	350043	01.5278	14.64	360062	01.5712	17.01	360136	01.1243	13.87
340030	01.8722	17.35	340124	01.0999	13.00	350044	00.8327	08.90	360063	01.1058	14.42	360137	01.5686	18.00
340031	01.0154	11.45	340125	01.4091	16.81	350047	01.1831	15.32	360064	01.4694	17.62	360139	00.9743	12.05
340032	01.2736	16.39	340126	01.3403	15.76	350049	01.1917	09.83	360065	01.2442	15.02	360140	01.0780	14.54
340034	01.2686	16.12	340127	01.2586	15.62	350050	01.0158	11.38	360066	01.2236	14.92	360141	01.4099	18.14
340035	01.1562	15.17	340129	01.2571	17.74	350051	00.9788	12.48	360067	01.1075	11.39	360142	01.0062	13.89
340036	01.1861	15.00	340130	01.3265	14.86	350053	00.8959	11.10	360068	01.5775	18.67	360143	01.2491	16.84
340037	01.2293	15.38	340131	01.3162	15.31	350055	00.9074	11.18	360069	01.0213	15.38	360144	01.2708	18.65
340038	01.1347	13.31	340132	01.2827	12.54	350056	00.9586	11.87	360070	01.5546	15.73	360145	01.5305	15.26
340039	01.2821	16.55	340133	01.1553	14.11	350058	01.0392	11.16	360071	01.2517	14.03	360147	01.2000	14.87
340040	01.8061	16.34	340136	00.9837	16.24	350060	00.9417	07.24	360072	01.1876	14.87	360148	01.1722	14.28
340041	01.2486	14.67	340137	01.4444	12.18	350061	00.9976	12.32	360074	01.4123	16.37	360149	01.1040	15.84
340042	01.1515	13.14	340138	01.1751	14.43	350063	00.9146	.....	360075	01.4347	19.23	360150	01.2634	16.63
340044	01.0459	10.39	340141	01.5719	17.23	350064	00.7287	.....	360076	01.3232	15.96	360151	01.3390	15.61
340045	01.0286	09.87	340142	01.2200	14.37	350065	00.9497	10.34	360077	01.4129	16.81	360152	01.4837	16.15
340047	01.9040	16.64	340143	01.3553	17.58	350066	00.6282	.....	360078	01.2635	17.46	360153	01.1782	12.99
340048	01.2550	07.91	340144	01.2895	17.53	360001	01.2318	15.77	360079	01.6716	18.23	360154	01.0398	11.51
340049	00.6445	15.08	340145	01.2739	17.27	360002	01.1534	14.33	360080	01.1335	14.11	360155	01.3267	17.47
340050	01.1703	14.78	340146	01.0497	12.17	360003	01.6359	18.41	360081	01.3223	17.76	360156	01.1304	16.04
340051	01.2070	15.20	340147	01.3448	15.57	360006	01.7543	18.70	360082	01.3216	17.76	360159	01.2104	16.45
340052	01.0038	16.81	340148	01.4339	15.52	360007	01.0831	15.64	360083	01.3053	15.20	360161	01.2553	18.08
340053	01.5864	17.14	340151	01.2056	13.47	360008	01.2059	14.53	360084	01.6031	16.81	360162	01.2698	15.67
340054	01.0825	12.08	340153	01.9188	19.98	360009	01.3259	17.41	360085	01.7507	18.24	360163	01.7578	18.19
340055	01.2212	15.33	340154	00.7612	14.62	360010	01.1667	14.40	360086	01.4164	15.83	360164	00.8600	13.58
340060	01.1257	14.49	340155	01.4494	20.53	360011	01.2476	16.40	360087	01.3185	15.92	360165	01.1166	13.53
340061	01.6405	17.49	340156	00.8025	.....	360012	01.2386	17.96	360088	01.1425	14.18	360166	01.1834	15.77
340063	01.0344	11.52	340158	01.1027	15.90	360013	01.1028	16.12	360089	01.0943	15.10	360169	01.0871	16.28
340064	01.1708	14.10	340159	01.1214	14.10	360014	01.1275	15.02	360090	01.2463	17.34	360170	01.1101	16.93

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
360172	01.3501	15.73	370034	01.1511	11.98	370153	01.1505	13.77	380064	01.2983	18.01	390055	01.6951	19.09
360174	01.2039	14.63	370035	01.4865	14.39	370154	00.9983	11.80	380065	01.0296	17.02	390056	01.1105	15.26
360175	01.1487	15.64	370036	00.9836	08.68	370156	01.1475	12.70	380066	01.3878	15.59	390057	01.2599	17.60
360176	01.2231	12.33	370037	01.5519	15.41	370158	01.0613	12.52	380068	01.0179	18.42	390058	01.3006	16.59
360177	01.2790	16.76	370038	00.9814	10.14	370159	01.3848	14.16	380069	01.1849	15.99	390059	01.3068	15.15
360178	01.2346	14.42	370039	01.3170	17.93	370161	01.1867	16.35	380070	01.1736	18.67	390060	01.0954	14.69
360179	01.2754	17.80	370040	01.0365	09.92	370163	00.8697	09.85	380071	01.2557	21.69	390061	01.3869	17.33
360180	02.2165	20.03	370041	00.9739	12.74	370165	01.1600	10.92	380072	00.9976	13.01	390062	01.1690	14.09
360184	00.6996	14.70	370042	00.8919	10.84	370166	01.1736	16.00	380075	01.4436	18.03	390063	01.6704	17.69
360185	01.2021	15.85	370043	00.9414	10.62	370169	01.0442	10.00	380078	01.1587	16.41	390064	01.4469	15.00
360186	01.2453	14.82	370045	01.0557	10.20	370170	00.9497	.....	380081	01.0971	15.77	390065	01.2240	17.69
360187	01.3438	16.16	370046	00.9896	12.64	370171	01.0047	.....	380082	01.2171	18.63	390066	01.2517	16.74
360188	01.0363	14.70	370047	01.2384	12.34	370172	00.8760	.....	380083	01.1325	16.57	390067	01.7140	17.24
360189	01.0689	14.46	370048	01.1242	11.45	370173	01.3875	.....	380084	01.2186	19.45	390068	01.3575	16.97
360192	01.3454	17.97	370049	01.3478	14.08	370174	00.9106	.....	380087	01.0498	12.17	390069	01.3063	16.98
360193	01.2980	14.54	370051	01.0263	10.47	370176	01.2597	17.68	380088	00.9537	14.76	390070	01.2732	18.91
360194	01.1427	14.46	370054	01.2804	14.57	370177	00.9686	09.39	380089	01.2716	19.78	390071	01.0913	11.99
360195	01.1534	16.45	370056	01.4467	14.44	370178	01.0643	11.08	380090	01.2968	18.73	390072	01.0770	14.85
360197	01.1662	15.43	370057	01.1446	13.92	370179	00.9625	12.90	380091	01.1835	22.18	390073	01.5256	17.40
360200	01.1548	10.65	370059	01.2056	12.34	370180	01.0308	.....	380897	05.0059	.....	390074	01.2084	15.50
360203	01.1387	14.52	370060	01.1681	11.89	370183	01.1562	11.67	390001	01.3124	16.25	390075	01.3120	14.60
360204	01.2181	15.73	370063	01.1628	11.88	370186	00.9969	09.16	390002	01.3148	16.65	390076	01.2692	18.60
360210	01.1414	17.25	370064	01.0038	08.92	370189	01.0572	09.26	390003	01.2013	15.23	390078	01.0384	15.47
360211	01.1987	15.45	370065	01.0730	13.47	370190	01.7487	18.02	390004	01.4003	15.76	390079	01.7125	15.49
360212	01.4238	17.91	370069	01.0292	12.62	380001	01.2816	17.45	390005	01.0353	13.42	390080	01.2033	17.54
360213	01.0795	14.45	370071	01.0864	10.25	380002	01.1913	16.54	390006	01.7625	16.22	390081	01.2631	18.98
360218	01.2589	15.27	370072	00.9423	11.20	380003	01.1784	16.59	390007	01.1940	16.97	390083	01.1639	20.47
360230	01.2987	18.07	370076	01.2221	10.80	380004	01.7899	20.49	390008	01.1381	15.38	390084	01.1674	14.93
360231	01.1015	14.13	370077	01.2835	16.00	380005	01.2162	17.60	390009	01.6008	16.25	390086	01.0807	14.19
360232	01.1465	19.54	370078	01.6115	15.06	380006	01.3029	16.06	390010	01.2451	16.77	390088	01.2601	18.26
360234	01.3213	17.45	370079	00.8642	11.46	380007	01.7970	20.52	390011	01.2162	15.72	390090	01.7269	18.51
360236	01.2256	16.91	370080	00.9710	10.78	380008	01.1211	16.02	390012	01.1715	18.00	390091	01.1490	17.98
360238	00.9264	12.13	370082	01.1282	11.98	380009	01.7538	21.31	390013	01.2003	15.66	390093	01.1607	14.74
360239	01.1692	18.24	370083	01.0320	10.50	380010	01.0442	19.43	390014	00.9655	13.70	390095	01.1991	12.94
360240	00.6112	13.30	370084	01.0554	09.02	380011	01.2294	13.31	390015	01.1704	11.85	390096	01.2562	15.43
360241	00.5726	16.05	370085	00.9051	12.29	380013	01.2257	18.80	390016	01.1675	14.71	390097	01.3078	19.40
360242	01.4552	.....	370086	01.1848	09.55	380014	01.3465	17.78	390017	01.1817	13.65	390098	01.7371	18.83
360243	00.8582	15.30	370089	01.2778	11.60	380017	01.7404	20.25	390018	01.2110	17.81	390100	01.6715	17.60
360244	00.8716	15.00	370091	01.6302	14.59	380018	01.7752	17.51	390019	01.1292	14.54	390101	01.2777	15.00
360245	00.9364	.....	370092	01.1135	11.69	380019	01.3337	17.00	390022	01.3753	19.40	390102	01.3193	19.48
360246	00.6407	.....	370093	01.7767	18.82	380020	01.4155	17.79	390023	01.2519	18.52	390103	01.0539	14.93
370001	01.6763	15.99	370094	01.4243	16.65	380021	01.2001	18.54	390024	00.7670	20.53	390104	01.0670	14.28
370002	01.2402	12.02	370095	00.9144	10.73	380022	01.1495	18.26	390025	00.8539	14.06	390106	00.9835	14.65
370004	01.3474	12.31	370097	01.3461	18.53	380023	01.2610	17.05	390026	01.2263	18.67	390107	01.1973	17.38
370005	01.0827	10.63	370099	01.2014	12.43	380025	01.2684	19.95	390027	01.8636	21.73	390108	01.3352	18.98
370006	01.1941	14.06	370100	01.0390	11.67	380026	01.3583	15.93	390028	01.7410	18.13	390109	01.1639	13.33
370007	01.1085	12.64	370103	00.9238	10.13	380027	01.2532	18.02	390029	01.6984	20.55	390110	01.5611	17.01
370008	01.3576	15.20	370105	02.0562	13.71	380029	01.1894	15.62	390030	01.2226	15.45	390111	01.7401	24.12
370011	01.1189	12.74	370106	01.4740	16.23	380031	01.0192	15.90	390031	01.1580	15.93	390112	01.1451	11.94
370012	00.8871	10.18	370108	01.1804	09.27	380033	01.6618	19.92	390032	01.1990	16.58	390113	01.2517	15.48
370013	01.6817	17.44	370110	00.9905	12.01	380035	01.3229	16.28	390035	01.2759	16.49	390114	01.0987	19.32
370014	01.2968	16.19	370112	01.0335	12.14	380036	01.0848	16.10	390036	01.2444	16.78	390115	01.3002	20.16
370015	01.2131	13.44	370113	01.0858	12.37	380037	01.2695	18.94	390037	01.2074	17.47	390116	01.1726	18.88
370016	01.3651	13.98	370114	01.5710	14.55	380038	01.2293	20.44	390039	01.1180	15.31	390117	01.1666	14.44
370017	01.0434	10.30	370121	01.3260	12.36	380039	01.2853	17.76	390040	00.9419	12.20	390118	01.2353	15.42
370018	01.3096	15.49	370122	01.2328	08.56	380040	01.3016	17.85	390041	01.2543	17.32	390119	01.3573	16.18
370019	01.2298	10.56	370123	01.2636	13.79	380042	01.1269	15.46	390042	01.3018	18.62	390121	01.2805	16.71
370020	01.2834	11.37	370125	01.0162	10.72	380047	01.6536	16.43	390043	01.0198	13.85	390122	01.0573	14.83
370021	00.9852	09.49	370126	01.1444	08.72	380048	01.0343	13.09	390044	01.5555	16.77	390123	01.2230	18.51
370022	01.2994	13.75	370131	00.9804	11.32	380050	01.2488	15.78	390045	01.4370	16.03	390125	01.2550	13.82
370023	01.3328	13.57	370133	01.1332	09.86	380051	01.5073	17.52	390046	01.4394	16.75	390126	01.2706	19.96
370025	01.3962	13.86	370138	01.1179	14.59	380052	01.2272	15.01	390047	01.6934	22.77	390127	01.1649	19.13
370026	01.3733	15.30	370139	01.0286	11.63	380055	01.1953	22.55	390048	01.1651	14.69	390128	01.1286	17.07
370028	01.6703	15.88	370140	01.0181	10.01	380056	01.1050	14.28	390049	01.5137	18.00	390130	01.1470	15.37
370029	01.2134	11.58	370141	01.3874	19.42	380060	01.4527	20.35	390050	02.0268	19.37	390131	01.2141	16.10
370030	01.2926	12.91	370146	01.1131	10.05	380061	01.5814	19.88	390051	02.0948	21.73	390132	01.1887	19.61
370032	01.4018	14.36	370148	01.3470	17.30	380062	01.1223	12.73	390052	01.1507	15.00	390133	01.7111	19.44
370033	01.1205	10.55	370149	01.1830	13.75	380063	01.2123	21.13	390054	01.1338	12.61	390135	01.2420	19.44

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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
390136	01.2231	15.15	390224	00.9339	12.60	400102	01.1571	07.50	420056	01.1036	12.61	430054	00.9870	11.56
390137	01.1502	15.82	390225	01.2209	15.00	400103	01.4620	08.99	420057	01.1808	13.51	430056	00.8973	09.09
390138	01.1896	17.08	390226	01.6978	20.96	400104	01.2361	07.79	420059	01.0104	12.84	430057	00.9116	10.70
390139	01.4319	22.21	390228	01.2064	17.13	400105	01.2043	07.09	420061	01.2115	14.38	430060	00.9919	08.54
390142	01.6525	23.32	390229	01.5645	17.58	400106	01.1958	07.10	420062	01.4202	16.13	430062	00.8284	10.11
390145	01.2597	18.61	390231	01.3312	21.13	400109	01.5763	08.48	420064	01.1426	12.20	430064	01.1199	10.40
390146	01.2356	15.78	390233	01.3486	16.52	400110	01.1548	07.68	420065	01.3357	15.64	430065	01.0518	10.46
390147	01.2429	17.19	390235	01.8132	22.16	400111	01.1442	07.53	420066	00.9708	13.59	430066	00.9866	11.12
390148	01.0573	16.31	390236	01.2367	15.25	400112	01.1294	06.36	420067	01.2409	15.33	430073	01.1130	12.81
390149	01.2014	16.23	390237	01.5158	18.07	400113	01.1748	06.45	420068	01.2133	14.59	430076	01.0517	08.42
390150	01.2188	17.11	390238	01.1068	16.03	400114	01.0550	07.83	420069	01.1289	12.28	430077	01.5274	14.81
390151	01.2333	16.00	390242	01.3139	17.49	400115	00.9692	06.66	420070	01.2809	14.64	430079	00.9599	10.06
390152	01.0829	15.09	390244	00.8984	12.14	400117	01.1822	07.29	420071	01.3513	15.19	430080	01.2387	09.20
390153	01.2559	20.26	390245	01.3591	21.15	400118	01.1587	07.27	420072	00.9360	09.89	430081	00.9416	.....
390154	01.1573	13.46	390246	01.1831	15.09	400120	01.3381	08.45	420073	01.3091	17.39	430082	00.8089	.....
390155	01.2416	20.35	390247	01.0548	17.29	400122	01.0084	.....	420074	00.9671	10.42	430083	00.8805	.....
390156	01.3463	20.78	390249	01.0225	11.44	400123	01.1240	.....	420075	00.9840	12.37	430084	00.8674	.....
390157	01.2153	16.84	390256	01.7622	18.11	400124	03.0498	.....	420076	01.2166	20.07	430085	00.8849	.....
390158	01.2792	17.26	390258	01.2902	18.83	410001	01.3190	21.02	420078	01.7195	17.31	430086	00.8381	.....
390159	01.3235	19.13	390260	01.2455	16.31	410002	01.1241	18.61	420079	01.4784	15.84	430087	00.9523	08.98
390160	01.1786	17.04	390262	01.8505	16.11	410004	01.4017	18.86	420080	01.2105	16.23	430088	00.8629	10.78
390161	01.1982	13.09	390263	01.4938	18.44	410005	01.3471	20.92	420081	00.8136	17.83	440001	01.0923	11.94
390162	01.2774	17.98	390265	01.2991	16.95	410006	01.2044	19.91	420082	01.4316	16.58	440002	01.5969	14.74
390163	01.1520	16.65	390266	01.0944	15.78	410007	01.6561	19.87	420083	01.2217	16.12	440003	01.0918	13.82
390164	02.0309	18.51	390267	01.2116	18.58	410008	01.1989	19.67	420084	01.0603	11.81	440006	01.3790	16.17
390166	01.1026	16.02	390268	01.2841	18.08	410009	01.3190	19.81	420085	01.2758	16.15	440007	01.0212	10.86
390167	01.2717	19.78	390270	01.3192	15.08	410010	01.0217	23.33	420086	01.4243	16.19	440008	00.9794	13.80
390168	01.1840	16.49	390272	00.5344	21.19	410011	01.2093	20.92	420087	01.6204	15.15	440009	01.0389	11.29
390169	01.1978	16.06	390275	00.4818	.....	410012	01.6437	18.74	420088	01.2297	14.81	440010	00.9651	11.46
390170	01.8159	19.83	390277	00.5113	17.97	410013	01.2298	23.20	420089	01.3302	19.45	440011	01.2455	14.86
390171	01.1343	15.68	390278	00.8250	15.98	420002	01.3554	19.58	420091	00.5742	.....	440012	01.3188	15.12
390172	01.2634	18.70	390279	01.0946	.....	420004	01.8451	16.90	430004	01.0741	13.84	440014	01.0847	11.29
390173	01.1582	16.62	400001	01.1952	06.56	420005	01.1443	12.82	430005	01.2632	13.13	440015	01.5392	14.85
390174	01.6021	22.13	400002	01.4051	08.59	420006	01.2294	15.90	430007	01.1784	11.22	440016	00.9769	10.44
390176	01.1447	15.39	400003	01.1723	08.08	420007	01.5344	15.37	430008	01.2470	13.36	440017	01.5557	16.57
390178	01.2721	16.67	400004	01.2055	07.64	420009	01.2447	14.71	430009	01.1039	10.57	440018	01.3772	16.57
390179	01.2329	21.05	400005	01.0596	05.93	420010	01.0667	13.24	430010	01.1656	08.61	440019	01.5520	17.86
390180	01.4620	21.29	400006	01.1804	06.79	420011	01.0843	13.76	430011	01.3343	12.88	440020	01.1738	16.04
390181	01.0520	19.17	400007	01.1941	06.70	420014	01.0271	11.42	430012	01.3016	13.57	440022	01.1395	12.73
390183	01.1218	26.56	400008	01.2294	06.13	420015	01.3035	16.41	430013	01.2225	14.39	440023	00.9979	10.57
390184	01.1498	16.80	400009	00.9723	06.84	420016	01.0820	15.23	430014	01.3146	15.40	440024	01.2945	14.98
390185	01.1490	15.23	400010	00.9425	07.03	420018	01.5696	16.53	430015	01.2066	13.41	440025	01.1031	12.43
390186	00.9988	15.14	400011	01.0339	07.66	420019	01.1579	13.94	430016	01.7294	16.10	440026	00.8359	15.50
390189	01.1270	20.06	400012	01.1223	07.74	420020	01.2261	14.85	430018	00.9495	12.97	440029	01.2461	14.99
390191	01.0680	13.79	400013	01.0714	07.16	420022	00.9931	15.20	430022	00.9637	09.90	440030	01.1295	12.38
390192	01.1108	15.96	400014	01.3436	07.22	420023	01.3521	17.43	430023	00.9377	08.41	440031	01.0301	12.09
390193	01.1718	14.58	400015	01.3019	09.68	420026	01.8623	17.53	430024	00.9725	11.02	440032	00.9747	10.65
390194	01.1110	17.87	400016	01.3266	09.18	420027	01.3224	14.19	430025	01.0084	09.69	440033	01.0740	16.12
390195	01.7068	20.60	400017	01.1463	.....	420028	01.1146	11.11	430026	00.9375	10.09	440034	01.4230	17.40
390196	01.2145	.....	400018	01.2630	09.43	420029	01.7591	13.19	430027	01.7460	15.94	440035	01.2710	14.48
390197	01.2696	18.10	400019	01.5568	08.81	420030	01.2045	16.33	430028	01.0503	11.61	440039	01.5860	17.12
390198	01.2361	13.92	400021	01.3669	07.92	420031	01.0195	10.68	430029	01.0075	12.71	440040	00.9527	13.60
390199	01.2454	14.23	400022	01.3140	08.71	420033	01.1522	17.58	430031	00.9785	10.28	440041	00.8479	13.66
390200	01.0135	14.23	400024	01.0591	07.19	420035	00.7751	11.27	430033	01.0808	12.29	440046	01.3194	13.16
390201	01.2876	17.68	400026	00.9117	06.15	420036	01.2327	14.69	430034	01.0286	10.85	440047	00.9167	11.74
390203	01.2606	19.47	400027	01.1389	07.18	420037	01.2485	18.15	430036	00.9902	08.36	440048	01.7477	15.49
390204	01.2923	17.60	400028	01.0784	06.70	420038	01.2217	12.41	430037	00.9860	11.79	440049	01.6483	15.27
390205	01.2589	20.89	400029	01.1183	06.21	420039	01.1048	13.26	430038	00.9978	08.43	440050	01.1715	14.53
390206	01.3311	18.69	400031	01.0008	07.72	420040	01.2006	13.54	430039	01.0023	09.15	440051	00.9316	12.36
390209	01.0001	13.32	400032	01.1314	07.65	420042	01.2096	11.67	430040	00.9160	11.35	440052	01.1894	13.51
390211	01.2333	16.85	400044	01.1746	08.66	420043	01.2497	15.44	430041	00.9265	11.35	440053	01.2488	14.72
390213	00.9999	13.22	400048	01.0480	07.77	420044	01.2167	15.58	430042	01.1134	15.25	440054	01.0527	13.96
390215	01.1275	20.18	400061	01.5946	11.46	420048	01.1525	13.91	430043	01.1510	13.05	440056	01.0871	11.91
390217	01.2163	17.46	400079	01.2811	09.22	420049	01.2237	14.11	430044	00.9290	11.74	440057	01.0223	12.82
390219	01.2171	16.47	400087	01.2290	06.69	420051	01.5551	16.53	430047	01.1156	11.70	440058	01.1756	14.16
390220	01.1604	17.46	400088	00.5413	06.69	420053	01.0939	14.06	430048	01.2381	14.21	440059	01.1607	12.77
390222	01.2521	18.22	400094	01.0012	06.74	420054	01.2267	16.05	430049	00.9249	10.80	440060	01.1756	12.90
390223	01.6770	20.79	400098	01.2601	07.55	420055	01.0766	13.01	430051	00.9629	11.03	440061	01.2131	13.36

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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
440063	01.5138	16.30	440180	01.0624	15.21	450076	01.4717	.....	450181	00.9547	13.38	450325	01.2675	08.99
440064	01.0929	13.98	440181	01.0104	10.47	450078	01.0114	12.31	450184	01.4935	19.07	450327	01.0103	10.48
440065	01.1853	15.06	440182	00.9547	13.66	450079	01.4787	19.22	450185	01.0617	08.32	450330	01.1725	15.70
440067	01.0909	15.26	440183	01.5121	16.14	450080	01.2485	16.13	450187	01.3045	14.52	450334	00.9992	11.28
440068	01.1912	15.49	440184	01.4429	17.96	450081	01.1290	11.51	450188	01.0288	11.94	450337	01.1923	14.08
440069	01.1399	13.16	440185	01.0961	16.67	450082	00.9955	11.00	450190	01.1300	18.27	450340	01.3265	14.37
440070	01.0038	12.32	440186	01.1340	18.54	450083	01.6360	16.05	450191	01.1515	15.56	450341	00.9963	14.42
440071	01.4109	14.79	440187	01.1847	15.17	450085	01.1242	12.97	450192	01.0649	17.15	450346	01.3544	15.28
440072	01.3557	15.41	440189	01.4992	15.23	450087	01.5114	19.75	450193	02.0715	18.54	450347	01.1744	15.06
440073	01.3107	15.18	440192	01.1110	13.88	450090	01.1148	11.65	450194	01.2566	15.44	450348	01.0156	10.55
440074	00.8046	12.15	440193	01.2560	17.17	450092	01.2034	13.55	450195	01.3153	17.30	450349	01.0999	23.66
440078	01.0165	11.32	440194	01.3012	18.28	450094	01.3955	19.86	450196	01.4334	14.92	450351	01.2648	22.84
440079	00.7294	.....	440196	00.9401	14.86	450096	01.4495	16.16	450197	01.1655	16.99	450352	01.2137	20.49
440081	01.1643	12.85	440197	01.3707	17.37	450097	01.4276	17.31	450200	01.4943	13.71	450353	01.2269	15.17
440082	01.8429	19.28	440200	01.1142	16.36	450098	01.2082	12.67	450201	00.9942	13.72	450355	01.0818	12.14
440083	01.2537	09.96	440203	00.9909	13.79	450099	01.2009	17.78	450203	01.2816	14.24	450358	02.0420	18.56
440084	01.1852	10.14	440205	01.2436	12.39	450101	01.3497	14.40	450209	01.4242	15.63	450362	01.0638	10.60
440087	01.0430	12.08	440206	00.9017	07.60	450102	01.6894	17.28	450210	01.1084	13.40	450365	00.9342	.....
440090	01.0381	12.38	450002	1.4852	15.52	450104	01.2719	12.65	450211	01.3187	13.86	450366	01.4737	18.29
440091	01.5433	15.71	450004	01.1355	11.11	450107	01.5378	16.81	450213	01.3555	14.21	450369	01.1127	11.81
440095	01.0850	19.37	450005	01.1381	14.76	450108	01.0003	11.41	450214	01.4068	17.51	450370	01.2119	12.06
440100	01.1004	12.24	450007	01.2595	12.30	450109	01.2410	13.96	450217	01.0771	10.09	450371	01.1583	10.89
440102	01.0834	12.02	450008	01.3853	14.03	450110	01.2134	12.04	450219	01.0450	11.49	450372	01.3460	16.37
440103	01.2252	16.56	450010	01.3300	13.75	450111	01.2523	17.62	450221	01.0202	13.07	450373	01.1579	11.09
440104	01.5364	16.76	450011	01.5489	15.71	450112	01.2629	12.44	450222	01.6908	22.10	450374	00.9156	11.01
440105	01.2990	16.68	450014	01.1763	12.60	450113	01.2389	16.17	450224	01.3697	18.01	450376	01.4794	10.63
440109	01.1307	11.86	450015	01.5321	13.56	450118	01.4696	15.64	450229	01.4657	15.37	450378	01.1011	17.92
440110	00.9556	13.92	450016	01.7128	15.62	450119	01.3313	14.65	450231	01.5196	16.40	450379	01.6117	20.14
440111	01.2167	18.15	450018	01.5585	18.52	450121	01.4403	17.44	450233	00.9976	12.70	450381	00.9540	10.67
440114	01.0345	11.65	450020	01.0135	13.40	450123	01.0894	19.97	450234	00.9630	10.46	450388	01.6240	16.61
440115	01.0487	13.80	450021	01.9203	17.49	450124	01.5053	16.88	450235	00.9601	11.12	450389	01.2048	15.78
440120	01.4662	15.49	450023	01.3903	13.94	450126	01.3973	16.17	450236	01.1377	15.95	450393	01.2694	18.35
440121	01.0427	11.93	450024	01.3328	12.06	450127	00.9875	09.55	450237	01.4897	14.79	450395	01.0482	15.15
440125	01.4766	15.68	450025	01.4792	15.27	450128	01.2480	12.38	450239	01.1696	12.14	450399	01.0623	12.15
440130	01.1075	13.38	450027	01.4255	18.45	450130	01.5040	14.99	450241	00.8530	13.09	450400	01.1677	14.98
440131	01.0593	13.10	450028	01.4607	16.21	450131	01.2607	19.36	450243	00.8661	10.77	450403	01.2575	19.01
440132	01.1081	12.72	450029	01.4212	11.79	450132	01.4931	14.53	450246	00.9890	13.87	450410	01.1316	17.45
440133	01.4572	17.01	450031	01.6835	16.35	450133	01.5493	15.33	450249	00.9424	.....	450411	00.9843	11.22
440135	01.4126	18.07	450032	01.2423	12.31	450135	01.7031	18.60	450250	01.0420	15.96	450417	01.0336	12.26
440136	01.0683	15.73	450033	01.6423	14.49	450137	01.4294	19.17	450253	01.1271	10.67	450418	01.3502	15.53
440137	01.0083	11.27	450034	01.5042	15.36	450140	00.7344	16.53	450258	01.1194	10.75	450419	01.2377	18.02
440141	01.1507	11.96	450035	01.4629	16.70	450142	01.3689	18.81	450259	01.1512	17.45	450422	00.6567	24.82
440142	01.0831	09.45	450037	01.5273	16.26	450143	01.0261	10.41	450264	00.8325	11.39	450423	01.2999	21.90
440143	01.0555	15.56	450039	01.4288	16.93	450144	01.1532	14.41	450269	01.0779	13.62	450424	01.2514	13.96
440144	01.1975	17.10	450040	01.5797	16.30	450145	00.8863	14.64	450270	01.0791	08.60	450429	01.0330	12.10
440145	01.0549	10.86	450042	01.6082	15.48	450146	00.9826	15.24	450271	01.1263	14.62	450431	01.5885	16.57
440146	01.0442	11.21	450043	01.4527	18.41	450147	01.3439	17.43	450272	01.2170	15.57	450438	01.0871	16.17
440147	00.8996	14.36	450044	01.5820	18.55	450148	01.2056	18.48	450276	01.0040	08.60	450446	00.9550	11.85
440148	01.2025	17.31	450046	01.3944	12.38	450149	01.3408	16.76	450278	01.0542	10.91	450447	01.3189	16.08
440149	01.2308	14.70	450047	01.1025	10.47	450150	00.9606	12.20	450280	01.3016	15.64	450450	01.0270	12.30
440150	01.2409	16.92	450050	01.1986	13.96	450151	01.1414	12.24	450283	01.0793	11.48	450451	01.0230	15.22
440151	01.2861	15.49	450051	01.5619	17.57	450152	01.2853	14.87	450286	01.0253	12.11	450457	01.6912	16.01
440152	01.6104	16.13	450052	01.1098	12.62	450153	01.5695	16.68	450288	01.2288	12.61	450460	01.0144	13.30
440153	01.2677	14.17	450053	01.0843	13.58	450154	01.1379	11.32	450289	01.3300	15.80	450462	01.8334	16.67
440154	00.7575	.....	450054	01.6881	19.72	450155	01.0745	14.52	450292	01.3389	15.96	450464	00.9903	16.00
440156	01.4974	18.20	450055	01.1112	11.31	450157	01.0363	12.65	450293	00.9767	14.15	450465	01.2460	15.09
440157	01.0485	11.50	450056	01.6722	16.78	450160	00.8899	16.67	450296	01.2584	18.17	450467	01.0221	12.74
440159	01.2089	15.33	450058	01.5129	14.26	450162	01.2815	16.42	450297	01.1615	12.08	450469	01.3061	15.75
440160	00.8997	12.59	450059	01.3713	12.34	450163	01.0847	15.33	450299	01.4740	16.11	450473	00.9922	14.40
440161	01.5923	18.01	450060	01.3962	20.84	450164	01.0330	12.98	450303	00.8879	09.86	450475	01.1115	12.45
440166	01.4819	16.87	450063	01.0607	09.22	450165	01.0302	14.37	450306	01.0579	11.18	450484	01.5588	18.13
440168	01.0229	13.35	450064	01.5464	15.22	450166	01.0477	10.59	450307	01.0089	12.30	450488	01.2249	17.64
440170	01.2998	18.38	450065	01.0185	14.74	450169	00.8630	13.97	450309	01.1017	10.84	450489	00.9473	14.79
440173	01.4970	15.75	450068	01.7532	17.99	450170	01.0853	12.10	450315	01.1977	19.49	450497	01.1786	10.99
440174	00.9321	13.46	450070	01.1738	17.31	450176	01.2754	12.94	450320	01.4034	19.32	450498	01.0325	13.08
440175	01.1861	16.89	450072	01.2594	16.10	450177	01.1252	12.06	450321	00.8596	11.25	450508	01.6026	15.77
440176	01.2939	16.07	450073	01.1636	11.84	450178	01.1510	14.59	450322	00.9743	16.67	450514	01.1170	16.87
440178	01.2263	18.49	450074	01.2878	16.43	450179	00.9523	.....	450324	01.5460	15.52	450517	00.9434	11.05

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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
450518	01.4144	16.16	450660	01.5790	18.85	450769	00.9320	09.57	470013	01.1467	18.22	490089	01.0505	14.04
450523	01.5387	19.98	450661	01.2547	18.21	450770	01.0700	12.31	470015	01.1877	18.87	490090	01.1894	13.06
450530	01.3085	23.01	450662	01.3950	17.00	450771	01.7568	15.16	470018	01.1282	18.39	490091	01.1790	18.85
450534	00.9786	13.79	450665	00.9778	10.88	450774	00.7228	.....	470020	01.0126	12.85	490092	01.1790	13.48
450535	01.1992	14.83	450666	01.2580	17.39	450775	01.2516	15.68	470023	01.2324	16.33	490093	01.2862	14.17
450537	01.3952	15.96	450668	01.5927	17.53	450776	00.8655	.....	470024	01.1338	16.25	490094	01.2211	15.14
450538	01.1922	19.68	450669	01.2426	18.67	450777	01.0269	.....	490001	01.1182	17.17	490095	01.2315	15.14
450539	01.2053	15.30	450670	01.2996	15.92	450778	00.8848	.....	490002	01.0320	13.41	490097	01.1433	12.72
450544	01.2967	20.24	450672	01.6463	18.49	450779	01.2579	.....	490003	00.6533	15.73	490098	01.3158	11.12
450545	01.2474	16.20	450673	01.0975	10.02	450780	01.4717	.....	490004	01.2171	15.40	490099	00.9625	13.59
450546	01.2729	18.68	450674	00.8239	19.25	450781	01.4634	.....	490005	01.4576	15.40	490100	01.3151	14.13
450547	01.0006	12.78	450675	01.3903	18.32	450782	01.4054	.....	490006	01.1427	11.75	490101	01.1133	20.90
450550	01.0579	19.47	450677	01.3377	16.32	450783	01.1067	.....	490007	02.0127	15.62	490104	00.9622	14.01
450551	01.1795	12.60	450678	01.5651	20.04	450784	01.0594	.....	490008	01.0542	20.97	490105	00.7039	14.74
450558	01.7511	17.98	450681	01.5756	15.51	450785	00.7492	.....	490009	01.6789	17.21	490106	00.8313	15.97
450559	00.8716	11.92	450682	01.2603	17.44	450786	00.8128	.....	490010	01.0908	15.40	490107	01.2642	19.56
450561	01.6595	16.21	450683	01.3244	19.60	450787	01.0967	.....	490011	01.3318	16.32	490108	00.8124	15.00
450563	01.2509	19.54	450684	01.2661	17.89	450897	04.9148	.....	490012	01.1150	13.90	490109	00.8790	14.56
450565	01.3451	13.56	450686	01.5880	15.55	460001	01.6481	18.22	490013	01.1660	13.67	490110	01.1805	16.71
450570	01.0638	12.07	450688	01.3829	17.26	460003	01.5838	17.26	490014	01.6015	19.87	490111	01.1901	14.35
450571	01.4721	13.89	450690	01.3692	21.21	460004	01.7182	18.05	490015	01.4062	13.85	490112	01.6117	18.29
450573	00.9884	11.89	450691	01.5252	17.57	460005	01.3774	17.46	490017	01.3798	15.60	490113	01.2900	19.16
450574	01.0190	13.95	450694	01.2113	16.02	460006	01.2683	17.00	490018	01.2067	15.63	490114	01.0733	13.76
450575	00.9777	20.31	450696	01.6328	20.21	460007	01.3036	16.89	490019	01.1148	13.78	490115	01.2167	12.44
450578	00.9309	14.41	450697	01.3794	15.11	460008	01.4573	16.76	490020	01.1572	13.14	490116	01.1799	16.33
450580	01.1561	12.24	450698	00.9368	10.48	460009	01.6847	16.97	490021	01.4354	15.75	490117	01.0841	11.43
450583	00.9523	11.81	450700	00.9251	11.65	460010	02.0637	18.28	490022	01.2461	15.68	490118	01.6559	19.99
450584	01.1670	10.95	450702	01.4889	18.28	460011	01.4136	15.96	490023	01.2265	15.58	490119	01.3127	15.33
450586	01.0115	12.39	450703	01.4711	19.68	460013	01.5168	17.24	490024	01.6107	15.30	490120	01.3657	15.93
450587	01.2735	17.28	450704	01.3988	16.67	460014	01.0224	11.67	490027	01.1661	12.49	490122	01.2879	20.07
450591	01.1456	13.04	450705	00.7976	15.32	460015	01.2597	17.66	490028	01.3351	17.29	490123	01.1181	14.53
450596	01.2539	16.69	450706	01.2191	21.01	460016	00.8736	12.40	490030	01.2487	10.92	490124	01.1848	15.29
450597	01.0357	13.57	450709	01.1547	17.85	460017	01.3132	15.07	490031	01.0973	11.91	490126	01.2602	13.61
450603	00.8565	13.23	450711	01.6884	16.47	460018	00.9433	11.56	490032	01.6879	18.77	490127	01.0434	13.33
450604	01.2523	12.49	450712	00.9561	12.74	460019	00.9335	15.01	490033	01.1437	14.76	490130	01.2044	14.96
450605	01.2746	18.23	450713	01.4165	17.31	460020	00.9188	12.14	490035	01.1319	11.43	490131	00.9682	12.94
450607	00.9751	14.12	450715	01.2952	21.28	460021	01.3942	17.12	490037	01.1566	11.92	500001	01.2917	20.32
450609	00.9014	09.27	450716	01.2075	16.91	460022	00.9647	17.88	490038	01.2792	12.36	500002	01.4148	17.35
450610	01.4555	16.09	450717	01.2316	20.68	460023	01.1761	18.70	490040	01.3644	19.78	500003	01.2762	18.46
450614	01.0603	11.94	450718	01.2065	19.69	460024	00.9286	13.00	490041	01.2136	14.32	500005	01.7781	21.33
450615	00.9577	09.40	450723	01.2859	17.26	460025	00.7859	11.54	490042	01.3582	14.34	500007	01.3290	18.20
450617	01.3512	17.98	450724	01.2170	18.65	460026	00.9389	17.49	490043	01.2426	17.27	500008	01.9169	20.34
450620	01.1047	08.97	450725	01.0629	17.55	460027	00.9938	16.69	490044	01.3138	15.46	500009	01.2963	19.68
450623	01.1715	16.27	450726	00.9033	11.21	460029	01.0714	16.94	490045	01.1785	16.83	500011	01.3316	18.64
450626	01.0472	14.93	450727	00.9057	08.79	460030	01.1618	19.40	490046	01.4643	16.26	500012	01.4961	18.45
450628	00.9576	11.42	450728	00.9012	15.06	460032	00.9842	15.30	490047	01.0832	14.15	500014	01.7362	20.69
450630	01.5476	23.91	450730	01.4095	19.15	460033	00.9693	20.50	490048	01.4868	15.77	500015	01.3111	20.70
450631	01.6445	16.88	450732	01.1562	16.76	460035	00.9174	14.06	490050	01.3516	19.03	500016	01.3511	20.11
450632	01.0110	09.73	450733	01.3764	16.49	460036	00.9084	17.97	490052	01.5248	14.03	500019	01.2895	18.38
450633	01.5521	17.13	450734	01.4829	15.76	460037	00.9966	15.82	490053	01.2446	12.69	500021	01.4453	18.44
450634	01.3935	20.07	450735	00.7508	10.25	460039	00.9376	19.39	490054	01.0624	16.12	500023	01.1876	17.72
450637	01.4224	18.37	450742	01.3064	20.55	460041	01.2061	17.85	490057	01.4278	15.27	500024	01.6274	20.14
450638	01.5916	21.33	450743	01.4100	18.11	460042	01.5101	14.92	490059	01.5179	16.77	500025	01.8019	20.46
450639	01.4516	19.76	450745	00.9354	17.81	460043	01.4113	19.64	490060	01.0740	17.38	500026	01.3594	20.11
450641	00.9887	10.24	450746	00.9637	12.33	460044	01.1434	18.02	490063	01.5911	21.01	500027	01.5307	20.29
450643	01.1398	16.08	450747	01.3085	15.66	460046	01.3442	10.37	490066	01.2283	16.33	500028	01.1173	13.44
450644	01.6173	20.13	450749	01.0665	12.76	460047	01.6644	17.76	490067	01.2791	13.99	500029	00.9747	11.90
450646	01.5763	18.06	450750	00.9694	10.69	460049	01.9396	.....	490069	01.4003	13.38	500030	01.3190	20.51
450647	02.0318	20.54	450751	01.2886	15.02	460050	01.1824	.....	490071	01.4828	17.01	500031	01.3011	18.25
450648	01.0958	10.99	450754	01.0756	10.22	470001	01.1496	16.20	490073	01.3416	22.26	500033	01.2637	16.60
450649	01.0262	14.87	450755	01.1690	14.46	470003	01.9350	18.36	490074	01.3089	15.43	500035	01.4790	.....
450651	01.8330	19.22	450757	00.9501	13.00	470004	01.0460	13.47	490075	01.2759	14.78	500036	01.2627	16.94
450652	00.9846	12.60	450758	01.7735	18.93	470005	01.1858	17.48	490077	01.1987	16.35	500037	01.1291	16.54
450653	01.2220	16.37	450760	01.2015	18.66	470006	01.1347	15.80	490079	01.3410	13.39	500039	01.2978	17.66
450654	00.9821	11.04	450761	01.1017	12.48	470008	01.1925	15.30	490083	00.6488	13.89	500041	01.2704	20.31
450656	01.3304	15.64	450763	01.0954	13.74	470010 ...	01.0827	16.68	490084 ...	01.1989	14.87	500042	01.3475	18.95
450658	01.0107	11.01	450765	00.9207	16.55	470011 ...	01.1194	18.12	490085	01.1299	11.80	500043	01.2060	16.80
450659 ...	01.4508	18.74	450766 ..	01.9908	20.12	470012	01.2074	16.76	490088	01.2351	13.15	500044	01.9389	19.15

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
500045	01.0739	17.28	510007	01.4253	16.00	520021	01.2976	16.83	520113	01.1966	15.62	530029	00.9396	13.04
500048	00.9015	14.27	510008	01.1004	15.33	520024	01.0624	11.87	520114	01.1532	12.45	530031	00.8892	14.78
500049	01.3088	17.10	510009	00.9448	10.45	520025	01.1292	14.34	520115	01.3112	14.47	530032	01.1716	16.33
500050	01.4153	19.09	510012	01.0852	15.18	520026	01.0666	15.67	520116	01.2580	16.13			
500051	01.6700	20.33	510013	01.1868	14.27	520027	01.1579	17.08	520117	01.0787	14.87			
500052	01.2445	.....	510015	00.9526	12.81	520028	01.3517	16.26	520118	00.9850	09.46			
500053	01.2013	17.77	510016	01.0352	.....	520029	00.9354	13.66	520120	01.0571	16.55			
500054	01.8398	19.04	510018	01.0626	13.12	520030	01.6664	17.90	520121	00.9520	13.17			
500055	01.0564	17.78	510020	01.0647	08.93	520031	01.0988	13.75	520122	00.9943	12.50			
500057	01.2990	14.98	510022	01.6791	17.21	520032	01.1448	13.19	520123	01.0391	14.99			
500058	01.5172	17.59	510023	01.0371	15.15	520033	01.2270	15.24	520124	01.1683	13.76			
500059	01.1315	18.35	510024	01.3722	16.07	520034	01.1876	16.57	520130	01.0123	11.54			
500060	01.3508	19.19	510025	00.9409	10.47	520035	01.2591	14.62	520131	01.0303	14.68			
500061	01.0280	17.95	510026	00.9766	11.32	520037	01.6237	16.75	520132	01.1527	12.68			
500062	01.0023	15.69	510027	01.0563	12.43	520038	01.3642	16.08	520134	01.0808	13.78			
500064	01.5743	19.70	510028	01.1659	15.98	520039	00.9901	15.17	520135	00.9964	12.99			
500065	01.3091	16.39	510029	01.2587	15.48	520040	01.4144	16.73	520136	01.5004	17.75			
500068	01.0220	14.82	510030	01.1214	15.72	520041	01.2094	13.13	520138	01.8435	16.70			
500069	01.0579	16.11	510031	01.3048	14.02	520042	01.1116	15.88	520139	01.2228	16.83			
500071	01.3267	18.34	510033	01.2782	13.79	520044	01.3439	15.51	520140	01.4916	17.20			
500072	01.1533	18.80	510035	00.9768	15.60	520045	01.6482	16.77	520141	01.1388	15.13			
500073	01.0024	17.71	510036	00.9688	11.73	520047	01.0145	13.50	520142	00.9936	11.46			
500074	01.1751	13.37	510038	01.0385	13.84	520048	01.3800	15.97	520144	01.0547	14.49			
500075	01.1884	18.49	510039	01.3972	14.67	520049	01.9372	15.82	520145	01.0244	14.95			
500076	01.3655	.....	510043	01.0465	10.44	520051	01.8782	17.94	520146	01.1530	12.32			
500077	01.2936	20.09	510046	01.2264	15.98	520053	01.0619	14.07	520148	01.1038	13.98			
500079	01.2919	17.92	510047	01.1688	15.81	520054	01.0483	15.31	520149	00.9350	11.73			
500080	00.8630	11.55	510048	01.0872	16.24	520056	01.3226	17.01	520151	01.1298	13.70			
500084	01.1314	17.71	510050	01.2928	14.05	520057	01.0874	14.88	520152	01.1347	15.70			
500085	01.0811	15.46	510053	01.0211	12.15	520058	01.0794	16.79	520153	00.9377	11.67			
500086	01.4095	16.28	510055	01.2080	17.17	520059	01.2532	16.21	520154	01.1102	14.96			
500088	01.2673	20.73	510058	01.2215	15.08	520060	01.2984	14.92	520156	01.0594	15.29			
500089	01.0325	13.23	510059	01.3416	12.84	520062	01.2040	14.41	520157	00.9525	12.75			
500090	00.9143	13.62	510060	01.0639	12.88	520063	01.1852	15.91	520159	00.9000	15.47			
500092	01.1567	13.51	510061	01.0469	12.53	520064	01.6371	16.58	520160	01.7820	16.13			
500094	00.9067	13.52	510062	01.2586	14.06	520066	01.2621	16.81	520161	01.0419	14.06			
500096	00.9663	16.16	510063	01.0303	11.35	520068	00.9534	14.38	520170	01.2354	17.02			
500097	01.1483	14.74	510065	00.9731	11.88	520069	01.2067	15.49	520171	01.0135	12.53			
500098	00.8540	14.51	510066	01.1099	12.88	520070	01.4192	15.29	520173	01.1181	17.29			
500101	00.9847	14.48	510067	01.1714	16.72	520071	01.1009	15.10	520174	01.4208	19.12			
500102	00.9810	14.87	510068	01.0710	14.18	520074	01.1117	14.32	520176	00.7514	14.08			
500104	01.2466	18.17	510070	01.1769	14.68	520075	01.4765	16.16	520177	01.5591	17.91			
500106	00.9946	12.54	510071	01.2708	14.60	520076	01.1048	14.78	520178	01.0843	13.06			
500107	01.1132	13.54	510072	01.0445	12.56	520077	00.9912	13.17	520180	00.9439	.....			
500108	01.6213	19.87	510076	01.0756	.....	520078	01.4344	14.81	530001	01.4675	13.50			
500110	01.2021	17.29	510077	01.1408	13.24	520082	01.2824	14.80	530002	01.2050	15.32			
500118	01.1170	18.17	510080	01.1368	10.05	520083	01.5777	19.35	530003	00.9244	08.83			
500119	01.3365	19.79	510081	00.9892	12.93	520084	01.0838	15.01	530004	00.9650	12.56			
500122	01.2708	17.54	510082	01.0716	10.95	520087	01.5714	15.92	530005	01.0990	12.06			
500123	00.9911	13.48	510084	00.9836	11.33	520088	01.2573	16.27	530006	01.1693	14.95			
500124	01.2764	19.76	510085	01.2709	17.35	520089	01.5028	17.22	530007	01.0343	11.54			
500125	00.9832	11.02	510086	01.0198	12.23	520090	01.1701	14.69	530008	01.1909	16.73			
500127	00.5986	14.25	520002	01.2827	15.62	520091	01.2712	15.62	530009	01.0331	14.78			
500129	01.6511	19.35	520003	01.1234	13.96	520092	01.1129	15.12	530010	01.2984	15.83			
500132	00.9546	15.33	520004	01.2040	15.11	520094	01.0910	15.78	530011	01.1439	14.63			
500134	00.7355	16.03	520006	01.0371	15.92	520095	01.3730	16.94	530012	01.6806	15.32			
500137	00.6377	16.87	520007	01.0579	12.43	520096	01.5478	15.50	530014	01.2753	13.81			
500138	12.2535	.....	520008	01.4766	17.90	520097	01.2842	16.40	530015	01.1417	15.80			
500139	01.4098	21.58	520009	01.6330	16.23	520098	01.7821	18.16	530016	01.2002	11.83			
500140	00.9994	14.50	520010	01.1200	16.81	520100	01.2514	14.46	530017	00.9299	13.78			
500141	01.2988	19.75	520011	01.1716	16.58	520101	01.1180	14.26	530018	01.0214	13.10			
500143	00.9927	17.55	520013	01.3297	16.24	520102	01.2045	16.89	530019	00.9986	15.03			
500898	00.7881	.....	520014	01.2288	14.17	520103	01.2815	16.41	530022	01.1653	15.74			
510001	01.6367	15.70	520015	01.1841	15.42	520107	01.2815	15.17	530023	01.0026	15.88			
510002	01.3716	16.27	520016	01.1230	12.12	520109	01.0395	14.86	530024	01.0512	12.11			
510004	00.9755	10.17	520017	01.2054	15.10	520110	01.0918	15.27	530025	01.2808	16.17			
510005	00.9400	13.48	520018	01.0639	14.58	520111	01.0981	12.09	530026	01.1212	13.08			
510006	01.2072	16.70	520019	01.2859	14.27	520112	01.1606	16.29	530027	00.9446	09.41			

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
NOTE: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1994.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (Constituent counties or county equivalents)	Wage index	GAF
0040 Abilene, TX	0.8892	0.9227
Taylor, TX		
0060 Aguadilla, PR	0.4758	0.6013
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9651	0.9760
Portage, OH		
Summit, OH		
0120 Albany, GA	0.8821	0.9177
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8871	0.9212
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9300	0.9515
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8302	0.8804
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0114	1.0078
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9203	0.9447
Blair, PA		
0320 Amarillo, TX	0.8582	0.9006
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3228	1.2112
Anchorage, AK		
0440 Ann Arbor, MI	1.2593	1.1710
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.7959	0.8553
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8842	0.9192
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.3798	0.5153
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9171	0.9425
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9052	0.9341
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 *Atlanta, GA	1.0261	1.0178
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		
0560 Atlantic City-Cape May, NJ	1.0878	1.0593
Atlantic City, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA-SC	0.8638	0.9046
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 Austin-San Marcos, TX	0.9113	0.9384
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA	1.0883	1.0597
Kern, CA		
0720 *Baltimore, MD	0.9866	0.9908
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Annes, MD		
0733 Bangor, ME	0.9489	0.9647
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3813	1.2476
Barnstable, MA		
0760 Baton Rouge, LA	0.8617	0.9031
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8648	0.9053
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1232	1.0828
Whatcom, WA		
0870 Benton Harbor, MI	0.8172	0.8709
Berrien, MI		
0875 *Bergen-Passaic, NJ	1.1494	1.1000
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.8718	0.9103
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8245	0.8762
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.9183	0.9433
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.8832	0.9185
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8616	0.9030
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8529	0.8968
Monroe, IN		
1040 Bloomington-Normal, IL	0.8463	0.8920
McLean, IL		
1080 Boise City, ID	0.9032	0.9327
Ada, ID		
Canyon, ID		
1123 *Boston-Brockton-Nashua, MA-NH	1.1733	1.1157
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.7979	0.8568
Boulder, CO		
1145 Brazoria, TX	0.8263	0.8775
Brazoria, TX		
1150 Bremerton, WA	0.9647	0.9757
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8218	0.8742
Cameron, TX		
1260 Bryan-College Station, TX	0.8673	0.9071
Brazos, TX		
1280 *Buffalo-Niagara Falls, NY	0.9183	0.9433
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9939	0.9958

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4373	0.5676
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8731	0.9113
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.8444	0.8906
Natrona, WY		
1360 Cedar Rapids, IA	0.8457	0.8916
Linn, IA		
1400 Champaign-Urbana, IL	0.8848	0.9196
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8845	0.9194
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9022	0.9319
Kanawha, WV		
Putnam, WV		
1520 *Charlotte-Gastonia-Rock Hill, NC-SC	0.9598	0.9723
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	0.9360	0.9557
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.8959	0.9275
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 Cheyenne, WY	0.7478	0.8195
Laramie, WY		
1600 *Chicago, IL	1.0666	1.0451
Cook, IL		
De Kalb, IL		
Du Page, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0434	1.0295
Butte, CA		
1640 *Cincinnati, OH-KY-IN	0.9451	0.9621
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN-KY	0.7515	0.8223
Christian, KY		
Montgomery, TN		
1680 *Cleveland-Lorain-Elyria, OH	0.9824	0.9879
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9194	0.9441
El Paso, CO		
1740 Columbia, MO	0.9212	0.9453
Boone, MO		
1760 Columbia, SC	0.8989	0.9296
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.7762	0.8407
Russell, AL		
Chattanoochee, GA		
Harris, GA		
Muscogee, GA		
1840 *Columbus, OH	0.9760	0.9835
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8372	0.8854
Nueces, TX		
San Patricio, TX		
1900 Cumberland, MD-WV	0.8165	0.8704
Allegany, MD		
Mineral, WV		
1920 *Dallas, TX	0.9521	0.9669
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8093	0.8651
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Rock Island-Moline, IA-IL	0.8226	0.8748
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9195	0.9441
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.8605	0.9022
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8074	0.8637
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.7913	0.8519
Macon, IL		
2080 *Denver, CO	1.0611	1.0414
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8669	0.9068
Dallas, IA		
Polk, IA		
Warren, IA		
2160 *Detroit, MI	1.0916	1.0619
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7974	0.8564
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9103	0.9377
Kent, DE		
2200 Dubuque, IA	0.7803	0.8438
Dubuque, IA		
2240 Duluth-Superior, MN-WI	0.9262	0.9489
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0696	1.0472
Dutchess, NY		
2290 Eau Claire, WI	0.8477	0.8930
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.8618	0.9032
El Paso, TX		
2330 Elkhart-Goshen, IN	0.8698	0.9089
Elkhart, IN		
2335 Elmira, NY	0.8648	0.9053
Chemung, NY		
2340 Enid, OK	0.8213	0.8739
Garfield, OK		
2360 Erie, PA	0.8959	0.9275

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Erie, PA		
2400 Eugene-Springfield, OR	1.0585	1.0397
Lane, OR		
2440 Evansville-Henderson, IN-KY	0.9031	0.9326
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND-MN	0.9217	0.9457
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8655	0.9058
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.6933	0.7781
Benton, AR		
Washington, AR		
2640 Flint, MI	1.0252	1.0172
Genesee, MI		
2650 Florence, AL	0.7880	0.8495
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8620	0.9033
Florence, SC		
2670 Fort Collins-Loveland, CO	0.9817	0.9874
Larimer, CO		
2680 *Ft. Lauderdale, FL	1.0615	1.0417
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9619	0.9737
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0107	1.0073
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR-OK	0.7868	0.8486
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.8897	0.9231
Okaloosa, FL		
2760 Fort Wayne, IN	0.8759	0.9133
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 *Forth Worth-Arlington, TX	0.9741	0.9822
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0340	1.0232
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8082	0.8643
Etowah, AL		
2900 Gainesville, FL	0.8852	0.9199
Alachua, FL		
2920 Galveston-Texas City, TX	1.0089	1.0061
Galveston, TX		
2960 Gary, IN	0.9334	0.9539
Lake, IN		
Porter, IN		
2975 Glens Falls, NY	0.9273	0.9496
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8453	0.8913
Wayne, NC		
2985 Grand Forks, ND-MN	0.9109	0.9381
Polk, MN		
Grand Forks, ND		
3000 Grand Rapids-Muskegon-Holland, MI	0.9823	0.9878
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.8980	0.9290
Cascade, MT		
3060 Greeley, CO	0.9296	0.9512
Weld, CO		
3080 Green Bay, WI	0.8817	0.9174
Brown, WI		
3120 *Greensboro-Winston-Salem-High. Point, NC	0.9165	0.9420
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.8948	0.9267
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.8883	0.9221
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.8947	0.9266
Washington, MD		
3200 Hamilton-Middletown, OH	0.8238	0.8757
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9629	0.9744
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 *Hartford, CT	1.2382	1.1576
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS	0.6577	0.7506
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton, NC	0.7828	0.8456
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1683	1.1124
Honolulu, HI		
3350 Houma, LA	0.7769	0.8412
Lafourche, LA		
Terrebonne, LA		
3360 *Houston, TX	0.9906	0.9936
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.8983	0.9292
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8142	0.8687
Limestone, AL		
Madison, AL		
3480 *Indianapolis, IN	0.9898	0.9930
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9059	0.9346
Johnson, IA		
3520 Jackson, MI	0.9176	0.9428
Jackson, MI		
3560 Jackson, MS	0.7551	0.8250
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8122	0.8672
Madison, TN		
3600 Jacksonville, FL	0.9019	0.9317
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC	0.7197	0.7983
Onslow, NC		
3610 Jamestown, NY	0.7531	0.8235

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Chautaqua, NY		
3620 Janesville-Beloit, WI	0.8541	0.8976
Rock, WI		
3640 Jersey City, NJ	1.1114	1.0750
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8621	0.9034
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA	0.8615	0.9029
Cambria, PA		
Somerset, PA		
3710 Joplin, MO	0.7797	0.8433
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0471	1.0320
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9381	0.9572
Kankakee, IL		
3760 *Kansas City, KS-MO	0.9473	0.9636
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.8809	0.9168
Kenosha, WI		
3810 Killeen-Temple, TX	1.0321	1.0219
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8572	0.8999
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9060	0.9346
Howard, IN		
Tipton, IN		
3870 La Crosse, WI-MN	0.8514	0.8957
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.7975	0.8565
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8310	0.8809
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.8237	0.8756
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8570	0.8997
Polk, FL		
4000 Lancaster, PA	0.9345	0.9547
Lancaster, PA		
4040 Lansing-East Lansing, MI	1.0025	1.0017
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.6967	0.7808
Webb, TX		
4100 Las Cruces, NM	0.8797	0.9160
Dona Ana, NM		
4120 Las Vegas, NV-AZ	1.1034	1.0697
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8554	0.8986
Douglas, KS		
4200 Lawton, OK	0.8494	0.8942
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9698	0.9792
Androscoggin, ME		
4280 Lexington, KY	0.8433	0.8898
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.8664	0.9065
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.8986	0.9294
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8323	0.8819
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8803	0.9164
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 *Los Angeles-Long Beach, CA	1.2517	1.1662
Los Angeles, CA		
4520 Louisville, KY-IN	0.9485	0.9644
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8644	0.9050
Lubbock, TX		
4640 Lynchburg, VA	0.8310	0.8809
Amherst, VA		
Bedford City, VA		
Bedford, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.9054	0.9342
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	0.9910	0.9938
Dane, WI		
4800 Mansfield, OH	0.8201	0.8730
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4533	0.5817
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8023	0.8600
Hidalgo, TX		
4890 Medford-Ashland, OR	0.9917	0.9943
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay Fl	0.8953	0.9271
Brevard, Fl		
4920 *Memphis, TN-AR-MS	0.8508	0.8953
Crittenden, AR		
De Soto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0207	1.0141
Merced, CA		
5000 *Miami, FL	0.8570	0.8997
Dade, FL		
5015 *Middlesex-Somerset-Hunterdon, NJ	1.1008	1.0680
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 *Milwaukee-Waukesha, WI	0.9326	0.9533
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 *Minneapolis-St Paul, MN-WI	1.0844	1.0571

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5160 Mobile, AL	0.7603	0.8289
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.1348	1.0905
Stanislaus, CA		
5190 *Monmouth-Ocean, NJ	1.0834	1.0564
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.7723	0.8378
Ouachita, LA		
5240 Montgomery, AL	0.8045	0.8616
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9501	0.9656
Delaware, IN		
5330 Myrtle Beach, SC	0.7951	0.8547
Horry, SC		
5345 Naples, FL	0.9727	0.9812
Collier, FL		
5360 *Nashville, TN	0.9312	0.9524
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 *Nassau-Suffolk, NY	1.3069	1.2012
Nassau, NY		
Suffolk, NY		
5483 *New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT	1.2281	1.1511
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2020	1.1343
New London, CT		
5560 *New Orleans, LA	0.9499	0.9654
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 *New York, NY	1.4132	1.2672
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 *Newark, NJ	1.1128	1.0759
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	0.8737	0.9117
Orange, NY		
Pike, PA		
5720 *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		
5775 *Oakland, CA	1.4658	1.2994
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.8781	0.9148
Marion, FL		
5800 Odessa-Midland, TX	0.8399	0.8874
Ector, TX		
Midland, TX		
5880 Oklahoma City, OK	0.8460	0.8918
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.1129	1.0760
Thurston, WA		
5920 Omaha, NE-IA	0.9796	0.9860
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 *Orange County, CA	1.0005	1.0003
Orange, CA		
5960 *Orlando, FL	0.9443	0.9615
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.7842	0.8466
Daviess, KY		
6015 Panama City, FL	0.7538	0.8240
Bay, FL		
6020 Parkersburg-Marietta, WV-OH	0.7963	0.8556
Washington, OH		
Wood, WV		
6080 Pensacola, FL	0.8232	0.8753
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8436	0.8901
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 *Philadelphia, PA-NJ	1.1129	1.0760
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 *Phoenix-Mesa, AZ	1.0077	1.0053
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.8604	0.9022
Jefferson, AR		
6280 *Pittsburgh, PA	0.9825	0.9880
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA	1.1313	1.0882
Berkshire, MA		
6360 Ponce, PR	0.4518	0.5804
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9448	0.9619

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 *Portland-Vancouver, OR-WA	1.1181	1.0794
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 *Providence-Warwick, RI	1.1136	1.0765
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9957	0.9971
Utah, UT		
6560 Pueblo, CO	0.8014	0.8593
Pueblo, CO		
6580 Punta Gorda, FL	0.8677	0.9074
Charlotte, FL		
6600 Racine, WI	0.8328	0.8822
Racine, WI		
6640 Raleigh-Durham-Chapel Hill, NC	0.9625	0.9742
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8110	0.8664
Pennington, SD		
6680 Reading, PA	0.9158	0.9415
Berks, PA		
6690 Redding, CA	1.1310	1.0880
Shasta, CA		
6720 Reno, NV	1.1080	1.0728
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	0.9648	0.9758
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9291	0.9509
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		
6780 *Riverside-San Bernardino, CA	1.1660	1.1109
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8364	0.8848
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.0516	1.0351
Olmsted, MN		
6840 *Rochester, NY	0.9808	0.9868
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8670	0.9069
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8606	0.9023
Edgecombe, NC		
Nash, NC		
6920 *Sacramento, CA	1.2292	1.1518
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9376	0.9568
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9549	0.9689
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8602	0.9020
Andrews, MO		
Buchanan, MO		
7040 *St. Louis, MO-IL	0.9110	0.9382
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		
7080 Salem, OR	0.9552	0.9691
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.3750	1.2437
Monterey, CA		
7160 *Salt Lake City-Ogden, UT	0.9542	0.9684
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7132	0.7934
Tom Green, TX		
7240 *San Antonio, TX	0.8266	0.8777
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 *San Diego, CA	1.2060	1.1369
San Diego, CA		
7360 *San Francisco, CA	1.4120	1.2665
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 *San Jose, CA	1.4272	1.2758
Santa Clara, CA		
7440 *San Juan-Bayamon, PR	0.4367	0.5670
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		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.2413	1.1595
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.1515	1.1014
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.0005	1.0003
Santa Cruz, CA		
7490 Santa Fe, NM	1.0782	1.0529
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3021	1.1981
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9701	0.9794
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9447	0.9618

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8638	0.9046
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 *Seattle-Bellevue-Everett, WA	1.1018	1.0686
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA	0.8925	0.9251
Mercer, PA		
7620 Sheboygan, WI	0.8046	0.8617
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8836	0.9187
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9036	0.9329
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.8492	0.8941
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8658	0.9060
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9621	0.9739
St. Joseph, IN		
7840 Spokane, WA	1.0505	1.0343
Spokane, WA		
7880 Springfield, IL	0.8725	0.9108
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.7887	0.8500
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA	1.0560	1.0380
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9903	0.9933
Centre, PA		
8080 Steubenville-Weirton, OH-WV	0.8367	0.8851
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.1450	1.0972
San Joaquin, CA		
8140 Sumter, SC	0.8016	0.8595
Sumter, SC		
8160 Syracuse, NY	0.9733	0.9816
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	0.9647	0.9757
Pierce, WA		
8240 Tallahassee, FL	0.8411	0.8883
Gadsden, FL		
Leon, FL		
8280 *Tampa-St. Petersburg-Clearwater, FL	0.9402	0.9587
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8593	0.9014
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8091	0.8650
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9954	0.9968
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9884	0.9920
Shawnee, KS		
8480 Trenton, NJ	1.0251	1.0171
Mercer, NJ		
8520 Tucson, AZ	0.9393	0.9580
Pima, AZ		
8560 Tulsa, OK	0.8223	0.8746
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8167	0.8705
Tuscaloosa, AL		
8640 Tyler, TX	0.9650	0.9759
Smith, TX		
8680 Utica-Rome, NY	0.8516	0.8958
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.2534	1.1673
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0005	1.0003
Ventura, CA		
8750 Victoria, TX	0.8703	0.9093
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0294	1.0200
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0300	1.0204
Tulare, CA		
8800 Waco, TX	0.8029	0.8604
McLennan, TX		
8840 *Washington, DC-MD-VA-WV	1.1096	1.0738
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		
8920 Waterloo-Cedar Falls, IA	0.8643	0.9050
Black Hawk, IA		
8940 Wausau, WI	0.9802	0.9864
Marathon, WI		
8960 West Palm Beach-Boca Raton, FL	1.0005	1.0003
Palm Beach, FL		
9000 Wheeling, OH-WV	0.7662	0.8333
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9987	0.9991
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7906	0.8514
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8425	0.8893
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.0716	1.0485
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9138	0.9401
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	0.9541	0.9665
Yakima, WA		
9270 Yolo, CA	1.1844	1.1229
Yolo, CA		
9280 York, PA	0.9003	0.9306
York, PA		
9320 Youngstown-Warren, OH	0.9422	0.9600

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index	GAF
Columbiana, OH Mahoning, OH Trumbull, OH		
9340 Yuba City, CA ... Sutter, CA Yuba, CA	1.0192	1.0131
9360 Yuma, AZ ..... Yuma, AZ	0.8675	0.9072

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7009	0.7840
Alaska	1.2592	1.1710
Arizona	0.8278	0.8786
Arkansas	0.6848	0.7716
California	1.0005	1.0003
Colorado	0.7979	0.8568
Connecticut	1.2234	1.1481
Delaware	0.8430	0.8896
Florida	0.8570	0.8997
Georgia	0.7564	0.8260
Hawaii	0.9521	0.9669
Idaho	0.8380	0.8860
Illinois	0.7364	0.8110
Indiana	0.7948	0.8545
Iowa	0.7270	0.8039
Kansas	0.7270	0.8039
Kentucky	0.7487	0.8202
Louisiana	0.7358	0.8105
Maine	0.8414	0.8885
Maryland	0.8500	0.8947
Massachusetts	1.0744	1.0504
Michigan	0.8695	0.9087
Minnesota	0.8129	0.8677
Mississippi	0.6577	0.7506
Missouri	0.7291	0.8054
Montana	0.8146	0.8690
Nebraska	0.7282	0.8048
Nevada	0.9078	0.9359
New Hampshire	0.9766	0.9839
New Jersey [1].		
New Mexico	0.8071	0.8635
New York	0.8737	0.9117
North Carolina	0.7828	0.8456
North Dakota	0.7347	0.8097
Ohio	0.8238	0.8757
Oklahoma	0.6842	0.7711
Oregon	0.9227	0.9464
Pennsylvania	0.8588	0.9010
Puerto Rico	0.4364	0.5668
Rhode Island [1].		
South Carolina	0.7645	0.8320
South Dakota	0.6953	0.7797
Tennessee	0.7435	0.8163
Texas	0.7510	0.8219
Utah	0.8867	0.9210
Vermont	0.9158	0.9415
Virginia	0.7807	0.8441
Washington	0.9647	0.9757
West Virginia	0.8120	0.8671

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Wisconsin	0.8328	0.8822
Wyoming	0.7977	0.8566

[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	0.9300	0.9515
Alexandria, LA	0.8302	0.8804
Amarillo, TX	0.8582	0.9006
Anchorage, AK	1.3228	1.2112
Appleton-Oshkosh-Neenah, WI	0.8842	0.9192
Asheville, NC	0.9171	0.9425
Atlanta, GA	1.0261	1.0178
Baton Rouge, LA	0.8617	0.9031
Benton Harbor, MI	0.8172	0.8709
Benton Harbor, MI (Rural Michigan Hosp.)	0.8695	0.9087
Bergen-Passaic, NJ	1.1494	1.1000
Biloxi-Gulfport-Pascagoula, MS	0.7954	0.8549
Birmingham, AL	0.8832	0.9185
Bismarck, ND	0.8616	0.9030
Boise City, ID	0.9032	0.9327
Boston-Brockton-Nashua, MA-NH	1.1733	1.1157
Brazoria, TX	0.8263	0.8775
Bremerton, WA	0.8591	0.9012
Bremerton, WA (Rural Wahington Hosp.)	0.9647	0.9757
Bryan-College Station, TX	0.8673	0.9071
Casper, WY	0.8444	0.8906
Charlotte-Gastonia-Rock Hill, NC-SC	0.9598	0.9723
Charlottesville, VA	0.9201	0.9446
Chattanooga, TN-GA	0.8959	0.9275
Chicago, IL	1.0666	1.0451
Cincinnati, OH-KY-IN	0.9451	0.9621
Cleveland-Lorain-Elyria, OH	0.9824	0.9879
Columbia, MO	0.9076	0.9358
Columbus, GA-AL	0.7762	0.8407
Columbus, OH	0.9760	0.9835
Cumberland, MD-WV	0.8165	0.8704
Dallas, TX	0.9521	0.9669
Davenport-Rock Island-Moline, IA-IL	0.8226	0.8748
Dayton-Springfield, OH .	0.9195	0.9441
Denver, CO	1.0611	1.0414
Des Moines, IA	0.8533	0.8971
Detroit, MI	1.0916	1.0619
Dothan, AL	0.7974	0.8564
Duluth-Superior, MN-WI	0.9262	0.9489
Dutchess County, NY ...	1.0539	1.0366
Eau Claire, WI	0.8477	0.8930
El Paso, TX	0.8618	0.9032
Eugene-Springfield, OR	1.0585	1.0397

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to...	Wage index	GAF
Fargo-Moorhead, ND-MN	0.9051	0.9340
Fayetteville, NC	0.8385	0.8864
Flint, MI	1.0252	1.0172
Florence, AL	0.7880	0.8495
Florence, SC	0.8620	0.9033
Fort Lauderdale, FL	1.0370	1.0252
Fort Pierce-Port St. Lucie, FL	1.0107	1.0073
Fort Smith, AR-OK	0.7868	0.8486
Fort Walton Beach, FL .	0.8744	0.9122
Fort Wayne, IN	0.8759	0.9133
Fort Worth-Arlington, TX	0.9741	0.9822
Gadsden, AL	0.8082	0.8643
Gainesville, FL	0.8852	0.9199
Glens Falls, NY	0.9273	0.9496
Grand Forks, ND-MN	0.9109	0.9381
Great Falls, MT	0.8980	0.9290
Greeley, CO	0.9125	0.9392
Greenville-Spartanburg-Anderson, SC	0.8883	0.9221
Harrisburg-Lebanon-Carlisle, PA	0.9629	0.9744
Hartford, CT	1.2226	1.1476
Houston, TX	0.9906	0.9936
Huntington-Ashland, WV-KY-OH	0.8983	0.9292
Huntsville, AL	0.7942	0.8540
Indianapolis, IN	0.9898	0.9930
Jackson, MS	0.7551	0.8250
Jackson, TN	0.8122	0.8672
Johnson City-Kingsport-Bristol, TN-VA	0.8621	0.9034
Joplin, MO	0.7797	0.8433
Kalamazoo-Battlecreek, MI	1.0471	1.0320
Kansas City, KS-MO	0.9473	0.9636
Knoxville, TN	0.8572	0.8999
Lafayette, LA	0.7975	0.8565
Lansing-East Lansing, MI	1.0025	1.0017
Las Cruces, NM	0.8797	0.9160
Las Vegas, NV-AZ	1.1034	1.0697
Lexington, KY	0.8433	0.8898
Lima, OH	0.8664	0.9065
Lincoln, NE	0.8765	0.9137
Little Rock-North Little Rock, AR	0.8323	0.8819
Longview-Marshall, TX .	0.8586	0.9009
Los Angeles-Long Beach, CA	1.2517	1.1662
Louisville, KY-IN	0.9485	0.9644
Lubbock, TX	0.8644	0.9050
Macon, GA	0.8647	0.9052
Madison, WI	0.9910	0.9938
Mansfield, OH	0.8201	0.8730
Mansfield, OH (Rural Ohio only)	0.8238	0.8757
Medford-Ashland, OR ...	0.9917	0.9943
Memphis, TN-AR-MS	0.8386	0.8864
Merced, CA	1.0207	1.0141
Middlesex-Somerset-Hunterdon, NJ	1.0770	1.0521
Milwaukee-Waukesha, WI	0.9326	0.9533
Minneapolis-St. Paul, MN-WI	1.0844	1.0571

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to...	Wage index	GAF
Modesto, CA	1.1348	1.0905
Monroe, LA	0.7723	0.8378
Montgomery, AL	0.8045	0.8616
Nashville, TN	0.9176	0.9428
New London-Norwich, CT	1.2020	1.1343
New Orleans, LA	0.9499	0.9654
New York, NY	1.4132	1.2672
Newark, NJ	1.0848	1.0573
Newburgh, NY-PA	0.9454	0.9623
Oakland, CA	1.4658	1.2994
Oklahoma City, OK	0.8460	0.8918
Omaha, NE-IA	0.9796	0.9860
Orange County, CA	1.5215	1.3330
Peoria-Pekin, IL	0.8436	0.8901
Philadelphia, PA-NJ	1.1129	1.0760
Pittsburgh, PA	0.9825	0.9880
Portland-Vancouver, OR-WA	1.1181	1.0794
Provo-Orem, UT	0.9601	0.9725
Raleigh-Durham-Chapel Hill, NC	0.9625	0.9742
Roanoke, VA	0.8364	0.8848
Rochester, MN	1.0376	1.0256
Rockford, IL	0.8670	0.9069
Rocky Mount, NC	0.8606	0.9023
Saginaw-Bay City-Midland, MI	0.9376	0.9568
St. Cloud, MN	0.9549	0.9689
St. Louis, MO-IL	0.9110	0.9382
Salem, OR	0.9552	0.9691
Salt Lake City-Ogden, UT	0.9542	0.9684
San Francisco, CA	1.4120	1.2665
San Jose, CA	1.4272	1.2758
Sarasota-Bradenton, FL	0.9701	0.9794
Scranton-Wilkes-Barre-Hazelton, PA	0.8638	0.9046
Seattle-Bellevue-Everett, WA	1.0826	1.0559
Sherman-Denison, TX	0.8836	0.9187
Sioux City, IA-NE	0.8340	0.8831
Sioux Falls, SD	0.8658	0.9060
South Bend, IN	0.9621	0.9739
Springfield, IL	0.8725	0.9108
Syracuse, NY	0.9733	0.9816
Tampa-St. Petersburg-Clearwater, FL	0.9402	0.9587
Texarkana, TX-Texarkana, AR	0.8091	0.8650
Topeka, KS	0.9884	0.9920
Trenton, NJ	1.2495	1.1648
Tucson, AZ	0.9393	0.9580
Tulsa, OK	0.8223	0.8746
Tyler, TX	0.9245	0.9477
Ventura, CA	1.2807	1.1846
Waco, TX	0.8029	0.8604
Washington, DC-MD-VA-WV	1.1096	1.0738
Waterloo-Cedar Falls, IA	0.8643	0.9050
Wausau, WI	0.9385	0.9575
Wichita, KS	0.9694	0.9789
Rural Alabama	0.7009	0.7840
Rural Louisiana	0.7358	0.8105
Rural Missouri	0.7291	0.8054
Rural New Hampshire	0.9766	0.9839
Rural Ohio	0.8238	0.8757
Rural Virginia	0.7807	0.8441
Rural West Virginia	0.8120	0.8671
Rural Wyoming	0.7977	0.8566

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to...	Wage index	GAF
Rural Ohio	0.8238	0.8757
Rural Virginia	0.7807	0.8441
Rural West Virginia	0.8120	0.8671
Rural Wyoming	0.7977	0.8566

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	16.2390
Aguadilla, PR	8.6888
Akron, OH	17.2298
Albany, GA	16.1099
Albany-Schenectady-Troy, NY	16.1998
Albuquerque, NM	16.9834
Alexandria, LA	15.1620
Allentown-Bethlehem-Easton, PA-NJ	18.4715
Altoona, PA	16.8070
Amarillo, TX	15.6736
Anchorage, AK	24.0896
Ann Arbor, MI	22.9974
Anniston, AL	14.5345
Appleton-Oshkosh-Neenah, WI	16.1474
Arecibo, PR	6.9358
Asheville, NC	16.7477
Athens, GA	16.5317
Atlanta, GA	18.7400
Atlantic City-Cape May, NJ	19.8657
Augusta-Aiken, GA-SC	15.7746
Austin-San Marcos, TX	16.6425
Bakersfield, CA	19.8748
Baltimore, MD	18.0181
Bangor, ME	17.3289
Barnstable-Yarmouth, MA	25.2260
Baton Rouge, LA	15.7376
Beaumont-Port Arthur, TX	15.7934
Bellingham, WA	20.5119
Benton Harbor, MI	14.8759
Bergen-Passaic, NJ	21.0835
Billings, MT	15.9221
Biloxi-Gulfport-Pascagoula, MS	15.0572
Binghamton, NY	16.7713
Birmingham, AL	16.1296
Bismarck, ND	15.7353
Bloomington, IN	15.5760
Bloomington-Normal, IL	15.4563
Boise City, ID	16.4944
Boston-Brockton-Nashua, MA-NH	21.4264
Boulder-Longmont, CO	17.9719
Brazoria, TX	15.9482
Bremerton, WA	17.6611
Brownsville-Harlingen-San Benito, TX	15.0080
Bryan-College Station, TX	15.8389
Buffalo-Niagara Falls, NY	16.7713
Burlington, VT	18.1518
Caguas, PR	7.9854
Canton-Massillon, OH	15.9456
Casper, WY	15.3186
Cedar Rapids, IA	15.4439
Champaign-Urbana, IL	16.1590
Charleston-North Charleston, SC	16.1537
Charleston, WV	16.4759

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Charlotte-Gastonia-Rock Hill, NC-SC	17.4798
Charlottesville, VA	17.0943
Chattanooga, TN-GA	16.3611
Cheyenne, WY	13.6561
Chicago, IL	19.4782
Chico-Paradise, CA	19.0544
Cincinnati, OH-KY-IN	17.2605
Clarksville-Hopkinsville, TN-KY	13.7237
Cleveland-Lorain-Elyria, OH	17.9419
Colorado Springs, CO	16.7908
Columbia, MO	16.8243
Columbia, SC	16.4154
Columbus, GA-AL	14.1755
Columbus, OH	17.8234
Corpus Christi, TX	15.2899
Cumberland, MD-WV	14.7426
Dallas, TX	17.3874
Danville, VA	14.7798
Davenport-Moline-Rock Island, IA-IL	15.0227
Dayton-Springfield, OH	17.1168
Daytona Beach, FL	15.7149
Decatur, AL	14.7445
Decatur, IL	14.4506
Denver, CO	19.3789
Des Moines, IA	15.8324
Detroit, MI	19.9346
Dothan, AL	14.5621
Dover, DE	16.6236
Dubuque, IA	14.2498
Duluth-Superior, MN-WI	16.8727
Dutchess County, NY	19.5331
Eau Claire, WI	15.3631
El Paso, TX	15.7386
Elkhart-Goshen, IN	15.8850
Elmira, NY	15.7932
Enid, OK	14.9984
Erie, PA	16.3613
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	12.6619
Flint, MI	18.8129
Florence, AL	13.9337
Florence, SC	15.7220
Fort Collins-Loveland, CO	17.9280
Fort Lauderdale, FL	19.3863
Fort Myers-Cape Coral, FL	17.5672
Fort Pierce-Fort St. Lucie, FL	18.2169
Fort Smith, AR-OK	14.3610
Fort Walton Beach, FL	16.2490
Fort Wayne, IN	15.9958
Fort Worth-Arlington, TX	17.7622
Fresno, CA	18.8835
Gadsden, AL	14.7595
Gainesville, FL	16.1250
Galveston-Texas City, TX	18.5274
Gary, IN	17.6879
Glens Falls, NY	16.6860
Goldsboro, NC	15.4377
Grand Forks, ND-MN	16.5506
Grand Rapids-Muskegon-Holland, MI	17.9395
Great Falls, MT	15.7811
Greeley, CO	16.9775
Green Bay, WI	16.1023

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Greensboro-Winston-Salem-High Point, NC	16.7379
Greenville, NC	16.3414
Greenville-Spartanburg-Anderson, SC	16.2233
Hagerstown, MD	16.3387
Hamilton-Middletown, OH	16.0265
Harrisburg-Lebanon-Carlisle, PA	17.5548
Hartford, CT	22.6120
Hattiesburg, MS	13.1174
Hickory-Morganton, NC	15.9128
Honolulu, HI	21.3363
Houma, LA	14.1874
Houston, TX	18.0712
Huntington-Ashland, WV-KY-OH	16.4056
Huntsville, AL	14.8690
Indianapolis, IN	18.0754
Iowa City, IA	16.5438
Jackson, MI	16.7570
Jackson, MS	13.6437
Jackson, TN	14.8324
Jacksonville, FL	16.4719
Jacksonville, NC	13.1433
Jamestown, NY	13.7544
Janesville-Beloit, WI	15.5973
Jersey City, NJ	20.2964
Johnson City-Kingsport-Bristol, TN-VA	15.7450
Johnstown, PA	15.7335
Joplin, MO	14.1549
Kalamazoo-Battle Creek, MI	19.1226
Kankakee, IL	17.1314
Kansas City, KS-MO	17.3002
Kenosha, WI	16.0882
Killeen-Temple, TX	18.8494
Knoxville, TN	15.6535
Kokomo, IN	16.5463
LaCrosse, WI-MN	15.5484
Lafayette, LA	14.4264
Lafayette, IN	15.1766
Lake Charles, LA	15.0433
Lakeland-Winter Haven, FL	15.7741
Lancaster, PA	17.0658
Lansing-East Lansing, MI	18.3091
Laredo, TX	12.7235
Las Cruces, NM	16.0660
Las Vegas, NV-AZ	20.1498
Lawrence, KS	15.6222
Lawton, OK	15.5118
Lewiston-Auburn, ME	17.7114
Lexington, KY	15.3464
Lima, OH	15.8233
Lincoln, NE	16.4101
Little Rock-North Little Rock, AR	15.2008
Longview-Marshall, TX	16.0767
Los Angeles-Long Beach, CA	22.8625
Louisville, KY-IN	17.3214
Lubbock, TX	15.7866
Lynchburg, VA	15.1754
Macon, GA	16.5340
Madison, WI	18.0981
Mansfield, OH	14.9778
Mayaguez, PR	8.2780
McAllen-Edinburg-Mission, TX	14.6517
Medford-Ashland, OR	17.6815
Melbourne-Titusville-Palm Bay, FL	16.3510
Memphis, TN-AR-MS	15.5377
Merced, CA	17.9988
Miami, FL	18.6138

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Middlesex-Somerset-Hunterdon, NJ	19.4924
Milwaukee-Waukesha, WI	17.0313
Minneapolis-St. Paul, MN-WI	19.8042
Mobile, AL	14.0947
Modesto, CA	20.7245
Monmouth-Ocean, NJ	19.7865
Monroe, LA	13.9777
Montgomery, AL	14.6928
Muncie, IN	17.3507
Myrtle Beach, SC	14.5213
Naples, FL	17.7633
Nashville, TN	17.0052
Nassau-Suffolk, NY	25.0266
New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT	22.7334
New London-Norwich, CT	21.7403
New Orleans, LA	17.3485
New York, NY	25.6680
Newark, NJ	21.9178
Newburgh, NY-PA	18.6175
Norfolk-Virginia Beach-Newport News, VA-NC	15.1815
Oakland, CA	26.7287
Ocala, FL	16.0357
Odessa-Midland, TX	15.3382
Oklahoma City, OK	15.4498
Olympia, WA	20.3246
Omaha, NE-IA	17.8896
Orange County, CA	22.4725
Orlando, FL	17.2448
Owensboro, KY	14.3219
Panama City, FL	13.7657
Parkersburg-Marietta, WV-OH	14.5430
Pensacola, FL	15.0335
Peoria-Pekin, IL	15.4069
Philadelphia, PA-NJ	20.3573
Phoenix-Mesa, AZ	18.4023
Pine Bluff, AR	15.7140
Pittsburgh, PA	17.9430
Pittsfield, MA	20.6597
Ponce, PR	8.2504
Portland, ME	17.3007
Portland-Vancouver, OR-WA	20.4201
Providence-Warwick, RI	20.3374
Provo-Orem, UT	18.1838
Pueblo, CO	14.6354
Punta Gorda, FL	16.4253
Racine, WI	15.7220
Raleigh-Durham-Chapel Hill, NC	17.5768
Rapid City, SD	14.8116
Reading, PA	16.7253
Redding, CA	20.6553
Reno, NV	20.2340
Richland-Kennewick-Pasco, WA	17.6199
Richmond-Petersburg, VA	16.9685
Riverside-San Bernardino, CA	21.4766
Roanoke, VA	15.0995
Rochester, MN	19.2043
Rochester, NY	17.9126
Rockford, IL	15.8339
Rocky Mount, NC	15.6891
Sacramento, CA	22.4479
Saginaw-Bay City-Midland, MI	17.0878
St. Cloud, MN	17.4385
St. Joseph, MO	15.7097
St. Louis, MO-IL	16.6369
Salem, OR	17.4562
Salinas, CA	25.1117

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Salt Lake City-Ogden, UT	17.4211
San Angelo, TX	13.0251
San Antonio, TX	15.0956
San Diego, CA	22.0249
San Francisco, CA	25.7496
San Jose, CA	26.0635
San Juan-Bayamon, PR	7.9754
San Luis Obispo-Atascadero-Paso Robles, CA	22.6693
Santa Barbara-Santa Maria-Lompoc, CA	21.0302
Santa Cruz-Watsonville, CA	24.7020
Santa Fe, NM	19.6904
Santa Rosa, CA	23.5918
Sarasota-Bradenton, FL	17.7033
Savannah, GA	17.2535
Scranton-Wilkes Barre-Hazleton, PA	15.6190
Seattle-Bellevue-Everett, WA	20.1224
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	19.1855
Springfield, IL	15.9339
Springfield, MO	14.4034
Springfield, MA	19.2856
State College, PA	18.0846
Steubenville-Weirton, OH-WV	15.2796
Stockton-Lodi, CA	20.9108
Sumter, SC	14.6395
Syracuse, NY	17.7747
Tacoma, WA	19.0089
Tallahassee, FL	15.3608
Tampa-St. Petersburg-Clearwater, FL	17.1686
Terre Haute, IN	15.6927
Texarkana, TX-Texarkana, AR	14.4473
Toledo, OH	18.4170
Topeka, KS	18.0500
Trenton, NJ	18.7216
Tucson, AZ	17.1274
Tulsa, OK	15.0169
Tuscaloosa, AL	14.9142
Tyler, TX	17.6235
Utica-Rome, NY	15.5520
Vallejo-Fairfield-Napa, CA	23.8150
Ventura, CA	21.2188
Victoria, TX	15.8948
Vineland-Millville-Bridgeton, NJ	18.7995
Visalia-Tulare-Porterville, CA	18.8104
Waco, TX	14.6634
Washington, DC-MD-VA-WV	20.2639
Waterloo-Cedar Falls, IA	15.7836
Wausau, WI	17.9018
West Palm Beach-Boca Raton, FL	18.5566
Wheeling, WV-OH	13.9932
Wichita, KS	18.2393
Wichita Falls, TX	14.4379
Williamsport, PA	15.3868
Wilmington-Newark, DE-MD	19.5698
Wilmington, NC	16.6887
Yakima, WA	17.4240
Yolo, CA	21.6301
York, PA	16.4426

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Youngstown-Warren, OH	17.2067
Yuba City, CA	18.6136
Yuma, AZ	15.8434

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	12.7964
Alaska	22.9951
Arizona	15.1182
Arkansas	12.5053
California	18.2723
Colorado	14.5708
Connecticut	22.3424
Delaware	15.3947
Florida	15.6504
Georgia	13.8146

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Hawaii	17.3871
Idaho	15.3040
Illinois	13.4481
Indiana	14.5148
Iowa	13.2762
Kansas	13.2765
Kentucky	13.6733
Louisiana	13.4020
Maine	15.3657
Maryland	15.5228
Massachusetts	19.6216
Michigan	15.8784
Minnesota	14.8463
Mississippi	12.0121
Missouri	13.3156
Montana	14.8763
Nebraska	13.2995
Nevada	16.5787
New Hampshire	17.8209
New Jersey [1].	
New Mexico	14.7391
New York	15.9555

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
North Carolina	14.2958
North Dakota	13.4168
Ohio	15.0372
Oklahoma	12.4951
Oregon	16.8507
Pennsylvania	15.6839
Puerto Rico	7.9697
Rhode Island [1].	
South Carolina	13.9612
South Dakota	12.6982
Tennessee	13.5784
Texas	13.7144
Utah	16.1932
Vermont	16.7241
Virginia	14.2474
Washington	17.6177
West Virginia	14.7441
Wisconsin	15.2092
Wyoming	14.4896

[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	3.1565	9.6	13.5	32
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0968	9.8	13.9	32
3	01	SURG	*CRANIOTOMY AGE 0–17	3.0398	12.7	12.7	35
4	01	SURG	SPINAL PROCEDURES	2.3292	7.2	11.0	29
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5601	4.4	5.6	26
6	01	SURG	CARPAL TUNNEL RELEASE	.6339	2.2	3.2	24
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC.	2.5005	10.1	17.4	32
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	.9185	2.9	4.7	25
9	01	MED	SPINAL DISORDERS & INJURIES	1.2553	6.0	8.8	28
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2618	6.7	9.7	29
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.7734	3.8	5.5	26
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9574	6.3	9.0	28
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7813	5.7	7.2	28
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA.	1.1956	6.4	8.7	28
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS.	.6909	3.8	4.9	26
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC.	1.0488	5.8	7.8	28
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.	.6195	3.5	4.6	26
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9126	5.5	7.2	27
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.5925	3.7	4.8	26
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS.	2.0828	8.2	11.7	30
21	01	MED	VIRAL MENINGITIS	1.4342	6.4	8.6	28
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.7806	4.2	5.4	26
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8004	4.0	5.6	26
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9647	4.8	6.6	27
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5515	3.2	4.1	25
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6270	2.8	4.3	25
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3457	3.9	7.4	26
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC.	1.2170	5.5	8.3	27
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	.6200	3.2	4.6	25
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17.	.3687	2.0	2.0	17
31	01	MED	CONCUSSION AGE >17 W CC	.7627	4.0	5.6	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
32	01	MED	CONCUSSION AGE >17 W/O CC	.4635	2.5	3.4	23
33	01	MED	*CONCUSSION AGE 0–17	.2559	1.6	1.6	9
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0862	5.3	7.5	27
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5866	3.5	4.9	26
36	02	SURG	RETINAL PROCEDURES	.5989	1.5	1.8	8
37	02	SURG	ORBITAL PROCEDURES	.8089	2.6	3.9	25
38	02	SURG	PRIMARY IRIS PROCEDURES	.4005	2.0	2.7	16
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5055	1.5	1.9	9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	.6241	2.3	3.6	24
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17.	.3810	1.6	1.6	7
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	.5637	1.7	2.2	12
43	02	MED	HYPHEMA	.3400	3.0	3.6	20
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.5755	4.9	6.0	27
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6211	3.5	4.3	25
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7553	4.4	6.1	26
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4331	3.0	3.9	25
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.4186	2.9	2.9	25
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7106	4.9	6.8	27
50	03	SURG	SIALOADENECTOMY	.7131	1.9	2.3	11
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	.6838	2.0	3.0	22
52	03	SURG	CLEFT LIP & PALATE REPAIR	.9152	2.3	3.0	20
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.8647	2.2	3.4	24
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.7176	3.2	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.6455	1.8	2.8	20
56	03	SURG	RHINOPLASTY	.7684	2.2	3.1	24
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0174	3.4	5.2	25
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.3227	1.5	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.4602	1.5	1.9	9
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2724	1.5	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.0019	2.9	5.1	25
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.3217	1.3	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.1047	3.4	5.0	25
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1419	5.0	8.4	27
65	03	MED	DYSEQUILIBRIUM	.5067	3.0	3.8	22
66	03	MED	EPISTAXIS	.5076	3.1	3.9	24
67	03	MED	EPIGLOTTITIS	.8381	3.8	4.7	26
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.7100	4.4	5.4	26
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5133	3.5	4.2	22
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.5812	3.6	4.4	24
71	03	MED	LARYNGOTRACHEITIS	.6508	3.5	4.2	22
72	03	MED	NASAL TRAUMA & DEFORMITY	.6160	3.1	4.4	25
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	.7616	4.1	5.5	26
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3571	2.1	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES	3.0551	9.9	12.4	32
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5126	10.0	13.9	32
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.0630	4.0	6.0	26
78	04	MED	PULMONARY EMBOLISM	1.4211	7.8	9.2	30
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.6955	8.3	10.7	30
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9259	5.9	7.4	28
81	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17.	1.4323	5.7	7.1	28
82	04	MED	RESPIRATORY NEOPLASMS	1.3237	6.3	8.9	28
83	04	MED	MAJOR CHEST TRAUMA W CC	.9530	5.5	7.2	28
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.4996	3.2	4.3	25
85	04	MED	PLEURAL EFFUSION W CC	1.1890	6.2	8.2	28
86	04	MED	PLEURAL EFFUSION W/O CC	.6753	3.8	4.9	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
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3306	5.5	7.5	27
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0053	5.6	6.9	28
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.1317	6.5	8.0	29
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6924	4.9	5.7	27
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.6834	3.8	4.4	20
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2084	6.4	8.1	28
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7700	4.5	5.7	26
94	04	MED	PNEUMOTHORAX W CC	1.2427	6.5	8.5	28
95	04	MED	PNEUMOTHORAX W/O CC	.6146	3.9	4.9	26
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.8488	5.2	6.2	27
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.6122	4.1	4.9	24
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.5356	3.1	4.1	25
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.7019	3.2	4.1	25
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5051	2.3	2.8	15
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.9055	4.6	6.2	27
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5339	3.0	4.0	25
103	05	SURG	HEART TRANSPLANT	13.5495	25.4	35.8	47
104	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.6076	15.2	18.0	37
105	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.7656	11.0	13.0	33
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.6683	12.1	13.6	34
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.1974	9.3	10.4	31
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	6.1081	11.4	14.7	33
109			NO LONGER VALID	.0000	.0	.0	0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.0796	9.1	12.2	31
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.3024	6.5	7.5	28
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9881	3.9	5.3	26
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7765	12.7	17.2	35
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5385	7.9	10.9	30
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK.	3.5936	10.4	12.7	32
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GENERATOR PROC.	2.4514	4.7	6.5	27
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.1671	3.3	4.9	25
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5582	2.3	3.5	24
119	05	SURG	VEIN LIGATION & STRIPPING	.9949	3.3	5.6	25
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9616	6.3	10.7	28
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE.	1.6022	7.0	8.6	29
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE.	1.1292	4.9	6.0	27
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4286	2.9	5.1	25
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.2657	4.2	5.5	26
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	.8451	2.4	3.2	23
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.7724	13.7	18.4	36
127	05	MED	HEART FAILURE & SHOCK	1.0239	5.5	7.1	27
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7820	6.7	7.5	29
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1308	2.1	3.8	24
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9177	5.8	7.4	28
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5889	4.5	5.6	27
132	05	MED	ATHEROSCLEROSIS W CC	.7296	3.6	4.7	26
133	05	MED	ATHEROSCLEROSIS W/O CC	.5348	2.7	3.5	21
134	05	MED	HYPERTENSION	.5761	3.5	4.4	25
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.8507	4.3	5.8	26
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5600	2.9	3.7	23
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	.6578	3.3	3.3	25
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC.	.7964	3.9	5.2	26
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	.4939	2.6	3.3	20
140	05	MED	ANGINA PECTORIS	.6258	3.2	4.0	23
141	05	MED	SYNCOPE & COLLAPSE W CC	.7025	3.9	5.1	26
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5174	2.9	3.6	21

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
143	05	MED	CHEST PAIN	.5169	2.4	3.0	16
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0580	4.5	6.4	27
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6155	2.8	3.7	25
146	06	SURG	RECTAL RESECTION W CC	2.5367	10.7	12.2	33
147	06	SURG	RECTAL RESECTION W/O CC	1.5469	7.4	8.0	28
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.2220	12.2	14.7	34
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.5022	7.6	8.2	26
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.5652	10.5	12.8	32
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.1814	5.5	6.8	27
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.7829	8.3	9.7	30
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.1151	6.0	6.7	26
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1740	13.3	17.0	35
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3898	6.1	7.2	28
156	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8732	6.0	6.0	28
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.0320	4.4	6.1	26
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5445	2.3	3.0	18
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.1066	4.3	5.6	26
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.6574	2.5	3.1	18
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	.9053	3.2	4.6	25
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.5156	1.8	2.2	11
163	06	SURG	HERNIA PROCEDURES AGE 0–17	.7275	3.9	4.8	24
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	2.1645	8.8	10.2	31
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.1976	5.7	6.3	24
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	1.3465	5.2	6.3	27
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	.7828	3.2	3.7	16
168	03	SURG	MOUTH PROCEDURES W CC	1.0856	3.5	5.4	25
169	03	SURG	MOUTH PROCEDURES W/O CC	.6149	2.1	2.7	16
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7813	9.8	14.6	32
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.0638	4.3	5.9	26
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.2990	6.5	9.4	29
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6262	3.2	4.6	25
174	06	MED	G.I. HEMORRHAGE W CC	.9726	4.9	6.2	27
175	06	MED	G.I. HEMORRHAGE W/O CC	.5359	3.3	3.9	19
176	06	MED	COMPLICATED PEPTIC ULCER	1.0436	5.3	6.9	27
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8062	4.5	5.6	27
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.5807	3.3	3.9	19
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.1143	6.4	8.2	28
180	06	MED	G.I. OBSTRUCTION W CC	.9139	5.2	6.8	27
181	06	MED	G.I. OBSTRUCTION W/O CC	.4975	3.4	4.2	23
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7685	4.3	5.6	26
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5356	3.1	3.8	22
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.4240	2.6	3.4	21
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8312	4.1	5.7	26
186	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.4282	2.9	2.9	23
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.6350	2.8	3.8	25
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC.	1.0201	4.9	6.8	27
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	.5027	2.7	3.7	25
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.6707	3.2	4.5	25
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.4176	13.6	18.2	36

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
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC ...	1.7609	6.9	8.9	29
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.1497	12.9	15.7	35
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6562	7.3	9.2	29
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.4576	9.7	11.4	32
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.4861	6.5	7.5	29
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.0796	8.1	9.7	30
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.0930	4.6	5.3	24
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.3603	9.9	13.2	32
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	2.9698	8.4	13.1	30
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.2322	12.1	17.0	34
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3087	6.4	8.7	28
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.2384	6.3	8.9	28
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1376	5.7	7.3	28
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC.	1.2284	6.1	8.4	28
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.6220	3.4	4.7	25
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0063	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 OF LOWER EXTREMITY.	2.3173	7.7	8.6	29
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8427	9.0	10.6	31
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2990	7.0	7.9	29
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	.9084	3.6	4.1	19
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7234	8.2	11.3	30
214	08	SURG	BACK & NECK PROCEDURES W CC	1.9237	6.5	8.2	28
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.0977	3.9	4.8	24
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1046	9.3	13.3	31
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	3.0084	12.3	18.9	34
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4028	5.7	7.4	28
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	.9132	3.6	4.4	23
220	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.9626	5.3	5.3	27
221	08	SURG	KNEE PROCEDURES W CC	1.7911	6.7	9.3	29
222	08	SURG	KNEE PROCEDURES W/O CC	.9852	3.5	4.7	25
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.8162	2.5	3.2	18
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.6932	2.2	2.7	13
225	08	SURG	FOOT PROCEDURES	.9006	3.3	5.1	25
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.3381	5.0	7.7	27
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6999	2.4	3.2	20
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	.8409	2.3	3.5	24
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	.5964	1.9	2.5	15
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	.9145	3.5	5.5	26
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.1275	3.5	5.4	25
232	08	SURG	ARTHROSCOPY	1.1560	3.2	5.8	25
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	1.9051	7.4	10.6	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
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	.9529	3.5	4.8	26
235	08	MED	FRACTURES OF FEMUR	.8964	5.7	8.8	28
236	08	MED	FRACTURES OF HIP & PELVIS	.7772	5.5	7.6	27
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	.5535	3.7	5.0	26
238	08	MED	OSTEOMYELITIS	1.4939	9.1	12.3	31
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0338	6.8	9.0	29
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1889	6.4	8.7	28
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5835	3.9	5.2	26
242	08	MED	SEPTIC ARTHRITIS	1.1440	7.0	9.3	29
243	08	MED	MEDICAL BACK PROBLEMS	.7122	4.9	6.4	27
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7346	4.9	6.6	27
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	.4813	3.4	4.7	25
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5529	3.7	4.8	26
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5532	3.3	4.5	25
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7117	4.4	5.8	26
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6486	3.4	5.0	25
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6950	4.1	5.7	26
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4510	2.5	3.4	23
252	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	.3642	1.8	1.8	15
253	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7617	5.0	7.0	27
254	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4324	3.2	4.3	25
255	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.4831	2.9	2.9	25
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.6397	3.4	4.7	25
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.8843	3.5	4.2	20
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6989	2.7	3.1	12
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8291	2.8	4.1	25
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.5840	1.9	2.2	10
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.7432	2.0	2.5	12
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	.6491	2.5	3.9	25
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.3540	12.5	17.6	35
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1663	7.1	9.6	29
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.3953	5.4	8.3	27
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.7358	2.9	4.0	25
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.6935	2.6	4.2	25
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	.8356	2.5	3.9	25
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7025	7.4	10.9	29
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.6610	2.5	3.6	25
271	09	MED	SKIN ULCERS	1.1343	7.6	10.0	30
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0072	6.3	8.2	28
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.6339	4.6	6.1	27
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1084	5.9	9.2	28
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5132	2.6	4.1	25
276	09	MED	NON-MALIGANT BREAST DISORDERS	.6137	4.0	5.4	26
277	09	MED	CELLULITIS AGE >17 W CC	.8804	6.2	7.6	28
278	09	MED	CELLULITIS AGE >17 W/O CC	.5850	4.8	5.7	27
279	09	MED	CELLULITIS AGE 0–17	.5708	3.7	4.3	22
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	.6729	4.2	5.7	26
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4344	2.9	3.9	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
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17. .	.3566	2.2	2.2	19
283	09	MED	MINOR SKIN DISORDERS W CC	.7155	4.8	6.3	27
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4342	3.3	4.3	25
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.5270	12.6	17.5	35
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2621	7.6	9.3	30
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	2.1035	11.4	16.4	33
288	10	SURG	O.R. PROCEDURES FOR OBESITY	1.9030	5.8	8.0	28
289	10	SURG	PARATHYROID PROCEDURES	1.0063	3.2	4.6	25
290	10	SURG	THYROID PROCEDURES	.7931	2.4	3.0	15
291	10	SURG	THYROGLOSSAL PROCEDURES	.5102	1.6	2.0	9
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.	2.7197	10.2	15.0	32
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.1604	4.7	6.6	27
294	10	MED	DIABETES AGE >35	.7463	5.2	6.5	27
295	10	MED	DIABETES AGE 0–35	.7433	3.9	5.1	26
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	.9179	5.4	7.4	27
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5305	3.7	4.7	26
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17.	.5421	2.7	4.3	25
299	10	MED	INBORN ERRORS OF METABOLISM	.8118	4.3	6.1	26
300	10	MED	ENDOCRINE DISORDERS W CC	1.0982	6.3	8.3	28
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6003	3.7	4.9	26
302	11	SURG	KIDNEY TRANSPLANT	4.1394	12.6	14.6	35
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.5739	9.7	11.6	32
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3313	8.7	11.7	31
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1366	4.5	5.6	26
306	11	SURG	PROSTATECTOMY W CC	1.2101	5.4	7.3	27
307	11	SURG	PROSTATECTOMY W/O CC	.6619	3.0	3.6	18
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4465	5.4	8.1	27
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.7971	2.6	3.4	22
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	.9159	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 W CC	.8458	3.5	5.3	26
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.4774	2.0	2.6	16
314	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4503	2.3	2.3	24
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES.	2.0323	6.0	10.7	28
316	11	MED	RENAL FAILURE	1.2840	5.9	8.4	28
317	11	MED	ADMIT FOR RENAL DIALYSIS	.5149	2.8	3.9	25
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1196	5.5	8.1	28
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5530	2.4	3.3	24
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC.	.9451	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	.5464	3.9	4.7	25
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7221	2.9	3.9	25
324	11	MED	URINARY STONES W/O CC	.3872	1.9	2.3	12
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6476	3.9	5.2	26
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4186	2.6	3.4	22
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	.7222	3.1	3.1	25
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.6732	3.5	4.8	26
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4291	1.9	2.5	15
330	11	MED	*URETHRAL STRICTURE AGE 0–17	.2903	1.6	1.6	9
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	.9943	5.1	7.0	27
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6019	3.1	4.3	25

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				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17.	1.0377	4.9	7.2	27
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.7172	6.8	7.5	24
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.3447	5.6	6.1	19
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8523	4.0	4.8	23
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6130	3.0	3.3	12
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.9738	3.7	5.7	26
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17 ..	.8265	3.1	4.4	25
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.4516	2.4	2.4	13
341	12	SURG	PENIS PROCEDURES	1.0192	2.9	3.8	24
342	12	SURG	CIRCUMCISION AGE >17	.6689	2.7	4.1	25
343	12	SURG	*CIRCUMCISION AGE 0–17	.3945	1.7	1.7	6
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	.9941	2.7	3.6	25
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.7521	3.1	4.5	25
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC .	.9598	5.3	7.7	27
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	.4899	2.5	3.7	25
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6724	3.7	5.1	26
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4094	2.4	3.2	22
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	.6787	4.5	5.4	27
351	12	MED	*STERILIZATION, MALE	.3472	1.3	1.3	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES ..	.5807	3.2	4.3	25
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8865	8.0	9.8	30
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ ADNEXAL MALIG W CC.	1.3747	5.9	6.9	28
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ ADNEXAL MALIG W/O CC.	.8773	4.0	4.3	12
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7162	3.2	3.6	14
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.2834	8.9	10.9	31
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC.	1.1018	4.7	5.4	20
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/ O CC.	.7987	3.5	3.8	11
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8186	3.5	4.3	22
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION .	1.1047	3.1	4.8	25
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.5189	1.4	1.4	5
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	.6470	2.8	3.7	21
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.6239	2.6	3.7	25
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	1.7127	6.3	9.2	28
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC.	1.2111	5.9	9.1	28
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.	.4486	2.3	3.3	24
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.9704	5.6	7.3	28
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5095	2.9	4.0	25
370	14	SURG	CESAREAN SECTION W CC	.8976	4.9	5.9	24
371	14	SURG	CESAREAN SECTION W/O CC	.6340	3.6	3.8	9
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4902	2.7	3.4	17
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3387	1.9	2.2	8
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6152	2.4	3.1	16
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/ OR D&C.	.7101	4.4	4.4	26
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.3513	2.4	3.4	21
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.9762	3.4	5.7	25
378	14	MED	ECTOPIC PREGNANCY	.7052	2.6	3.0	15
379	14	MED	THREATENED ABORTION	.3204	2.1	2.8	18
380	14	MED	ABORTION W/O D&C	.3481	1.6	2.1	11
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.4063	1.7	2.2	12

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
382	14	MED	FALSE LABOR	.1856	1.3	1.5	5
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.4060	3.0	4.0	25
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.2909	1.9	2.5	15
385	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.2741	1.8	1.8	24
386	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	3.7999	17.9	17.9	40
387	15		*PREMATURITY W MAJOR PROBLEMS	1.9028	13.3	13.3	35
388	15		*PREMATURITY W/O MAJOR PROBLEMS	1.2053	8.6	8.6	31
389	15		FULL TERM NEONATE W MAJOR PROBLEMS	1.2972	5.6	7.7	28
390	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	.5385	3.1	4.8	25
391	15		*NORMAL NEWBORN	.2311	3.1	3.1	11
392	16	SURG	SPLENECTOMY AGE >17	3.2021	10.1	13.2	32
393	16	SURG	*SPLENECTOMY AGE 0–17	1.5839	9.1	9.1	31
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.5713	5.0	8.5	27
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8118	4.3	6.0	26
396	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	.2859	1.7	2.1	13
397	16	MED	COAGULATION DISORDERS	1.2490	5.0	6.9	27
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC.	1.2139	5.8	7.4	28
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	.6723	3.8	4.8	26
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.5674	7.6	11.8	30
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.4043	9.2	13.7	31
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	.9212	3.2	4.8	25
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6956	7.4	10.7	29
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.7571	3.7	5.2	26
405	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	1.0840	4.9	4.9	27
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.6496	9.4	12.8	31
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.1262	4.1	5.3	26
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.5586	5.0	8.4	27
409	17	MED	RADIOTHERAPY	.9785	5.4	7.7	27
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.6749	2.7	3.3	20
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4476	2.7	3.7	25
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4515	2.1	3.0	21
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3595	6.8	9.9	29
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.6704	3.7	5.4	26
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	3.5136	13.4	18.7	35
416	18	MED	SEPTICEMIA AGE >17	1.4927	6.9	9.5	29
417	18	MED	SEPTICEMIA AGE 0–17	1.4250	5.2	7.5	27
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9628	6.0	7.6	28
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.9293	5.2	6.6	27
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6368	4.0	4.9	26
421	18	MED	VIRAL ILLNESS AGE >17	.6868	4.0	5.1	26
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17.	.5859	3.4	4.3	25
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.5846	7.1	10.0	29
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.5573	13.5	22.6	36
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION.	.7079	4.1	5.7	26
426	19	MED	DEPRESSIVE NEUROSES	.5960	4.6	6.5	27
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5969	4.4	6.4	26
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7521	5.7	9.4	28
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.9269	7.0	10.4	29
430	19	MED	PSYCHOSES	.8980	8.0	11.5	30

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
431	19	MED	CHILDHOOD MENTAL DISORDERS	.6316	5.2	7.6	27
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7538	4.6	7.2	27
433	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3356	2.8	4.1	25
434	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7235	4.9	6.7	27
435	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4372	4.1	5.5	26
436	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY.	.9156	14.5	17.2	36
437	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.9021	11.5	13.6	34
438	.....		NO LONGER VALID	.0000	.0	.0	0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.3295	5.6	8.9	28
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.7495	7.0	11.2	29
441	21	SURG	HAND PROCEDURES FOR INJURIES	.7840	2.3	3.5	24
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.0135	5.8	9.5	28
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.7547	2.4	3.3	24
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7399	4.6	6.2	27
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4640	3.1	4.0	25
446	21	MED	*TRAUMATIC INJURY AGE 0–17	.4995	2.4	2.4	22
447	21	MED	ALLERGIC REACTIONS AGE >17	.4676	2.3	3.1	20
448	21	MED	*ALLERGIC REACTIONS AGE 0–17	.3614	2.9	2.9	17
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.	.7801	3.5	5.1	26
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	.4168	2.0	2.7	17
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17 .	1.0341	2.1	2.1	17
452	21	MED	COMPLICATIONS OF TREATMENT W CC	.8577	4.0	5.6	26
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4355	2.6	3.4	22
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.	.8864	4.1	6.4	26
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	.4379	2.2	3.2	24
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	2.1721	5.2	10.2	27
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	1.6307	3.0	5.6	25
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.5089	14.0	19.8	36
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC.	1.7543	8.5	12.5	30
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0023	5.6	8.0	28
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	.9432	2.5	5.2	24
462	23	MED	REHABILITATION	1.6623	13.4	16.7	35
463	23	MED	SIGNS & SYMPTOMS W CC	.7170	4.5	6.0	26
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4740	3.1	4.1	25
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.4464	2.0	3.2	23
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5319	2.4	4.9	24
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.3722	2.6	5.1	25
468	.....		EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.5769	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.	3.7499	9.4	11.0	31
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	11.6375	15.9	30.4	38
473	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.6120	9.3	16.3	31
474	.....		NO LONGER VALID	.0000	.0	.0	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.7005	9.5	13.7	31
476	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2327	12.3	15.6	34
477	.....	SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.5221	5.8	9.5	28
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2227	6.3	9.5	28
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.3503	3.9	5.1	26
480	.....	SURG	LIVER TRANSPLANT	18.2581	27.1	34.7	49

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
481	.....	SURG	BONE MARROW TRANSPLANT	15.3076	35.5	39.4	57
482	.....	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES.	3.6730	13.0	17.4	35
483	.....	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	16.8772	41.9	54.1	64
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.9807	12.5	20.2	35
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUM.	3.1540	11.4	14.4	33
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.9514	10.5	16.8	32
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9336	6.9	10.2	29
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.3854	15.1	21.5	37
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8158	8.3	12.5	30
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0630	5.1	8.0	27
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6235	4.4	5.3	24
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	3.6804	10.7	16.9	33
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.	1.5813	4.3	6.1	26
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	.8462	1.7	2.3	14
495	.....	SURG	LUNG TRANSPLANT	12.8346	20.2	26.3	42

*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

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
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
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	Vitiligo	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

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
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	Mechanical complication of automatic implantable cardiac defibrillator	Y	05	138, 139
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 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

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
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 for 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
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		
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 immuno- deficiency 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 immuno- deficiency 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
305.10	Tobacco use disorder, unspecified	N	23	467
305.11	Tobacco use disorder, continuous	N	23	467
305.12	Tobacco use disorder, episodic	N	23	467
305.13	Tobacco use disorder, in remission	N	23	467
312.8	Other specified disturbances of conduct, not elsewhere classified	N	19	431

TABLE 6C.—INVALID DIAGNOSIS CODES [1]—Continued

Diagnosis code	Description	CC	MDC	DRG
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 immuno- deficiency 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
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 aftercare following surgery	N	23	465, 466034Y

[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]

TABLE 6D.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis Code	Description	CC	MDC	DRG
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	Atherosclerosis of native arteries of extremities with gangrene	Y	05	130, 131
			15	387, 389 [1]
440.29	Other atherosclerosis 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

29644 3432 34409 34409 34400 *3449 *4411 63411
29654 34400 *34290 *34400 34401 34400 44100 63412
29664 34401 3432 3432 34402 34401 44101 63420
2980 34402 34400 34400 34403 34402 44102 63421
2983 34403 34401 34401 34404 34403 44103 63422
2984 34404 34402 34402 34409 34404 *4412 63430
29900 34409 34403 34403 *34432 34409 44100 63431
29910 *34201 34404 34404 3432 *3488 44101 63432
29980 3432 34409 34409 34400 34400 44102 63440
29990 34400 *34291 *34401 34401 34401 44103 63441
*31289 34401 3432 3432 34402 34402 *4413 63442
29500 34402 34400 34400 34403 34403 44100 63450
29501 34403 34401 34401 34404 34404 44101 63451
29502 34404 34402 34402 34409 34409 44102 63452
29503 34409 34403 34403 *34440 *3489 44103 63460
29504 *34202 34404 34404 3432 34400 *4414 63461
29510 3432 34409 34409 34400 34401 44100 63462
29511 34400 *34292 *34402 34401 34402 44101 63470
29512 34401 3432 3432 34402 34403 44102 63471
29513 34402 34400 34400 34403 34404 44103 63472
29514 34403 34401 34401 34404 34409 *4415 63480
29521 34404 34402 34402 34409 *34989 44100 63481
29522 34409 34403 34403 *34441 34400 44101 63482
29523 *34210 34404 34404 3432 34401 44102 63490
29524 3432 34409 34409 34400 34402 44103 63491
29530 34400 *3430 *34403 34401 34403 *4416 63492
29531 34401 34400 3432 34402 34404 44100 6390
29532 34402 34401 34400 34403 34409 44101 6391
29533 34403 34402 34401 34404 *3499 44102 6392
29534 34404 34403 34402 34409 34400 44103 6393
29540 34409 34404 34403 *34442 34401 *4417 6394
29541 7817 34409 34404 3432 34402 44100 6395
29542 *34211 *3431 34409 34400 34403 44101 6396
29543 3432 34400 *34404 34401 34404 44102 6398
29544 34400 34401 3432 34402 34409 44103 6399
29560 34401 34402 34400 34403 *44023 *4419 64000
29561 34402 34403 34401 34404 7071 44100 64001
29562 34403 34404 34402 34409 *44100 44101 64003
29563 34404 34409 34403 *3445 44100 44102 64080
29564 34409 *3432 34404 34400 44101 44103 64081
29570 7817 34400 34409 34401 44102 *45989 64083
29571 *34212 34401 *34409 34402 44103 44100 64090
29572 3432 34402 3432 34403 4411 44101 64091
29573 34400 34403 34400 34404 4413 44102 64093
29574 34401 34404 34401 34409 4415 44103 64100
29580 34402 34409 34402 *34460 4416 *4599 64101
29581 34403 *3433 34403 34400 *44101 44100 64103
29582 34404 34400 34404 34401 44100 44101 64110
29583 34409 34401 34409 34402 44101 44102 64111
29584 7817 34402 *3441 34403 44102 44103 64113
29590 *34280 34403 34400 34404 44103 *5120 64130
29591 3432 34404 34401 34409 4411 5121 64131
29592 34400 34409 34402 *34461 4413 *5121 64133
29593 34401 *3434 34403 34400 4415 5120 64180
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29614 34404 34402 *3442 34403 44100 *5128 64190
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7817 34403 34403 *34431 34404 4415 63402 64262
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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 06/94 GROUPER V11.0

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
001	30789	13.5837	3	6	10	17	28
002	6029	13.9756	4	6	10	17	27
003	2	41.5000	17	17	66	66	66
004	5470	11.0845	2	4	7	14	23
005	64742	5.8330	2	3	4	7	11
006	526	3.1920	1	1	2	4	7
007	6971	17.4116	2	5	10	19	35
008	2267	4.5368	1	1	3	6	10
009	1636	9.2219	2	4	6	11	17
010	20813	9.7252	2	4	7	12	20
011	3262	5.5880	1	2	4	7	11
012	21908	9.3495	2	4	6	11	17
013	6261	7.5787	3	4	6	9	13
014	356433	8.9406	2	4	7	11	17
015	132402	5.0854	2	2	4	6	9
016	11159	8.2904	2	4	6	10	15
017	3657	4.7060	1	2	4	6	9
018	18848	7.3077	2	3	6	9	14
019	7200	4.8607	1	2	4	6	9
020	7645	11.7438	3	5	9	15	23
021	1049	8.6883	2	4	7	11	17
022	3836	5.5792	2	3	4	7	10
023	4751	5.7925	1	2	4	7	11
024	55823	6.8735	2	3	5	8	13
025	21461	4.2265	1	2	3	5	8
026	42	4.3095	1	2	2	4	9
027	3097	7.8589	1	1	4	9	17
028	9250	8.5083	2	3	6	10	18
029	3423	4.6594	1	2	3	6	9
031	3730	5.9056	1	2	4	7	12
032	2173	3.5274	1	1	2	4	7
034	15102	7.7488	2	3	5	9	15
035	3477	4.9721	1	2	4	6	9
036	16219	1.8739	1	1	1	2	3
037	2345	4.1062	1	1	3	5	9
038	479	2.7307	1	1	2	3	5
039	5281	2.0364	1	1	1	2	4
040	2167	3.6470	1	1	2	4	8
042	13539	2.3944	1	1	1	3	5
043	146	4.2466	1	2	3	5	7
044	1707	6.0521	2	3	5	8	11
045	2453	4.3343	1	2	4	6	8
046	3000	6.3313	1	3	5	7	12
047	1517	3.9064	1	2	3	5	8
049	2298	6.9956	2	3	5	8	13
050	4068	2.3446	1	1	2	3	4
051	413	3.1017	1	1	2	3	7
052	102	3.3431	1	1	2	4	7
053	4619	3.5817	1	1	2	4	8
054	1	1.0000	1	1	1	1	1
055	2573	3.0377	1	1	1	3	7
056	850	3.1753	1	1	2	4	7
057	624	5.3333	1	2	3	6	11
059	128	2.3750	1	1	1	2	4
060	2	2.5000	2	2	3	3	3
061	298	5.2148	1	1	2	7	12
063	4536	5.3450	1	2	3	6	10
064	3756	8.3568	1	2	5	10	18
065	34411	3.8766	1	2	3	5	7
066	7620	4.0371	1	2	3	5	7
067	463	4.7451	2	3	4	6	9
068	12598	5.4822	2	3	4	7	10
069	3725	4.2545	2	2	4	5	7
070	36	4.3056	1	2	4	5	7
071	138	4.2174	2	2	3	5	8
072	623	4.3900	1	2	3	5	9
073	6364	5.6578	1	2	4	7	11
075	37044	12.6528	5	7	9	15	24
076	38643	14.2046	3	6	11	17	27
077	2854	6.0266	1	2	4	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V11.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
078	27188	9.3107	4	6	8	11	15
079	176402	10.8266	3	5	8	13	20
080	8662	7.4938	3	4	6	9	13
081	11	7.0000	1	4	6	7	13
082	68966	8.9400	2	4	7	11	18
083	7393	7.4088	2	3	6	9	14
084	1649	4.3475	1	2	3	5	8
085	17273	8.2564	2	4	7	10	16
086	1531	4.9458	1	2	4	6	10
087	51836	7.5535	1	3	6	10	14
088	335134	7.0079	3	4	6	8	12
089	413711	8.1065	3	4	7	10	14
090	41092	5.7549	2	3	5	7	10
091	40	4.4000	2	3	4	5	8
092	10461	8.1576	3	4	6	10	15
093	1390	5.9029	2	3	5	7	11
094	9988	8.6522	3	4	7	11	17
095	1116	4.9615	2	3	4	6	9
096	79116	6.3432	2	4	5	8	11
097	28365	4.8693	2	3	4	6	8
098	29	4.1034	1	2	3	4	7
099	27622	4.2452	1	2	3	5	8
100	11016	2.8297	1	1	2	3	5
101	18841	6.3787	2	3	5	8	12
102	3157	4.0602	1	2	3	5	8
103	375	36.7733	10	14	23	46	83
104	20761	18.1163	8	11	15	22	31
105	18135	13.3385	7	8	10	15	23
106	86394	13.8896	7	9	12	16	22
107	57166	10.6348	6	7	9	12	17
108	6384	14.6621	5	8	12	18	27
110	56199	12.2987	3	7	10	15	23
111	5540	7.5821	3	6	7	9	11
112	166651	5.3420	1	2	4	7	11
113	41621	17.4883	5	8	13	21	35
114	8843	11.1036	3	5	8	14	22
115	9528	12.8102	5	7	11	16	23
116	74533	6.5235	2	3	5	8	13
117	3788	5.0198	1	2	3	6	10
118	7713	3.5309	1	1	2	4	8
119	2438	5.7724	1	1	3	7	14
120	37215	10.6674	1	3	6	14	24
121	160886	8.7273	3	5	7	11	15
122	95449	6.0310	2	3	6	8	10
123	53564	5.1018	1	1	3	6	12
124	135111	5.5606	1	2	4	7	11
125	69007	3.2146	1	1	2	4	7
126	4416	18.3338	5	8	14	25	38
127	684379	7.2104	2	4	6	9	14
128	22330	7.7058	4	5	7	9	12
129	5431	3.8842	1	1	1	4	10
130	79749	7.5461	2	4	6	9	13
131	24506	5.6601	1	3	5	7	9
132	17170	4.8175	1	2	4	6	9
133	3818	3.5115	1	2	3	4	7
134	30893	4.4949	1	2	3	5	8
135	6243	6.0115	2	3	4	7	11
136	1221	3.8878	1	2	3	5	7
138	198569	5.3081	2	2	4	6	10
139	68517	3.3781	1	2	3	4	6
140	320756	4.0935	1	2	3	5	7
141	76663	5.2949	2	2	4	6	10
142	35435	3.6916	1	2	3	4	7
143	134668	3.0822	1	2	2	4	6
144	61548	6.5277	1	3	5	8	13
145	7340	3.7722	1	2	3	5	7
146	8207	12.3398	6	8	10	14	21
147	1483	7.9845	4	6	8	9	11
148	146601	14.9530	7	8	12	17	27
149	14784	8.3103	5	6	8	9	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V11.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
150	22866	12.9395	5	7	11	15	23
151	4350	6.8198	2	4	6	9	12
152	4940	9.9921	4	6	8	11	16
153	1779	6.7482	3	5	6	8	10
154	36964	17.1986	6	9	13	21	33
155	3772	7.4467	3	4	7	9	12
156	4	11.5000	2	2	9	13	22
157	12614	6.3773	2	3	4	8	13
158	7154	3.0415	1	1	2	4	6
159	17551	5.8036	2	3	4	7	11
160	11024	3.1692	1	2	3	4	6
161	18354	4.8137	1	2	3	6	10
162	11776	2.2116	1	1	2	3	4
163	16	4.7500	2	2	3	6	8
164	5026	10.3341	5	6	9	12	17
165	1523	6.3020	3	4	6	8	10
166	3221	6.4865	2	3	5	8	12
167	2244	3.6925	2	2	3	5	6
168	1916	5.6169	1	2	3	7	12
169	1223	2.6917	1	1	2	3	6
170	13027	14.7958	3	6	10	18	30
171	1218	5.8662	1	3	5	8	11
172	31171	9.4908	2	4	7	12	19
173	2494	4.6684	1	2	3	6	9
174	227976	6.3603	2	3	5	8	12
175	25636	3.9298	2	2	3	5	7
176	14948	7.0566	2	3	5	8	13
177	13026	5.6763	2	3	5	7	10
178	4996	3.9586	2	2	3	5	7
179	9786	8.3933	3	4	6	10	16
180	78727	6.9989	2	3	5	8	13
181	20704	4.2217	1	2	4	5	7
182	233792	5.7646	2	3	4	7	11
183	72289	3.8397	1	2	3	5	7
184	68	3.9853	1	2	3	4	5
185	3706	5.9331	1	2	4	7	12
186	5	4.0000	1	1	3	6	8
187	962	3.9314	1	1	3	5	8
188	53805	6.9627	2	3	5	8	14
189	7894	3.7683	1	1	3	5	8
190	58	4.4828	1	2	3	5	6
191	10463	18.3336	6	9	14	22	36
192	827	8.8295	2	5	8	11	16
193	10468	15.8828	6	9	13	19	28
194	916	9.1572	3	5	8	11	16
195	12514	11.7907	5	7	10	14	20
196	1041	7.5370	4	5	7	9	12
197	34315	9.9735	4	6	8	12	17
198	10471	5.3032	2	3	5	7	9
199	2719	13.3553	4	6	10	17	26
200	1717	13.2627	2	5	10	17	28
201	1707	17.0949	4	7	12	22	35
202	21167	8.7487	2	4	7	11	17
203	29609	8.8798	2	4	7	11	18
204	44863	7.5342	2	4	6	9	14
205	21797	8.5004	2	4	6	10	17
206	1815	4.6667	1	2	4	6	10
207	36949	6.5511	2	3	5	8	12
208	11536	3.6716	1	2	3	5	7
209	306116	8.7749	5	6	8	10	13
210	130491	10.9485	5	6	9	12	18
211	25285	7.9929	4	5	7	9	12
212	11	4.0909	1	3	4	5	6
213	6425	11.7387	3	5	8	14	23
214	49507	8.3687	3	4	6	10	15
215	39923	4.7950	2	3	4	6	8
216	6665	13.3539	3	6	10	17	27
217	18210	19.1730	4	7	13	23	41
218	21794	7.7061	2	4	6	9	14
219	19004	4.4786	2	2	4	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V11.0—Continued

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	4800	9.4481	2	4	7	11	19
222	4034	4.6931	1	2	4	6	9
223	18870	3.3388	1	2	2	4	6
224	8486	2.6704	1	1	2	3	5
225	7671	5.2045	1	2	3	6	12
226	5654	7.8857	2	3	5	9	17
227	5722	3.2242	1	1	2	4	6
228	3548	3.6863	1	1	2	4	8
229	1812	2.5204	1	1	2	3	5
230	2869	5.8323	1	2	3	7	12
231	10695	5.6342	1	2	3	7	13
232	785	5.9121	1	1	3	6	16
233	4945	10.7391	2	4	8	13	22
234	2461	4.8058	1	2	3	6	10
235	6207	9.0292	2	3	6	10	18
236	38925	7.8457	2	3	6	9	15
237	1622	5.3138	1	2	4	6	10
238	6844	12.7509	3	6	9	15	26
239	61512	9.2090	3	4	7	11	18
240	11346	8.9992	2	4	7	11	17
241	3300	5.1988	1	2	4	6	10
242	2305	9.4898	3	4	7	11	18
243	89931	6.5203	2	3	5	8	12
244	11437	6.8429	2	3	5	8	13
245	4627	4.9777	1	2	3	6	9
246	1450	4.8428	2	2	4	6	9
247	10123	4.6937	1	2	3	6	9
248	6602	6.0048	2	3	4	7	11
249	9534	5.2327	1	2	3	6	11
250	3352	6.1516	1	2	4	7	12
251	2556	3.4879	1	1	2	4	7
252	2	6.0000	2	2	10	10	10
253	17574	7.2871	2	3	5	8	14
254	10464	4.4119	1	2	3	5	8
255	1	10.0000	10	10	10	10	10
256	9618	4.8292	1	2	3	6	9
257	26910	4.2968	2	2	3	5	7
258	22133	3.1103	1	2	3	4	5
259	4389	4.4231	1	2	2	4	9
260	5654	2.2264	1	1	2	3	4
261	2679	2.5692	1	1	2	3	4
262	886	4.0113	1	1	2	5	8
263	30793	17.9259	5	7	13	21	36
264	3928	9.8154	3	4	7	12	20
265	4920	8.7287	1	3	6	10	18
266	3361	4.0896	1	1	3	5	8
267	233	4.1416	1	1	2	5	9
268	1280	4.2203	1	1	2	5	9
269	11534	11.1540	2	4	8	14	23
270	4485	3.6990	1	1	2	4	8
271	20964	10.3957	3	5	8	12	19
272	6833	8.5440	3	4	6	10	16
273	1772	6.1146	2	3	5	7	12
274	2604	9.2212	2	3	6	11	18
275	259	4.1158	1	1	2	5	9
276	869	5.7250	1	2	4	7	10
277	75672	7.8474	3	4	6	9	14
278	26559	5.7748	2	3	5	7	10
279	11	4.2727	1	3	4	5	7
280	13522	6.0379	1	3	4	7	11
281	6473	4.0403	1	2	3	5	8
282	1	1.0000	1	1	1	1	1
283	5461	6.5825	2	3	5	8	13
284	1984	4.4622	1	2	3	5	8
285	5012	17.6905	4	8	13	21	35
286	1919	9.7410	4	5	7	11	18
287	6559	16.7590	4	7	11	19	33
288	681	8.2966	3	4	5	8	15
289	4615	5.0550	1	2	3	5	11

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V11.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
290	9268	3.1631	1	2	2	3	5
291	113	1.9735	1	1	1	3	4
292	5234	15.1471	3	6	11	19	31
293	397	6.7809	1	2	5	8	14
294	81554	6.7451	2	3	5	8	12
295	3315	5.4163	2	2	4	6	10
296	229396	7.5914	2	3	5	9	15
297	40518	4.8318	2	2	4	6	9
298	86	4.2791	1	2	2	4	10
299	919	6.3972	1	2	4	8	13
300	12823	8.5192	2	4	6	10	16
301	1909	4.9602	1	2	4	6	10
302	7421	14.9716	7	9	12	18	26
303	18390	11.8336	5	7	9	14	21
304	13592	11.9551	3	5	9	14	24
305	2743	5.6132	2	3	5	7	10
306	11934	7.5380	2	3	5	10	15
307	3326	3.7081	1	2	3	4	6
308	10015	8.2702	2	3	6	10	17
309	3820	3.4382	1	2	3	4	7
310	33148	5.1730	1	2	3	6	11
311	14216	2.5036	1	1	2	3	5
312	2566	5.4228	1	2	4	7	11
313	1173	2.6326	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	29860	10.9882	1	3	7	14	24
316	58365	8.4963	2	3	6	11	17
317	709	4.3202	1	2	3	4	8
318	6274	8.2596	2	3	6	10	17
319	551	3.2886	1	1	2	4	7
320	169655	7.6216	3	4	6	9	14
321	26478	5.3676	2	3	4	6	9
322	75	4.6667	2	3	4	5	10
323	19448	4.0346	1	2	3	5	8
324	11001	2.3168	1	1	2	3	4
325	8671	5.3905	1	2	4	6	10
326	2855	3.4396	1	2	3	4	7
327	3	3.0000	1	1	4	4	4
328	1036	5.0097	1	2	4	6	10
329	199	2.6834	1	1	2	3	5
331	34069	7.1510	2	3	5	9	14
332	4817	4.1391	1	2	3	5	8
333	323	7.2136	1	3	5	10	16
334	28803	7.6281	4	5	7	8	11
335	12802	6.0783	4	5	6	7	9
336	82570	4.9586	2	3	4	6	9
337	59010	3.3024	2	2	3	4	5
338	8907	5.8485	1	2	4	7	13
339	3141	4.7450	1	2	3	5	10
340	3	2.3333	1	1	2	4	4
341	9306	4.0466	1	2	3	4	7
342	304	4.0592	1	1	2	5	10
344	6646	3.8432	1	1	3	5	7
345	1830	4.8781	1	2	3	6	10
346	6711	7.8051	2	3	5	9	16
347	559	3.7084	1	1	3	5	8
348	3711	5.1576	1	2	4	6	10
349	1032	3.3304	1	1	2	4	6
350	7511	5.5387	2	3	5	7	10
352	766	4.8316	1	2	3	6	9
353	2458	10.1644	4	5	8	11	19
354	10030	7.2722	3	4	6	8	12
355	5593	4.3152	3	3	4	5	6
356	35013	3.7038	2	2	3	4	6
357	6795	11.1837	4	6	9	13	21
358	26727	5.6056	3	4	4	6	9
359	26677	3.8030	2	3	4	4	5
360	9550	4.5982	2	3	3	5	8
361	522	4.9904	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 FY93 MEDPAR UPDATE 06/94 GROUPER V11.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
363	5168	4.0035	1	2	3	4	7
364	2105	3.7648	1	1	2	5	8
365	2672	9.5236	2	3	6	12	20
366	4705	9.1237	2	3	6	11	19
367	633	3.8547	1	1	2	4	7
368	1778	7.4156	2	4	6	9	15
369	2362	4.0157	1	1	3	5	8
370	926	6.1760	3	3	4	6	10
371	926	3.9525	3	3	3	4	5
372	626	3.5591	1	2	3	4	6
373	3288	2.2202	1	1	2	2	3
374	138	3.1667	1	2	2	3	5
375	4	51.5000	2	2	3	11	190
376	182	3.4835	1	2	2	4	7
377	34	5.6765	1	1	3	10	13
378	142	3.0282	1	2	3	4	5
379	356	2.8792	1	1	2	3	6
380	74	2.0676	1	1	1	3	4
381	234	2.6068	1	1	1	3	5
382	49	1.4898	1	1	1	1	2
383	1239	4.1114	1	2	3	5	8
384	133	2.7218	1	1	2	3	5
385	2	2.5000	1	1	4	4	4
387	1	96.0000	96	96	96	96	96
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	2475	13.3208	5	6	10	16	26
393	1	3.0000	3	3	3	3	3
394	1875	9.1568	1	2	5	10	20
395	67817	6.1000	1	3	4	7	12
396	16	2.1250	1	1	1	3	4
397	13912	6.9811	2	3	5	9	14
398	16364	7.4887	3	4	6	9	14
399	1472	4.7772	1	2	4	6	9
400	8198	11.8862	2	4	8	15	26
401	6474	13.7359	3	5	10	17	29
402	1910	4.8005	1	2	3	6	10
403	32109	10.7763	2	4	8	14	22
404	4368	5.2097	1	2	4	7	10
406	3699	13.0338	3	6	9	16	26
407	824	5.3228	1	2	4	7	10
408	3652	8.5783	1	2	5	10	20
409	6951	7.8958	2	4	5	8	17
410	116918	3.4340	1	2	3	4	6
411	88	3.7159	1	1	3	4	6
412	86	3.2791	1	1	2	4	6
413	8708	9.9641	2	4	7	12	21
414	1126	5.5320	1	2	4	7	11
415	35127	18.8135	5	8	14	23	37
416	166879	9.5806	2	5	8	12	18
417	35	7.4571	2	3	5	7	17
418	15991	7.7532	3	4	6	9	14
419	16927	6.7616	2	3	5	8	12
420	3110	5.0559	2	3	4	6	9
421	13460	5.2491	2	3	4	6	10
422	96	4.4479	2	2	3	5	8
423	8140	10.1158	3	4	7	12	21
424	2386	23.6282	3	8	15	27	47
425	17702	5.9108	1	2	4	7	12
426	5406	6.6595	2	3	5	8	13
427	1967	6.5379	1	2	4	8	14
428	1062	10.1224	1	3	6	12	21
429	33360	11.1442	2	4	7	12	21
430	57419	11.5978	2	5	9	15	23
431	192	7.5938	2	3	5	9	16
432	486	7.3519	1	2	4	9	16
433	7105	4.1161	1	1	3	5	9
434	19457	6.8855	2	3	5	8	13
435	13392	5.6022	1	3	4	6	11

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V11.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
436	2478	17.0282	5	10	16	24	28
437	12667	13.5997	5	8	12	18	25
439	885	9.6475	1	3	6	12	22
440	4513	11.5203	2	4	7	14	25
441	674	3.8353	1	1	2	4	7
442	13113	9.7342	1	3	6	12	21
443	4430	3.3151	1	1	2	4	7
444	3326	6.5541	2	3	5	8	12
445	1588	4.1159	1	2	3	5	8
447	3389	3.1467	1	1	2	4	6
448	1	2.0000	2	2	2	2	2
449	29032	5.3059	1	2	4	6	11
450	6523	2.7887	1	1	2	3	5
451	7	2.0000	1	1	1	2	3
452	19259	5.8733	1	2	4	7	12
453	4247	3.4490	1	1	2	4	7
454	4613	6.5808	1	2	4	7	14
455	1135	3.5480	1	1	2	4	7
456	191	10.2147	1	2	5	12	25
457	129	5.6434	1	1	3	8	15
458	1640	19.9061	5	9	15	25	39
459	584	12.4640	3	5	9	15	28
460	2319	8.3182	2	3	6	10	16
461	4408	5.4226	1	1	2	4	14
462	10437	16.6802	5	8	14	22	31
463	9266	6.2893	2	3	5	7	12
464	2296	4.1376	1	2	3	5	8
465	314	3.1656	1	1	2	3	7
466	2919	5.6262	1	1	2	4	9
467	3026	5.1021	1	1	2	5	9
468	65013	17.7402	4	8	13	22	35
471	8389	11.3348	5	7	9	13	18
472	154	30.3961	2	8	21	38	63
473	8459	16.2898	2	4	9	25	39
475	81206	13.7356	2	6	11	18	27
476	8813	15.7757	5	9	13	19	27
477	35802	9.8340	1	3	7	12	20
478	112660	9.6443	2	4	7	12	20
479	16364	5.1058	1	2	4	7	10
480	290	36.0586	12	15	26	45	69
481	127	38.8346	21	26	35	44	60
482	7297	17.8390	6	8	13	20	34
483	36182	53.5939	17	27	42	65	99
484	329	20.1429	2	7	14	26	42
485	2893	14.6619	6	7	11	17	27
486	2178	16.7929	1	6	12	22	35
487	3498	10.2704	2	4	8	13	21
488	906	21.5088	6	9	15	26	40
489	9555	12.5051	3	5	8	15	25
490	3125	8.1600	2	3	5	9	16
491	8305	5.3404	2	3	4	6	9
492	1565	16.8863	3	5	8	27	37
493	50329	6.2752	1	2	5	8	13
494	31920	2.3314	1	1	1	3	5
	10657022						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
001	30789	13.5837	3	6	10	17	28
002	6029	13.9756	4	6	10	17	27
003	2	41.5000	17	17	66	66	66
004	5470	11.0845	2	4	7	14	23
005	64742	5.8330	2	3	4	7	11
006	526	3.1920	1	1	2	4	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
007	7929	17.9653	3	5	10	19	36
008	2330	4.6991	1	1	3	6	11
009	1636	9.2219	2	4	6	11	17
010	20813	9.7252	2	4	7	12	20
011	3262	5.5880	1	2	4	7	11
012	21908	9.3495	2	4	6	11	17
013	6261	7.5787	3	4	6	9	13
014	356425	8.9404	2	4	7	11	17
015	132399	5.0854	2	2	4	6	9
016	11159	8.2904	2	4	6	10	15
017	3657	4.7060	1	2	4	6	9
018	18848	7.3077	2	3	6	9	14
019	7200	4.8607	1	2	4	6	9
020	7645	11.7438	3	5	9	15	23
021	1049	8.6883	2	4	7	11	17
022	3836	5.5792	2	3	4	7	10
023	4751	5.7925	1	2	4	7	11
024	55823	6.8735	2	3	5	8	13
025	21460	4.2266	1	2	3	5	8
026	42	4.3095	1	2	2	4	9
027	3097	7.8589	1	1	4	9	17
028	9249	8.5089	2	3	6	10	18
029	3423	4.6594	1	2	3	6	9
031	3730	5.9056	1	2	4	7	12
032	2173	3.5274	1	1	2	4	7
034	15102	7.7488	2	3	5	9	15
035	3477	4.9721	1	2	4	6	9
036	16219	1.8739	1	1	1	2	3
037	2345	4.1062	1	1	3	5	9
038	479	2.7307	1	1	2	3	5
039	5281	2.0364	1	1	1	2	4
040	3432	3.6005	1	1	2	4	8
042	12274	2.2783	1	1	1	2	5
043	146	4.2466	1	2	3	5	7
044	1707	6.0521	2	3	5	8	11
045	2453	4.3343	1	2	4	6	8
046	2990	6.3164	1	3	5	7	12
047	1512	3.9061	1	2	3	5	8
049	2298	6.9956	2	3	5	8	13
050	4065	2.3454	1	1	2	3	4
051	412	3.1044	1	1	2	3	7
052	102	3.3431	1	1	2	4	7
053	4619	3.5817	1	1	2	4	8
054	1	1.0000	1	1	1	1	1
055	2573	3.0377	1	1	1	3	7
056	854	3.1674	1	1	2	4	7
057	624	5.3333	1	2	3	6	11
059	128	2.3750	1	1	1	2	4
060	2	2.5000	2	2	3	3	3
061	298	5.2148	1	1	2	7	12
063	4536	5.3450	1	2	3	6	10
064	3756	8.3568	1	2	5	10	18
065	34410	3.8767	1	2	3	5	7
066	7619	4.0374	1	2	3	5	7
067	463	4.7451	2	3	4	6	9
068	12598	5.4822	2	3	4	7	10
069	3725	4.2545	2	2	4	5	7
070	36	4.3056	1	2	4	5	7
071	138	4.2174	2	2	3	5	8
072	623	4.3900	1	2	3	5	9
073	6364	5.6578	1	2	4	7	11
075	36955	12.6172	5	7	9	15	24
076	38636	14.2058	3	6	11	17	27
077	2861	6.0304	1	2	4	8	13
078	27188	9.3107	4	6	8	11	15
079	176400	10.8265	3	5	8	13	20
080	8662	7.4938	3	4	6	9	13
081	10	7.1000	1	4	6	10	13
082	68966	8.9400	2	4	7	11	18
083	7393	7.4088	2	3	6	9	14

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
084	1649	4.3475	1	2	3	5	8
085	17273	8.2564	2	4	7	10	16
086	1531	4.9458	1	2	4	6	10
087	51836	7.5535	1	3	6	10	14
088	335129	7.0079	3	4	6	8	12
089	413681	8.1066	3	4	7	10	14
090	41082	5.7548	2	3	5	7	10
091	39	4.4359	2	3	4	5	8
092	10461	8.1576	3	4	6	10	15
093	1390	5.9029	2	3	5	7	11
094	9988	8.6522	3	4	7	11	17
095	1116	4.9615	2	3	4	6	9
096	79105	6.3437	2	4	5	8	11
097	28358	4.8701	2	3	4	6	8
098	29	4.1034	1	2	3	4	7
099	27622	4.2452	1	2	3	5	8
100	11016	2.8297	1	1	2	3	5
101	18830	6.3780	2	3	5	8	12
102	3168	4.0726	1	2	3	5	8
103	374	36.8235	10	14	23	46	83
104	20761	18.1163	8	11	15	22	31
105	18135	13.3385	7	8	10	15	23
106	86394	13.8896	7	9	12	16	22
107	57166	10.6348	6	7	9	12	17
108	6381	14.6552	5	8	12	18	27
110	56196	12.2957	3	7	10	15	23
111	5542	7.5832	3	6	7	9	11
112	166651	5.3420	1	2	4	7	11
113	41621	17.4883	5	8	13	21	35
114	8843	11.1036	3	5	8	14	22
115	9528	12.8102	5	7	11	16	23
116	74533	6.5235	2	3	5	8	13
117	3788	5.0198	1	2	3	6	10
118	7713	3.5309	1	1	2	4	8
119	2438	5.7724	1	1	3	7	14
120	40179	10.8965	1	3	7	14	24
121	160886	8.7273	3	5	7	11	15
122	95449	6.0310	2	3	6	8	10
123	53564	5.1018	1	1	3	6	12
124	135111	5.5606	1	2	4	7	11
125	69007	3.2146	1	1	2	4	7
126	4416	18.3338	5	8	14	25	38
127	684369	7.2104	2	4	6	9	14
128	22330	7.7058	4	5	7	9	12
129	5431	3.8842	1	1	1	4	10
130	81875	7.5149	2	4	6	9	13
131	24974	5.6244	1	3	5	7	9
132	17170	4.8175	1	2	4	6	9
133	3818	3.5115	1	2	3	4	7
134	30893	4.4949	1	2	3	5	8
135	6243	6.0115	2	3	4	7	11
136	1221	3.8878	1	2	3	5	7
138	198568	5.3081	2	2	4	6	10
139	68516	3.3781	1	2	3	4	6
140	320756	4.0935	1	2	3	5	7
141	76663	5.2949	2	2	4	6	10
142	35435	3.6916	1	2	3	4	7
143	134666	3.0822	1	2	2	4	6
144	59340	6.5381	1	3	5	8	13
145	6947	3.7669	1	2	3	5	7
146	8207	12.3398	6	8	10	14	21
147	1483	7.9845	4	6	8	9	11
148	146601	14.9530	7	8	12	17	27
149	14784	8.3103	5	6	8	9	12
150	22866	12.9395	5	7	11	15	23
151	4350	6.8198	2	4	6	9	12
152	4940	9.9921	4	6	8	11	16
153	1779	6.7482	3	5	6	8	10
154	36964	17.1986	6	9	13	21	33
155	3772	7.4467	3	4	7	9	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
156	4	11.5000	2	5	9	13	22
157	12614	6.3773	2	3	4	8	13
158	7154	3.0415	1	1	2	4	6
159	17551	5.8036	2	3	4	7	11
160	11024	3.1692	1	2	3	4	6
161	18354	4.8137	1	2	3	6	10
162	11776	2.2116	1	1	2	3	4
163	16	4.7500	2	2	3	6	8
164	5026	10.3341	5	6	9	12	17
165	1523	6.3020	3	4	6	8	10
166	3221	6.4865	2	3	5	8	12
167	2244	3.6925	2	2	3	5	6
168	1916	5.6169	1	2	3	7	12
169	1223	2.6917	1	1	2	3	6
170	13083	14.8143	3	6	11	18	30
171	1226	5.8728	1	3	5	8	11
172	31169	9.4910	2	4	7	12	19
173	2494	4.6684	1	2	3	6	9
174	227972	6.3604	2	3	5	8	12
175	25636	3.9298	2	2	3	5	7
176	14948	7.0566	2	3	5	8	13
177	13026	5.6763	2	3	5	7	10
178	4996	3.9586	2	2	3	5	7
179	9786	8.3933	3	4	6	10	16
180	78727	6.9989	2	3	5	8	13
181	20704	4.2217	1	2	4	5	7
182	233789	5.7645	2	3	4	7	11
183	72286	3.8396	1	2	3	5	7
184	68	3.9853	1	2	3	4	5
185	3706	5.9331	1	2	4	7	12
186	5	4.0000	1	1	3	6	8
187	962	3.9314	1	1	3	5	8
188	53804	6.9627	2	3	5	8	14
189	7894	3.7683	1	1	3	5	8
190	58	4.4828	1	2	3	5	6
191	10463	18.3336	6	9	14	22	36
192	827	8.8295	2	5	8	11	15
193	10463	15.8892	6	9	13	19	28
194	921	9.1205	3	5	8	11	16
195	12514	11.7907	5	7	10	14	20
196	1041	7.5370	4	5	7	9	12
197	34315	9.9735	4	6	8	12	17
198	10471	5.3032	2	3	5	7	9
199	2719	13.3553	4	6	10	17	26
200	1717	13.2627	2	5	10	17	28
201	1707	17.0949	4	7	12	22	35
202	21167	8.7487	2	4	7	11	17
203	29609	8.8798	2	4	7	11	18
204	44863	7.5342	2	4	6	9	14
205	21708	8.5126	2	4	6	10	17
206	1903	4.7078	1	2	4	6	10
207	36948	6.5512	2	3	5	8	12
208	11535	3.6717	1	2	3	5	7
209	306116	8.7749	5	6	8	10	13
210	130491	10.9485	5	6	9	12	18
211	25285	7.9929	4	5	7	9	12
212	11	4.0909	1	3	4	5	6
213	6425	11.7387	3	5	8	14	23
214	49507	8.3687	3	4	6	10	15
215	39923	4.7950	2	3	4	6	8
216	6665	13.3539	3	6	10	17	27
217	18210	19.1730	4	7	13	23	41
218	21794	7.7061	2	4	6	9	14
219	19004	4.4786	2	2	4	5	8
220	5	6.2000	2	2	6	7	10
221	4800	9.4481	2	4	7	11	19
222	4034	4.6931	1	2	4	6	9
223	18870	3.3388	1	2	2	4	6
224	8486	2.6704	1	1	2	3	5
225	7671	5.2045	1	2	3	6	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
226	5654	7.8857	2	3	5	9	17
227	5722	3.2242	1	1	2	4	6
228	3548	3.6863	1	1	2	4	8
229	1812	2.5204	1	1	2	3	5
230	2869	5.8323	1	2	3	7	12
231	10695	5.6342	1	2	3	7	13
232	785	5.9121	1	1	3	6	16
233	4945	10.7391	2	4	8	13	22
234	2461	4.8058	1	2	3	6	10
235	6207	9.0292	2	3	6	10	18
236	38922	7.8441	2	3	6	9	15
237	1622	5.3138	1	2	4	6	10
238	6842	12.7514	3	6	9	15	26
239	61512	9.2090	3	4	7	11	18
240	11345	8.9998	2	4	7	11	17
241	3300	5.1988	1	2	4	6	10
242	2305	9.4898	3	4	7	11	18
243	89931	6.5203	2	3	5	8	12
244	11437	6.8429	2	3	5	8	13
245	4627	4.9777	1	2	3	6	9
246	1449	4.8440	2	2	4	6	9
247	10123	4.6937	1	2	3	6	9
248	6602	6.0048	2	3	4	7	11
249	9534	5.2327	1	2	3	6	11
250	3352	6.1516	1	2	4	7	12
251	2556	3.4879	1	1	2	4	7
252	2	6.0000	2	2	10	10	10
253	17574	7.2871	2	3	5	8	14
254	10464	4.4119	1	2	3	5	8
255	1	10.0000	10	10	10	10	10
256	9618	4.8292	1	2	3	6	9
257	26910	4.2968	2	2	3	5	7
258	22133	3.1103	1	2	3	4	5
259	4389	4.4231	1	2	2	4	9
260	5654	2.2264	1	1	2	3	4
261	2679	2.5692	1	1	2	3	4
262	886	4.0113	1	1	2	5	8
263	30793	17.9259	5	7	13	21	36
264	3928	9.8154	3	4	7	12	20
265	4920	8.7287	1	3	6	10	18
266	3361	4.0896	1	1	3	5	8
267	233	4.1416	1	1	2	5	9
268	1280	4.2203	1	1	2	5	9
269	11534	11.1540	2	4	8	14	23
270	4485	3.6990	1	1	2	4	8
271	20961	10.3949	3	5	8	12	19
272	6833	8.5440	3	4	6	10	16
273	1772	6.1146	2	3	5	7	12
274	2604	9.2212	2	3	6	11	18
275	259	4.1158	1	1	2	5	9
276	869	5.7250	1	2	4	7	10
277	75655	7.8471	3	4	6	9	14
278	26553	5.7747	2	3	5	7	10
279	11	4.2727	1	3	4	5	7
280	13522	6.0379	1	3	4	7	11
281	6472	4.0383	1	2	3	5	8
282	1	1.0000	1	1	1	1	1
283	5470	6.5856	2	3	5	8	13
284	1989	4.4610	1	2	3	5	8
285	5012	17.6905	4	8	13	21	35
286	1919	9.7410	4	5	7	11	18
287	6559	16.7590	4	7	11	19	33
288	681	8.2966	3	4	5	8	15
289	4615	5.0550	1	2	3	5	11
290	9268	3.1631	1	2	2	3	5
291	113	1.9735	1	1	1	3	4
292	5234	15.1471	3	6	11	19	31
293	397	6.7809	1	2	5	8	14
294	81545	6.7447	2	3	5	8	12
295	3315	5.4163	2	2	4	6	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
296	229391	7.5914	2	3	5	9	15
297	40516	4.8318	2	2	4	6	9
298	86	4.2791	1	2	2	4	10
299	919	6.3972	1	2	4	8	13
300	12823	8.5192	2	4	6	10	16
301	1909	4.9602	1	2	4	6	10
302	7421	14.9716	7	9	12	18	26
303	18390	11.8336	5	7	9	14	21
304	13559	11.9655	3	5	9	14	24
305	2776	5.6380	2	3	5	7	10
306	11934	7.5380	2	3	5	10	15
307	3326	3.7081	1	2	3	4	6
308	10014	8.2706	2	3	6	10	17
309	3821	3.4384	1	2	3	4	7
310	33147	5.1730	1	2	3	6	11
311	14217	2.5038	1	1	2	3	5
312	2566	5.4228	1	2	4	7	11
313	1173	2.6326	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	29860	10.9882	1	3	7	14	24
316	58364	8.4964	2	3	6	11	17
317	709	4.3202	1	2	3	4	8
318	6274	8.2596	2	3	6	10	17
319	551	3.2886	1	1	2	4	7
320	169648	7.6216	3	4	6	9	14
321	26475	5.3671	2	3	4	6	9
322	75	4.6667	2	3	4	5	10
323	19448	4.0346	1	2	3	5	8
324	11001	2.3168	1	1	2	3	4
325	8671	5.3905	1	2	4	6	10
326	2855	3.4396	1	2	3	4	7
327	3	3.0000	1	1	4	4	4
328	1036	5.0097	1	2	4	6	10
329	199	2.6834	1	1	2	3	5
331	33402	7.1800	2	3	5	9	14
332	5484	4.3288	1	2	3	5	9
333	323	7.2136	1	3	5	10	16
334	28803	7.6281	4	5	7	8	11
335	12802	6.0783	4	5	6	7	9
336	82570	4.9586	2	3	4	6	9
337	59010	3.3024	2	2	3	4	5
338	8907	5.8485	1	2	4	7	13
339	3141	4.7450	1	2	3	5	10
340	3	2.3333	1	1	2	4	4
341	9306	4.0466	1	2	3	4	7
342	304	4.0592	1	1	2	5	10
344	6646	3.8432	1	1	3	5	7
345	1830	4.8781	1	2	3	6	10
346	6711	7.8051	2	3	5	9	16
347	559	3.7084	1	1	3	5	8
348	3711	5.1576	1	2	4	6	10
349	1032	3.3304	1	1	2	4	6
350	7511	5.5387	2	3	5	7	10
352	766	4.8316	1	2	3	6	9
353	2458	10.1644	4	5	8	11	19
354	10030	7.2722	3	4	6	8	12
355	5593	4.3152	3	3	4	5	6
356	35013	3.7038	2	2	3	4	6
357	6795	11.1837	4	6	9	13	21
358	26727	5.6056	3	4	4	6	9
359	26677	3.8030	2	3	4	4	5
360	9550	4.5982	2	3	3	5	8
361	522	4.9904	1	2	3	5	11
362	3	1.3333	1	1	1	2	2
363	5168	4.0035	1	2	3	4	7
364	2105	3.7648	1	1	2	5	8
365	2672	9.5236	2	3	6	12	20
366	4705	9.1237	2	3	6	11	19
367	633	3.8547	1	1	2	4	7
368	1778	7.4156	2	4	6	9	15

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
369	2362	4.0157	1	1	3	5	8
370	926	6.1760	3	3	4	6	10
371	926	3.9525	3	3	3	4	5
372	626	3.5591	1	2	3	4	6
373	3288	2.2202	1	1	2	2	3
374	138	3.1667	1	2	2	3	5
375	4	51.5000	2	2	3	11	190
376	182	3.4835	1	2	2	4	7
377	34	5.6765	1	1	3	10	13
378	142	3.0282	1	2	3	4	5
379	356	2.8792	1	1	2	3	6
380	74	2.0676	1	1	1	3	4
381	234	2.6068	1	1	1	3	5
382	49	1.4898	1	1	1	1	2
383	1239	4.1114	1	2	3	5	8
384	133	2.7218	1	1	2	3	5
385	2	2.5000	1	1	4	4	4
387	1	96.0000	96	96	96	96	96
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	2475	13.3208	5	6	10	16	26
393	1	3.0000	3	3	3	3	3
394	1875	9.1568	1	2	5	10	20
395	67817	6.1000	1	3	4	7	12
396	16	2.1250	1	1	1	3	4
397	13912	6.9811	2	3	5	9	14
398	16364	7.4887	3	4	6	9	14
399	1472	4.7772	1	2	4	6	9
400	8198	11.8862	2	4	8	15	26
401	6474	13.7359	3	5	10	17	29
402	1910	4.8005	1	2	3	6	10
403	32106	10.7768	2	4	8	14	22
404	4368	5.2097	1	2	4	7	10
406	3699	13.0338	3	6	9	16	26
407	824	5.3228	1	2	4	7	10
408	3652	8.5783	1	2	5	10	20
409	6951	7.8958	2	4	5	8	17
410	116918	3.4340	1	2	3	4	6
411	88	3.7159	1	1	3	4	6
412	86	3.2791	1	1	2	4	6
413	8708	9.9641	2	4	7	12	21
414	1126	5.5320	1	2	4	7	11
415	35127	18.8135	5	8	14	23	37
416	166877	9.5806	2	5	8	12	18
417	35	7.4571	2	3	5	7	17
418	15991	7.7532	3	4	6	9	14
419	16926	6.7615	2	3	5	8	12
420	3110	5.0559	2	3	4	6	9
421	13460	5.2491	2	3	4	6	10
422	95	4.4737	2	2	3	5	8
423	8140	10.1158	3	4	7	12	21
424	2386	23.6282	3	8	15	27	47
425	17702	5.9108	1	2	4	7	12
426	5405	6.6605	2	3	5	8	13
427	1967	6.5379	1	2	4	8	14
428	1062	10.1224	1	3	6	12	21
429	33360	11.1442	2	4	7	12	21
430	57419	11.5978	2	5	9	15	23
431	192	7.5938	2	3	5	9	16
432	486	7.3519	1	2	4	9	16
433	7105	4.1161	1	1	3	5	9
434	19456	6.8858	2	3	5	8	13
435	13390	5.6025	1	3	4	6	11
436	2478	17.0282	5	10	16	24	28
437	12667	13.5997	5	8	12	18	25
439	885	9.6475	1	3	6	12	22
440	4513	11.5203	2	4	7	14	25
441	674	3.8353	1	1	2	4	7
442	13113	9.7342	1	3	6	12	21

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY93 MEDPAR UPDATE 06/94 GROUPER V12.0—Continued

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
443	4430	3.3151	1	1	2	4	7
444	3324	6.5548	2	3	5	8	12
445	1587	4.1141	1	2	3	5	8
447	3389	3.1467	1	1	2	4	6
448	1	2.0000	2	2	2	2	2
449	29032	5.3059	1	2	4	6	11
450	6523	2.7887	1	1	2	3	5
451	7	2.0000	1	1	1	2	3
452	19259	5.8733	1	2	4	7	12
453	4247	3.4490	1	1	2	4	7
454	4613	6.5808	1	2	4	7	14
455	1135	3.5480	1	1	2	4	7
456	191	10.2147	1	2	5	12	25
457	129	5.6434	1	1	3	8	15
458	1640	19.9061	5	9	15	25	39
459	584	12.4640	3	5	9	15	28
460	2319	8.3182	2	3	6	10	16
461	4408	5.4226	1	1	2	4	14
462	10437	16.6802	5	8	14	22	31
463	9266	6.2893	2	3	5	7	12
464	2296	4.1376	1	2	3	5	8
465	314	3.1656	1	1	2	3	7
466	2917	5.6284	1	1	2	4	9
467	3026	5.1021	1	1	2	5	9
468	61267	17.8425	4	8	14	22	35
471	8389	11.3348	5	7	9	13	18
472	154	30.3961	2	8	21	38	63
473	8459	16.2898	2	4	9	25	39
475	81206	13.7356	2	6	11	18	27
476	8813	15.7781	5	9	13	19	27
477	35488	9.8159	1	3	7	12	20
478	112660	9.6443	2	4	7	12	20
479	16364	5.1058	1	2	4	7	10
480	290	36.0586	12	15	26	45	69
481	127	38.8346	21	26	35	44	60
482	7297	17.8390	6	8	13	20	34
483	36182	53.5939	17	27	42	65	99
484	329	20.1429	2	7	14	26	42
485	2893	14.6619	6	7	11	17	27
486	2178	16.7929	1	6	12	22	35
487	3498	10.2704	2	4	8	13	21
488	903	21.4895	6	9	15	26	40
489	9557	12.5103	3	5	8	15	25
490	3125	8.1590	2	3	5	9	16
491	8305	5.3404	2	3	4	6	9
492	1565	16.8863	3	5	8	27	37
493	50329	6.2752	1	2	5	8	13
494	31920	2.3314	1	1	1	3	5
495	105	28.0190	11	15	22	33	47
	10656824						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1994

State	Urban	Rural
ALABAMA	0.447	0.517
ALASKA	0.515	0.801
ARIZONA	0.484	0.638
ARKANSAS	0.585	0.516
CALIFORNIA	0.451	0.559
COLORADO	0.533	0.605
CONNECTICUT	0.572	0.596
DELAWARE	0.603	0.527
DISTRICT OF COLUMBIA	0.533	.....

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1994—Continued

State	Urban	Rural
FLORIDA	0.460	0.462
GEORGIA	0.555	0.553
HAWAII	0.547	0.633
IDAHO	0.590	0.672
ILLINOIS	0.530	0.608
INDIANA	0.604	0.660
IOWA	0.571	0.735
KANSAS	0.518	0.691

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1994—Continued

State	Urban	Rural
KENTUCKY	0.539	0.575
LOUISIANA	0.506	0.560
MAINE	0.685	0.577
MARYLAND	0.764	0.807
MASSACHUSETTS	0.656	0.643
MICHIGAN	0.546	0.669
MINNESOTA	0.586	0.669
MISSISSIPPI	0.553	0.554

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1994—Continued

State	Urban	Rural
MISSOURI	0.498	0.552
MONTANA	0.546	0.654
NEBRASKA	0.558	0.706
NEVADA	0.419	0.522
NEW HAMPSHIRE	0.607	0.645
NEW JERSEY	0.676	
NEW MEXICO	0.544	0.551
NEW YORK	0.625	0.731
NORTH CAROLINA	0.579	0.536
NORTH DAKOTA	0.660	0.692
OHIO	0.608	0.658
OKLAHOMA	0.524	0.570
OREGON	0.599	0.645
PENNSYLVANIA	0.464	0.592
PUERTO RICO	0.554	0.876
RHODE ISLAND	0.606	
SOUTH CAROLINA	0.528	0.526
SOUTH DAKOTA	0.569	0.648
TENNESSEE	0.541	0.569
TEXAS	0.507	0.611
UTAH	0.596	0.654
VERMONT	0.619	0.621
VIRGINIA	0.537	0.563
WASHINGTON	0.663	0.759
WEST VIRGINIA	0.585	0.523
WISCONSIN	0.651	0.707
WYOMING	0.617	0.759

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1994

State	Ratio
ALABAMA	0.059
ALASKA	0.093
ARIZONA	0.061
ARKANSAS	0.050
CALIFORNIA	0.044
COLORADO	0.053
CONNECTICUT	0.045
DELAWARE	0.055
DISTRICT OF COLUMBIA	0.043
FLORIDA	0.058
GEORGIA	0.049
HAWAII	0.056
IDAHO	0.073
ILLINOIS	0.049
INDIANA	0.063
IOWA	0.060
KANSAS	0.063
KENTUCKY	0.056
LOUISIANA	0.075
MAINE	0.043
MASSACHUSETTS	0.065
MICHIGAN	0.060
MINNESOTA	0.055
MISSISSIPPI	0.057
MISSOURI	0.058
MONTANA	0.068
NEBRASKA	0.060
NEVADA	0.038
NEW HAMPSHIRE	0.062
NEW JERSEY	0.056
NEW MEXICO	0.060
NEW YORK	0.059

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1994—Continued

State	Ratio
NORTH CAROLINA	0.050
NORTH DAKOTA	0.070
OHIO	0.062
OKLAHOMA	0.062
OREGON	0.054
PENNSYLVANIA	0.049
PUERTO RICO	0.090
RHODE ISLAND	0.027
SOUTH CAROLINA	0.067
SOUTH DAKOTA	0.068
TENNESSEE	0.060
TEXAS	0.065
UTAH	0.052
VERMONT	0.050
VIRGINIA	0.061
WASHINGTON	0.072
WEST VIRGINIA	0.057
WISCONSIN	0.046
WYOMING	0.074

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
010001	10/01/92	09/30/93	1.3433	0.9993
010004	10/01/92	09/30/93	1.0466	0.9444
010005	10/01/92	09/30/93	1.1202	0.9733
010007	10/01/92	09/30/93	1.0812	0.9620
010008	10/01/92	09/30/93	0.9865	0.9718
010009	08/01/92	07/31/93	1.0770	0.9671
010010	10/01/92	09/30/93	1.1173	0.9597
010016	10/01/92	09/30/93	1.1850	0.9771
010019	10/01/92	09/30/93	1.2418	0.9832
010021	10/01/92	09/30/93	1.2792	0.9748
010027	10/01/92	09/30/93	0.8655	0.9506
010029	10/01/92	09/30/93	1.4506	0.9970
010032	01/01/93	12/31/93	0.9329	0.9496
010033	10/01/92	09/30/93	1.8957	0.9967
010035	10/01/92	09/30/93	1.1933	0.9826
010040	01/01/93	12/31/93	1.4180	0.9937
010044	10/01/92	09/30/93	1.0645	0.9735
010045	10/01/92	09/30/93	1.1156	0.9635
010047	10/01/92	09/30/93	1.0002	0.9642
010051	10/01/92	09/30/93	0.9130	0.9802
010052	10/01/92	09/30/93	0.9391	0.9434
010053	10/01/92	09/30/93	1.0618	0.9563
010059	10/01/92	09/30/93	1.0529	0.9472
010061	10/01/92	09/30/93	1.0023	0.9678
010062	10/01/92	09/30/93	0.9841	0.9684
010065	01/01/93	12/31/93	1.4689	0.9719
010069	10/01/92	09/30/93	1.1411	0.9614
010073	10/01/92	09/30/93	0.9158	0.9593
010079	10/01/92	09/30/93	1.1386	0.9727
010081	09/01/92	08/31/93	1.8321	0.9961
010083	10/01/92	09/30/93	1.0498	0.9697
010084	01/01/93	12/31/93	1.3874	0.9955
010087	10/01/92	09/30/93	1.8142	0.9989
010092	10/01/92	09/30/93	1.3570	0.9996
010094	09/01/92	08/31/93	1.1644	0.9693
010095	10/01/92	09/30/93	1.0805	0.9399
010097	10/01/92	09/30/93	0.9091	0.9652
010099	10/01/92	09/30/93	1.0410	0.9597
010100	10/01/92	09/30/93	1.2224	0.9806
010102	10/01/92	09/30/93	0.8853	0.9411
010108	11/01/92	10/31/93	1.2356	0.9716
010109	10/01/92	09/30/93	1.0721	0.9841
010110	10/01/92	09/30/93	0.9970	0.9451
010112	10/01/92	09/30/93	1.1398	0.9660
010115	10/01/92	09/30/93	0.8687	0.9507
010117	10/01/92	09/30/93	0.9041	0.9982
010119	10/01/92	09/30/93	1.1049	0.9774

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
010120	10/01/92	09/30/93	0.9880	0.9516
010124	09/01/92	08/31/93	1.2680	0.9745
010125	10/01/92	09/30/93	1.0367	0.9706
010126	10/01/92	09/30/93	1.0645	0.9698
010127	09/01/92	08/31/93	1.5433	0.9978
010129	10/01/92	09/30/93	1.0713	0.9610
010130	10/01/92	09/30/93	1.0889	0.9744
010137	10/01/92	09/30/93	1.2871	0.9853
010143	10/01/92	09/30/93	1.1680	0.9602
010144	01/01/93	12/31/93	1.3363	0.9877
010145	10/01/92	09/30/93	1.2420	0.9945
010146	10/01/92	09/30/93	1.1099	0.9673
010149	09/01/92	08/31/93	1.4229	0.9894
010152	10/01/92	09/30/93	1.3715	0.9757
010155	10/01/92	09/30/93	0.9952	0.9859
020001	01/01/93	12/31/93	1.4832	0.9986
020005	10/01/92	09/30/93	0.8686	0.9075
020006	01/01/93	12/31/93	1.0889	0.9812
020012	01/01/93	12/31/93	1.2952	0.9877
020025	01/01/93	12/31/93	1.0283	0.9359
030001	01/01/93	12/31/93	1.3269	0.9853
030002	01/01/93	12/31/93	1.7749	0.9970
030004	10/01/92	09/30/93	1.0256	0.9655
030012	01/01/93	12/31/93	1.2245	0.9818
030013	10/01/92	09/30/93	1.2298	0.9841
030014	01/01/93	12/31/93	1.4786	0.9982
030018	01/01/93	12/31/93	1.7075	0.9953
030023	01/01/93	12/31/93	1.3075	0.9883
030025	01/01/93	12/31/93	1.1110	0.9598
030030	09/01/92	08/31/93	1.6860	0.9974
030035	01/01/93	12/31/93	1.2836	0.9937
030036	01/01/93	12/31/93	1.1651	0.9907
030038	10/01/92	09/30/93	1.5267	0.9998
030041	01/01/93	12/31/93	0.9269	0.9509
030044	10/01/92	09/30/93	1.0355	0.9394
030046	01/01/93	12/31/93	1.0221	0.9778
030047	01/01/93	12/31/93	0.9636	0.9575
030061	01/01/93	12/31/93	1.5871	0.9992
030062	01/01/93	12/31/93	1.2967	0.9677
030065	01/01/93	12/31/93	1.5321	0.9988
030067	10/01/92	09/30/93	1.0815	0.9406
030068	01/01/93	12/31/93	0.9356	0.9499
030069	01/01/93	12/31/93	1.3049	0.9781
030080	10/01/92	09/30/93	1.6483	0.9989
030085	09/01/92	08/31/93	1.4486	0.9968
030086	09/01/92	08/31/93	1.1495	0.9740
030087	10/01/92	09/30/93	1.6388	0.9989
030088	01/01/93	12/31/93	1.3592	0.9827
030089	01/01/93	12/31/93	1.3628	0.9808
030092	01/01/93	12/31/93	1.4826	0.9929
030093	01/01/93	12/31/93	1.3257	0.9663
030094	09/01/92	08/31/93	1.2844	0.9738
030095	01/01/93	12/31/93	1.1168	0.9695
040004	01/01/93	12/31/93	1.3390	0.9947
040005	10/01/92	09/30/93	0.9396	0.9612
040007	09/01/92	08/31/93	1.6562	0.9983
040010	01/01/93	12/31/93	1.2066	0.9908
040013	01/01/93	12/31/93	1.0104	0.9472
040014	09/01/92	08/31/93	1.2086	0.9932
040018	01/01/93	12/31/93	1.2789	0.9850
040020	10/01/92	09/30/93	1.4988	0.9982
040021	01/01/93	12/31/93	1.2715	0.9879
040024	10/01/92	09/30/93	1.0226	0.9409
040027	01/01/93	12/31/93	1.2968	0.9832
040028	10/01/92	09/30/93	1.0211	0.9593
040029	01/01/93	12/31/93	1.1751	0.9616
040036	01/01/93	12/31/93	1.3575	0.9924
040037	01/01/93	12/31/93	1.1443	0.9745
040041	09/01/92	08/31/93	1.3450	0.9875
040042	01/01/93	12/31/93	1.2758	0.9836
040044	01/01/93	12/31/93	0.9070	0.9504
040045	01/01/93	12/31/93	1.0599	0.9560
040050	10/01/92	09/30/93	1.1319	0.9606
040064	01/01/93	12/31/93	0.8712	0.9469
040066	01/01/93	12/31/93	1.0866	0.9612
040067	10/01/92	09/30/93	1.0668	0.9709
040072	12/01/92	11/30/93	1.1173	0.9739
040075	01/01/93	12/31/93	1.1201	0.9683
040078	01/01/93	12/31/93	1.3007	0.9926
040081	10/01/92	09/30/93	0.8836	0.9222
040085	01/01/93	12/31/93	1.2382	0.9876
040100	01/01/93	12/31/93	1.1253	0.9842
040105	10/01/92	09/30/93	1.0199	0.9663
040106	10/01/92	09/30/93	1.1878	0.9657

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
040107	10/01/92	09/30/93	1.1672	0.9729
040114	01/01/93	12/31/93	1.7809	0.9994
040118	01/01/93	12/31/93	1.1261	0.9892
040119	10/01/92	09/30/93	1.1533	0.9884
050002	10/01/92	09/30/93	1.3574	0.9879
050007	01/01/93	12/31/93	1.5513	0.9981
050008	01/01/93	12/31/93	1.5052	0.9981
050013	01/01/93	12/31/93	1.9438	0.9973
050016	01/01/93	12/31/93	1.1487	0.9877
050018	01/01/93	12/31/93	1.2754	0.9907
050021	09/01/92	08/31/93	1.2799	0.9936
050022	01/01/93	12/31/93	1.4911	0.9975
050024	01/01/93	12/31/93	1.4104	0.9897
050030	12/01/92	11/30/93	1.3479	0.9836
050032	09/01/92	08/31/93	1.2490	0.9853
050047	01/01/93	12/31/93	1.7302	0.9971
050058	10/01/92	09/30/93	1.4159	0.9967
050060	09/01/92	08/31/93	1.4852	0.9990
050061	09/01/92	08/31/93	1.2971	0.9899
050070	01/01/93	12/31/93	1.2554	0.9788
050071	01/01/93	12/31/93	1.2953	0.9849
050072	01/01/93	12/31/93	1.3242	0.9848
050073	01/01/93	12/31/93	1.2605	0.9859
050074	01/01/93	12/31/93	1.1108	0.9715
050075	01/01/93	12/31/93	1.3512	0.9925
050076	01/01/93	12/31/93	1.6112	0.9605
050078	01/01/93	12/31/93	1.3655	0.9867
050080	01/01/93	12/31/93	1.3107	0.9910
050081	09/01/92	08/31/93	1.6115	0.9958
050084	01/01/93	12/31/93	1.5821	0.9984
050091	09/01/92	08/31/93	1.1944	0.9946
050096	01/01/93	12/31/93	1.0886	0.9870
050097	01/01/93	12/31/93	1.4858	0.9928
050099	12/27/92	12/25/93	1.5579	0.9968
050100	10/01/92	09/30/93	1.8029	0.9979
050101	01/01/93	12/31/93	1.3925	0.9835
050102	01/01/93	12/31/93	1.4201	0.9880
050103	01/01/93	12/31/93	1.6526	0.9956
050107	12/01/92	11/30/93	1.3113	0.9930
050108	01/01/93	12/31/93	1.4929	0.9825
050109	01/01/93	12/31/93	2.1274	0.9977
050111	01/01/93	12/31/93	1.3195	0.9995
050112	10/01/92	09/30/93	1.4531	0.9978
050117	01/01/93	12/31/93	1.3029	0.9947
050121	01/01/93	12/31/93	1.4495	0.9833
050122	01/01/93	12/31/93	1.6172	0.9986
050125	01/01/93	12/31/93	1.3598	0.9989
050126	11/01/92	10/31/93	1.3877	0.9973
050127	10/01/92	09/30/93	1.2997	0.9863
050131	01/01/93	12/31/93	1.2868	0.9934
050132	10/01/92	09/30/93	1.3964	0.9869
050135	10/01/92	09/30/93	1.2077	0.9899
050137	01/01/93	12/31/93	1.2959	0.9777
050138	01/01/93	12/31/93	1.7742	0.9946
050139	01/01/93	12/31/93	1.3149	0.9909
050140	01/01/93	12/31/93	1.3623	0.9818
050144	09/01/92	08/31/93	1.5588	0.9955
050145	01/01/93	12/31/93	1.3646	0.9803
050149	10/01/92	09/30/93	1.3535	0.9930
050150	01/01/93	12/31/93	1.3093	0.9799
050154	10/01/92	09/30/93	1.3130	0.9727
050155	10/01/92	09/30/93	1.1514	1.0000
050169	10/01/92	09/30/93	1.5343	0.9846
050173	09/01/92	08/31/93	1.2499	0.9903
050189	10/01/92	09/30/93	0.9773	0.9706
050204	10/01/92	09/30/93	1.3659	0.9868
050205	01/01/93	12/31/93	1.3807	0.9981
050208	01/01/93	12/31/93	1.3047	0.9971
050211	01/01/93	12/31/93	1.3510	0.9918
050214	01/01/93	12/31/93	1.5123	0.9955
050217	01/01/93	12/31/93	1.2767	0.9670
050219	01/01/93	12/31/93	1.3006	0.9805
050222	10/01/92	09/30/93	1.5372	0.9957
050224	09/13/92	09/11/93	1.5804	0.9960
050226	10/01/92	09/30/93	1.3681	0.9972
050231	01/01/93	12/31/93	1.5282	0.9974
050233	10/01/92	09/30/93	1.2602	0.9763
050234	10/01/92	09/30/93	1.2816	0.9783
050235	01/01/93	12/31/93	1.4640	0.9984
050236	01/01/93	12/31/93	1.5519	0.9809
050238	01/01/93	12/31/93	1.5283	0.9964
050239	01/01/93	12/31/93	1.4828	0.9971
050241	01/01/93	12/31/93	1.3179	0.9816
050251	01/01/93	12/31/93	1.0903	0.9744

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
050253	10/01/92	09/30/93	0.9026	1.0000
050254	11/01/92	10/31/93	1.1784	0.9700
050256	11/01/92	10/31/93	1.8190	0.9965
050257	01/01/93	12/31/93	1.1399	0.9977
050270	10/01/92	09/30/93	1.3539	0.9883
050272	10/01/92	09/30/93	1.3906	0.9935
050281	10/01/92	09/30/93	1.4200	0.9839
050282	10/01/92	09/30/93	1.3143	0.9890
050286	08/01/92	07/31/93	0.9221	0.9535
050300	01/01/93	12/31/93	1.2845	0.9915
050301	01/01/93	12/31/93	1.3710	0.9809
050302	01/01/93	12/31/93	1.3718	0.9824
050305	12/27/92	12/25/93	1.6123	0.9973
050309	01/01/93	12/31/93	1.3577	0.9945
050310	09/01/92	08/31/93	1.2452	0.9920
050313	01/01/93	12/31/93	1.2179	0.9634
050317	01/01/93	12/31/93	1.2474	0.9882
050324	10/01/92	09/30/93	1.8331	0.9961
050327	01/01/93	12/31/93	1.6146	0.9959
050328	10/01/92	09/30/93	1.4276	0.9760
050329	01/01/93	12/31/93	1.2425	0.9892
050335	01/01/93	12/31/93	1.2587	0.9755
050336	01/01/93	12/31/93	1.3310	0.9794
050351	01/01/93	12/31/93	1.5080	0.9989
050352	01/01/93	12/31/93	1.3364	0.9676
050357	10/01/92	09/30/93	1.9566	0.9984
050360	01/01/93	12/31/93	1.4462	0.9944
050366	01/01/93	12/31/93	1.3021	0.9556
050367	01/01/93	12/31/93	1.2822	0.9711
050369	01/01/93	12/31/93	1.2719	0.9910
050391	01/01/93	12/31/93	1.3599	0.9888
050394	01/01/93	12/31/93	1.4610	0.9985
050396	01/01/93	12/31/93	1.5488	0.9991
050404	01/01/93	12/31/93	1.2001	0.9710
050407	01/01/93	12/31/93	1.2609	0.9961
050410	01/01/93	12/31/93	1.0783	0.9874
050411	01/01/93	12/31/93	1.3210	0.9872
050417	01/01/93	12/31/93	1.2138	0.9660
050420	01/01/93	12/31/93	1.4480	0.9939
050421	01/01/93	12/31/93	1.4439	0.9867
050424	10/01/92	09/30/93	1.7218	0.9987
050425	01/01/93	12/31/93	1.2542	0.9804
050426	09/01/92	08/31/93	1.3431	0.9925
050431	09/01/92	08/31/93	1.1278	0.9983
050438	10/01/92	09/30/93	1.5714	0.9969
050440	01/01/93	12/31/93	1.3226	0.9704
050441	09/01/92	08/31/93	1.8421	0.9972
050447	09/01/92	08/31/93	1.0827	0.9881
050455	01/01/93	12/31/93	1.8472	0.9983
050456	01/01/93	12/31/93	1.3057	0.9989
050458	01/01/93	12/31/93	0.8308	0.9604
050469	01/01/93	12/31/93	1.0933	0.9669
050471	09/01/92	08/31/93	1.7726	0.9950
050478	01/01/93	12/31/93	1.0128	0.9656
050483	10/01/92	09/30/93	1.1744	0.9987
050486	10/01/92	09/30/93	1.3872	0.9981
050492	09/01/92	08/31/93	1.1895	0.9889
050498	01/01/93	12/31/93	1.3214	0.9719
050503	10/01/92	09/30/93	1.2837	0.9896
050506	08/01/92	07/31/93	1.4421	0.9890
050510	01/01/93	12/31/93	1.3417	0.9852
050512	01/01/93	12/31/93	1.3298	0.9813
050515	01/01/93	12/31/93	1.3031	0.9877
050517	10/01/92	09/30/93	1.2715	0.9941
050523	01/01/93	12/31/93	1.1914	0.9756
050531	09/01/92	08/31/93	1.3777	0.9962
050537	01/01/93	12/31/93	1.2978	0.9776
050541	01/01/93	12/31/93	1.5563	0.9864
050543	01/01/93	12/31/93	0.9014	0.9830
050549	01/01/93	12/31/93	1.7848	0.9971
050550	09/01/92	08/31/93	2.4330	0.9844
050552	01/01/93	12/31/93	1.2377	0.9927
050557	10/01/92	09/30/93	1.5988	0.9983
050561	01/01/93	12/31/93	1.1689	0.9883
050564	12/24/92	12/31/93	1.2692	0.9852
050567	01/01/93	12/31/93	1.5625	0.9947
050570	11/01/92	10/31/93	1.7082	0.9967
050571	10/01/92	09/30/93	1.4523	0.9964
050575	10/01/92	09/30/93	1.2488	0.9949
050580	01/01/93	12/31/93	1.3808	0.9927
050585	01/01/93	12/31/93	1.3396	0.9737
050586	09/01/92	08/31/93	1.3497	0.9734
050587	01/01/93	12/31/93	1.3013	0.9877
050588	09/01/92	08/31/93	1.2428	0.9836

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
050590	01/01/93	12/31/93	1.3190	0.9821
050591	09/01/92	08/31/93	1.2035	0.9944
050592	09/01/92	08/31/93	1.2470	0.9791
050593	01/01/93	12/31/93	1.5002	0.9647
050597	10/01/92	09/30/93	1.2842	0.9726
050598	12/01/92	11/30/93	1.5210	0.9795
050604	01/01/93	12/31/93	1.4856	0.9661
050607	09/01/92	08/31/93	1.2420	0.9877
050608	01/01/93	12/31/93	1.1147	0.9908
050609	01/01/93	12/31/93	1.3146	0.9858
050619	01/01/93	12/31/93	1.3888	0.9899
050624	10/01/92	09/30/93	1.2602	0.9831
050630	01/01/93	12/31/93	1.2743	0.9865
050635	01/01/93	12/31/93	1.2974	0.9876
050644	09/01/92	08/31/93	0.9948	0.9968
050663	10/01/92	09/30/93	1.1093	0.9967
050674	01/01/93	12/31/93	1.2180	0.9916
050677	01/01/93	12/31/93	1.3124	0.9876
050680	01/01/93	12/31/93	1.2188	0.9649
050686	01/01/93	12/31/93	1.3632	0.9896
050690	01/01/93	12/31/93	1.3616	0.9863
050693	09/01/92	08/31/93	1.2709	0.9843
050695	01/01/93	12/31/93	1.1961	0.9452
050697	01/01/93	12/31/93	1.1902	1.0000
050698	01/01/93	12/31/93	0.9781	1.0000
050699	10/01/92	09/30/93	0.8471	0.9883
050701	10/01/92	09/30/93	1.2879	0.9753
050702	01/01/93	12/31/93	1.0669	0.9967
060001	01/01/93	12/31/93	1.4629	0.9965
060003	01/01/93	12/31/93	1.3022	0.9893
060004	01/01/93	12/31/93	1.0426	0.9756
060006	01/01/93	12/31/93	1.2149	0.9849
060007	01/01/93	12/31/93	1.2670	0.9710
060009	01/01/93	12/31/93	1.4190	0.9970
060010	01/01/93	12/31/93	1.5248	0.9971
060011	01/01/93	12/31/93	1.2120	0.9911
060014	09/01/92	08/31/93	1.7029	0.9977
060018	01/01/93	12/31/93	1.2288	0.9798
060022	01/01/93	12/31/93	1.6587	0.9982
060027	01/01/93	12/31/93	1.4640	0.9946
060029	01/01/93	12/31/93	0.9997	0.9531
060030	01/01/93	12/31/93	1.3358	0.9914
060033	01/01/93	12/31/93	1.0953	0.9707
060037	01/01/93	12/31/93	1.0331	0.9593
060038	01/01/93	12/31/93	1.0423	0.9493
060041	01/01/93	12/31/93	0.8930	0.9266
060042	01/01/93	12/31/93	0.9456	0.9418
060043	01/01/93	12/31/93	1.0208	0.9616
060044	01/01/93	12/31/93	1.2437	0.9754
060046	01/01/93	12/31/93	1.1137	0.9742
060047	01/01/93	12/31/93	0.9782	0.9457
060049	01/01/93	12/31/93	1.0338	0.9583
060050	01/01/93	12/31/93	1.2211	0.9507
060052	01/01/93	12/31/93	1.0787	0.9507
060053	01/01/93	12/31/93	0.9640	0.9566
060056	01/01/93	12/31/93	0.9222	0.9398
060057	01/01/93	12/31/93	0.9585	0.9708
060058	01/01/93	12/31/93	0.9147	0.9629
060060	01/01/93	12/31/93	1.0266	0.9686
060062	01/01/93	12/31/93	0.9691	0.9304
060063	01/01/93	12/31/93	1.1020	0.9840
060064	01/01/93	12/31/93	1.4188	0.9950
060066	01/01/93	12/31/93	0.9450	0.9469
060068	01/01/93	12/31/93	1.1910	0.9815
060070	01/01/93	12/31/93	1.0389	0.9685
060071	01/01/93	12/31/93	1.2673	0.9777
060072	10/01/92	10/08/93	0.8900	0.9406
060073	01/01/93	12/31/93	1.0258	0.9472
060075	01/01/93	12/31/93	1.2459	0.9923
060076	01/01/93	12/31/93	1.3894	0.9813
060085	01/01/93	12/31/93	0.9709	0.9513
060088	01/01/93	12/31/93	0.9647	0.9306
060090	01/01/93	12/31/93	0.8986	0.9781
060096	11/01/92	10/31/93	0.9969	0.9391
060103	01/01/93	12/31/93	1.2275	0.9914
070001	10/01/92	09/30/93	1.7468	0.9995
070002	10/01/92	09/30/93	1.8073	0.9993
070003	10/01/92	09/30/93	1.1509	0.9801
070004	10/01/92	09/30/93	1.1598	0.9783
070005	10/01/92	09/30/93	1.3284	0.9903
070006	10/01/92	09/30/93	1.3122	0.9965
070007	10/01/92	09/30/93	1.3826	0.9906
070008	10/01/92	09/30/93	1.2463	0.9916
070009	10/01/92	09/30/93	1.2626	0.9944

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
070010	10/01/92	09/30/93	1.4544	0.9992
070011	10/01/92	09/30/93	1.2095	0.9915
070012	10/01/92	09/30/93	1.1723	0.9940
070013	10/01/92	09/30/93	1.3301	0.9769
070015	10/01/92	09/30/93	1.3021	0.9867
070016	10/01/92	09/30/93	1.2493	0.9933
070017	10/01/92	09/30/93	1.3718	0.9831
070018	10/01/92	09/30/93	1.3489	0.9965
070019	10/01/92	09/30/93	1.2624	0.9817
070020	10/01/92	09/30/93	1.4096	0.9896
070021	10/01/92	09/30/93	1.1819	0.9891
070022	10/01/92	09/30/93	1.6432	0.9987
070023	10/01/92	09/30/93	1.2094	0.9976
070024	10/01/92	09/30/93	1.3177	0.9864
070025	10/01/92	09/30/93	1.6934	0.9994
070026	10/01/92	09/30/93	1.1729	0.9793
070027	10/01/92	09/30/93	1.2104	0.9883
070028	10/01/92	09/30/93	1.4691	0.9995
070029	10/01/92	09/30/93	1.2266	0.9920
070030	10/01/92	09/30/93	1.2069	0.9948
070031	10/01/92	09/30/93	1.2889	0.9855
070033	10/01/92	09/30/93	1.2704	0.9917
070034	10/01/92	09/30/93	1.3325	0.9943
070035	10/01/92	09/30/93	1.3533	0.9911
070036	10/01/92	09/30/93	1.3008	0.9858
080005	10/01/92	09/30/93	1.3852	0.9945
090002	01/01/93	12/31/93	1.1273	0.9940
090005	01/01/93	12/31/93	1.2744	0.9982
090006	01/01/93	12/31/93	1.3431	0.9959
090007	10/01/92	09/30/93	1.3393	0.9852
090008	01/01/93	12/31/93	1.5514	0.9904
100002	10/01/92	09/30/93	1.4459	0.9871
100004	10/01/92	09/30/93	1.0472	0.9329
100005	10/01/92	09/30/93	1.1603	0.9981
100006	10/01/92	09/30/93	1.5840	0.9981
100007	01/01/93	12/31/93	1.8342	0.9979
100008	10/01/92	09/30/93	1.6743	0.9974
100012	10/01/92	09/30/93	1.5381	0.9991
100014	10/01/92	09/30/93	1.2889	0.9777
100015	08/01/92	07/31/93	1.3096	0.9966
100017	10/01/92	09/30/93	1.6619	0.9945
100018	10/01/92	09/30/93	1.3538	0.9819
100019	10/01/92	09/30/93	1.4534	0.9994
100020	01/01/93	12/31/93	1.3707	0.9925
100022	10/01/92	09/30/93	1.6998	0.9977
100023	10/01/92	09/30/93	1.3266	0.9862
100024	10/01/92	09/30/93	1.3794	0.9797
100025	01/01/93	12/31/93	1.5878	0.9995
100026	10/01/92	09/30/93	1.5003	0.9995
100028	10/01/92	09/30/93	1.2755	0.9798
100029	10/01/92	09/30/93	1.4444	0.9962
100030	10/01/92	09/30/93	1.2704	0.9829
100034	01/01/93	12/31/93	1.7301	0.9993
100035	09/01/92	08/31/93	1.5521	0.9982
100040	01/01/93	12/31/93	1.6779	0.9977
100042	01/01/93	12/31/93	1.2060	0.9947
100043	10/01/92	09/30/93	1.4141	0.9899
100044	10/01/92	09/30/93	1.4433	0.9905
100045	10/01/92	09/30/93	1.4655	0.9793
100046	01/01/93	12/31/93	1.4069	0.9689
100047	01/01/93	12/31/93	1.7886	0.9975
100048	10/01/92	09/30/93	0.9967	0.9975
100049	10/01/92	09/30/93	1.2783	0.9726
100050	01/01/93	12/31/93	1.2132	0.9957
100051	10/01/92	09/30/93	1.2683	0.9531
100052	10/01/92	09/30/93	1.4153	0.9868
100053	10/01/92	09/30/93	1.3041	0.9965
100054	08/01/92	07/31/93	1.3313	0.9782
100055	10/01/92	09/30/93	1.3831	0.9934
100056	01/01/93	12/31/93	1.4712	0.9896
100057	01/01/93	12/31/93	1.3471	0.9685
100059	01/01/93	12/31/93	1.6610	0.9951
100061	09/01/92	08/31/93	1.5612	0.9979
100062	10/01/92	09/30/93	1.7330	0.9987
100063	01/01/93	12/31/93	1.2522	0.9876
100071	10/01/92	09/30/93	1.2496	0.9838
100072	10/01/92	09/30/93	1.2238	0.9844
100073	01/01/93	12/31/93	1.7831	0.9978
100074	10/01/92	09/30/93	1.2381	0.9861
100077	09/01/92	08/31/93	1.3229	0.9891
100078	10/01/92	09/30/93	1.1828	0.9782
100080	10/01/92	09/30/93	1.5553	0.9993
100081	10/01/92	09/30/93	1.1432	0.9986
100082	10/01/92	09/30/93	1.5102	0.9974

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
100083	01/01/93	12/31/93	1.3349	0.9879
100085	01/01/93	12/31/93	1.3241	0.9901
100087	10/01/92	09/30/93	1.7518	0.9993
100088	10/01/92	09/30/93	1.6045	0.9976
100090	10/01/92	09/30/93	1.3537	0.9883
100092	10/01/92	09/30/93	1.5224	0.9980
100093	10/01/92	09/30/93	1.4652	0.9949
100098	10/01/92	09/30/93	1.2642	0.9706
100100	01/01/93	12/31/93	1.4727	0.9958
100102	10/01/92	09/30/93	1.0568	0.9658
100103	10/01/92	09/30/93	1.0131	0.9690
100105	10/01/92	09/30/93	1.4025	0.9884
100107	09/01/92	08/31/93	1.2704	0.9670
100108	10/01/92	09/30/93	1.0523	0.9699
100109	01/01/93	12/31/93	1.3331	0.9712
100112	10/01/92	09/30/93	0.9795	0.9377
100117	10/01/92	09/30/93	1.2874	0.9724
100118	11/01/92	10/31/93	1.1863	0.9688
100121	10/01/92	09/30/93	1.2329	0.9813
100124	11/01/92	10/31/93	1.3538	0.9825
100125	10/01/92	09/30/93	1.1504	0.9841
100127	10/01/92	09/30/93	1.6126	0.9997
100128	10/01/92	09/30/93	2.1675	0.9975
100130	10/01/92	09/30/93	1.1689	0.9788
100132	01/01/93	12/31/93	1.4757	0.9832
100135	10/01/92	09/30/93	1.4995	0.9984
100138	10/01/92	09/30/93	0.9842	0.9370
100139	10/01/92	09/30/93	1.0409	0.9711
100140	10/01/92	09/30/93	1.1933	0.9704
100142	10/01/92	09/30/93	1.1731	0.9741
100144	10/01/92	09/30/93	1.3477	0.9877
100145	01/01/93	12/31/93	1.4111	0.9934
100146	10/01/92	09/30/93	1.1371	0.9615
100147	10/01/92	09/30/93	1.1212	0.9676
100150	09/01/92	08/31/93	1.3187	0.9811
100151	01/01/93	12/31/93	1.8320	0.9993
100154	10/01/92	09/30/93	1.6025	0.9994
100156	11/01/92	10/31/93	1.1535	0.9730
100157	10/01/92	09/30/93	1.5938	0.9990
100162	10/01/92	09/30/93	1.4031	0.9876
100165	01/01/93	12/31/93	1.1988	0.9946
100166	01/01/93	12/31/93	1.4537	0.9894
100167	09/01/92	08/31/93	1.3554	0.9952
100169	11/01/92	10/31/93	1.8210	0.9976
100170	10/01/92	09/30/93	1.4743	0.9948
100173	10/01/92	09/30/93	1.6373	0.9989
100174	10/01/92	09/30/93	1.4227	0.9923
100175	10/01/92	09/30/93	0.9447	0.9558
100176	10/01/92	09/30/93	1.9256	0.9976
100177	10/01/92	09/30/93	1.3221	0.9918
100180	09/01/92	08/31/93	1.4231	0.9936
100181	01/01/93	12/31/93	1.5828	0.9942
100183	01/01/93	12/31/93	1.3778	0.9938
100186	01/01/93	12/31/93	1.3814	0.9932
100187	01/01/93	12/31/93	1.3822	0.9936
100189	01/01/93	12/31/93	1.2692	0.9872
100203	10/01/92	09/30/93	1.1642	0.9816
100206	12/01/92	11/30/93	1.3816	0.9920
100208	01/01/93	12/31/93	1.5458	0.9823
100209	01/01/93	12/31/93	1.5477	0.9989
100210	01/01/93	12/31/93	1.7004	0.9972
100212	09/01/92	08/31/93	1.6311	0.9979
100217	09/01/92	08/31/93	1.1889	0.9809
100220	01/01/93	12/31/93	1.7917	0.9992
100222	01/01/93	12/31/93	1.2752	0.9901
100224	01/01/93	12/31/93	1.4444	0.9813
100232	10/01/92	09/30/93	1.2684	0.9834
100234	09/01/92	08/31/93	1.3603	0.9932
100235	10/01/92	09/30/93	1.3807	0.9868
100236	01/01/93	12/31/93	1.4841	0.9914
100237	10/01/92	09/30/93	2.1493	0.9979
100239	01/01/93	12/31/93	1.4709	0.9938
100241	10/01/92	09/30/93	0.9445	0.9787
100246	01/01/93	12/31/93	1.3364	0.9907
100248	08/01/92	07/31/93	1.6598	0.9987
100253	10/01/92	09/30/93	1.3651	0.9875
100255	01/01/93	12/31/93	1.3314	0.9908
100259	09/01/92	08/31/93	1.4569	0.9751
100260	10/01/92	09/30/93	1.3872	0.9861
100262	10/01/92	09/30/93	1.4019	0.9919
100265	10/01/92	09/30/93	1.3094	0.9779
100266	10/01/92	09/30/93	1.3014	0.9865
100267	01/01/93	12/31/93	1.3145	0.9893
100269	09/01/92	08/31/93	1.3409	0.9860

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
100275	01/01/93	12/31/93	1.3233	0.9933
100278	10/01/92	09/30/93	0.8733	0.9570
100279	01/01/93	12/31/93	1.4222	0.9878
100280	10/01/92	09/30/93	1.4211	0.9729
110001	10/01/92	09/30/93	1.2557	0.9913
110002	01/01/93	12/31/93	1.2239	0.9897
110004	10/01/92	09/30/93	1.2198	0.9930
110005	12/04/92	12/31/93	1.1966	0.9642
110006	10/01/92	09/30/93	1.2830	0.9953
110007	08/01/92	07/31/93	1.4633	0.9956
110009	11/01/92	10/31/93	1.0220	0.9558
110010	09/01/92	08/31/93	2.0085	0.9981
110013	10/01/92	09/30/93	1.1118	0.9622
110014	08/01/92	07/31/93	1.1991	0.9753
110016	10/04/92	10/02/93	1.2851	0.9877
110018	01/01/93	12/31/93	1.1904	0.9650
110023	01/01/93	12/31/93	1.2882	0.9525
110024	01/01/93	12/31/93	1.3957	0.9891
110025	10/01/92	09/30/93	1.3127	0.9845
110028	12/28/92	12/26/93	1.6169	0.9992
110029	10/01/92	09/30/93	1.3308	0.9869
110030	09/01/92	08/31/93	1.2809	0.9652
110032	10/01/92	09/30/93	1.1307	0.9731
110033	08/01/92	07/31/93	1.4026	0.9851
110036	01/01/93	12/31/93	1.6650	0.9980
110037	01/01/93	12/31/93	1.0586	0.9861
110038	10/01/92	09/30/93	1.3938	0.9944
110044	10/01/92	09/30/93	1.1404	0.9614
110045	08/01/92	07/31/93	1.1084	0.9685
110046	11/01/92	10/31/93	1.2151	0.9675
110048	10/01/92	09/30/93	1.1037	0.9637
110049	10/01/92	09/30/93	1.0603	0.9632
110050	01/01/93	12/31/93	1.0532	0.9796
110059	10/01/92	09/30/93	1.3049	0.9743
110061	10/01/92	09/30/93	1.0260	0.9546
110063	12/01/92	11/30/93	1.0974	0.9625
110065	01/01/93	12/31/93	0.9887	0.9903
110070	11/01/92	10/31/93	1.0075	0.9301
110072	01/01/93	12/31/93	1.0259	0.9669
110073	08/01/92	07/31/93	1.2792	0.9642
110074	10/01/92	09/30/93	1.4441	0.9967
110075	10/01/92	09/30/93	1.1354	0.9812
110076	10/01/92	09/30/93	1.3246	0.9874
110078	09/01/92	08/31/93	1.5682	0.9981
110079	01/01/93	12/31/93	1.3886	0.9974
110080	10/01/92	09/30/93	1.1839	0.9935
110082	01/01/93	12/31/93	2.0259	0.9976
110083	01/01/93	12/31/93	1.6418	0.9989
110086	09/01/92	08/31/93	1.0530	0.9697
110088	01/01/93	12/31/93	0.9289	0.9184
110089	01/01/93	12/31/93	1.2038	0.9736
110091	10/01/92	09/30/93	1.3842	0.9811
110092	10/01/92	09/30/93	1.0738	0.9734
110095	10/01/92	09/30/93	1.2536	0.9781
110096	01/01/93	12/31/93	1.0983	0.9678
110100	01/01/93	12/31/93	1.0867	0.9680
110105	10/01/92	09/30/93	1.1363	0.9780
110107	10/01/92	09/30/93	1.6421	0.9953
110111	10/01/92	09/30/93	1.1306	0.9828
110112	09/01/92	08/31/93	1.0049	0.9872
110115	01/01/93	12/31/93	1.6403	0.9981
110118	10/01/92	09/30/93	1.0298	0.9359
110120	10/01/92	09/30/93	1.0358	0.9465
110121	10/01/92	09/30/93	1.1447	0.9699
110122	10/01/92	09/30/93	1.2861	0.9855
110129	01/01/93	12/31/93	1.5456	0.9985
110130	12/01/92	11/30/93	1.0604	0.9714
110140	01/01/93	12/31/93	0.8325	0.9662
110142	10/01/92	09/30/93	1.0122	0.9633
110144	10/01/92	09/30/93	1.1674	0.9602
110146	01/01/93	12/31/93	0.8945	0.9345
110150	10/01/92	09/30/93	1.2982	0.9766
110161	10/01/92	09/30/93	1.2411	0.9934
110165	11/01/92	10/31/93	1.2941	0.9894
110166	10/01/92	09/30/93	1.4956	0.9877
110171	11/01/92	10/31/93	1.3434	0.9958
110172	10/01/92	09/30/93	1.2407	0.9925
110177	09/01/92	08/31/93	1.3872	0.9958
110179	01/01/93	12/31/93	1.1803	0.9799
110186	01/01/93	12/31/93	1.2706	0.9920
110187	01/01/93	12/31/93	1.1779	0.9592
110189	01/01/93	12/31/93	1.0753	0.9563
110190	01/01/93	12/31/93	1.0715	0.9599
110193	01/01/93	12/31/93	1.1315	0.9781

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
110195	10/01/92	09/30/93	1.2050	0.9902
110198	11/01/92	10/31/93	1.3634	0.9879
110200	10/01/92	09/30/93	1.9892	0.9929
110201	09/01/92	08/31/93	1.3992	0.9960
110203	10/01/92	09/30/93	0.9902	0.9674
110207	01/01/93	12/31/93	1.1500	0.9919
120006	01/01/93	12/31/93	1.1565	0.9885
120011	01/01/93	12/31/93	1.2601	0.9934
120022	01/01/93	12/31/93	1.6614	0.9969
130001	12/01/92	11/30/93	1.0137	0.9690
130002	10/01/92	09/30/93	1.3839	0.9869
130005	01/01/93	12/31/93	1.3733	0.9878
130006	10/01/92	09/30/93	1.7657	0.9990
130009	10/01/92	09/30/93	0.9674	0.9312
130010	10/01/92	09/30/93	0.9348	0.9694
130011	01/01/93	12/31/93	1.3335	0.9682
130012	10/01/92	09/30/93	0.9977	0.9500
130014	10/01/92	09/30/93	1.3563	0.9643
130015	10/01/92	09/30/93	0.8795	0.9297
130016	10/01/92	09/30/93	0.8531	0.9874
130018	10/01/92	09/30/93	1.5840	0.9977
130021	12/01/92	11/30/93	0.9193	0.9682
130024	09/01/92	08/31/93	1.0972	0.9446
130025	10/01/92	09/30/93	1.1052	0.9865
130026	01/01/93	12/31/93	1.1129	0.9667
130027	10/01/92	09/30/93	0.8806	0.9553
130028	10/01/92	09/30/93	1.1850	0.9908
130030	10/01/92	09/30/93	1.0382	0.9856
130031	10/01/92	09/30/93	1.0133	0.9752
130034	10/01/92	09/30/93	1.0463	0.9396
130036	01/01/93	12/31/93	1.2938	0.9778
130037	10/01/92	09/30/93	1.1210	0.9516
130043	10/01/92	09/30/93	1.0387	0.9800
130044	10/01/92	09/30/93	0.9705	0.9546
130045	10/01/92	09/30/93	0.8828	0.9445
130049	12/01/92	11/30/93	1.2283	0.9847
130054	10/01/92	09/30/93	0.8836	0.8705
130056	10/01/92	09/30/93	0.9516	0.9433
130058	09/01/92	08/31/93	0.9112	1.0000
130060	10/01/92	09/30/93	1.1938	0.9698
140002	01/01/93	12/31/93	1.2373	0.9883
140004	10/01/92	09/30/93	0.9830	0.9617
140007	09/01/92	08/31/93	1.4424	0.9959
140008	01/01/93	12/31/93	1.4505	0.9834
140010	10/01/92	09/30/93	1.3101	0.9979
140012	01/01/93	12/31/93	1.2000	0.9930
140013	01/01/93	12/31/93	1.6053	0.9966
140015	10/01/92	09/30/93	1.2287	0.9923
140019	09/01/92	08/31/93	0.9268	0.9558
140029	01/01/93	12/31/93	1.3185	0.9964
140031	01/01/93	12/31/93	1.0710	0.9461
140034	01/01/93	12/31/93	1.1563	0.9871
140036	10/01/92	09/30/93	1.1228	0.9780
140039	01/01/93	12/31/93	1.0160	0.9441
140046	01/01/93	12/31/93	1.2923	0.9737
140048	01/01/93	12/31/93	1.3052	0.9916
140049	11/01/92	10/31/93	1.3442	0.9912
140051	10/01/92	09/30/93	1.3457	0.9893
140052	01/01/93	12/31/93	1.2697	0.9908
140054	09/27/92	09/30/93	1.3005	0.9883
140058	10/01/92	09/30/93	1.1598	0.9859
140062	01/01/93	12/31/93	1.2344	0.9889
140063	01/01/93	12/31/93	1.3585	0.9933
140064	10/01/92	09/30/93	1.1858	0.9839
140065	01/01/93	12/31/93	1.4394	0.9967
140066	01/01/93	12/31/93	1.1728	0.9839
140074	10/01/92	09/30/93	1.0178	0.9501
140079	01/01/93	12/31/93	1.2727	0.9943
140080	01/01/93	12/31/93	1.7724	0.9945
140084	01/01/93	12/31/93	1.2105	0.9897
140087	01/01/93	12/31/93	1.3710	0.9944
140090	01/01/93	12/31/93	1.4769	0.9965
140093	09/01/92	08/31/93	1.1956	0.9866
140094	01/01/93	12/31/93	1.2822	0.9955
140095	09/01/92	09/30/93	1.2133	0.9819
140097	01/01/93	12/31/93	0.9935	0.9497
140101	12/01/92	11/30/93	1.1947	0.9779
140103	01/01/93	12/31/93	1.3628	0.9923
140105	01/01/93	12/31/93	1.3103	0.9966
140107	01/01/93	12/31/93	1.1188	0.9561
140108	01/01/93	12/31/93	1.3384	0.9877
140112	10/01/92	09/30/93	1.0830	0.9686
140113	01/01/93	12/31/93	1.4296	0.9979
140118	01/01/93	12/31/93	1.6349	0.9973

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
140122	01/01/93	12/31/93	1.5072	0.9961
140125	01/01/93	12/31/93	1.2456	0.9907
140128	10/01/92	09/30/93	1.0468	0.9665
140129	01/01/93	12/31/93	1.0820	0.9774
140130	01/01/93	12/31/93	1.1336	0.9932
140132	10/01/92	09/30/93	1.5264	0.9988
140135	10/01/92	09/30/93	1.2390	0.9816
140137	01/01/93	12/31/93	1.0342	0.9589
140139	10/01/92	09/30/93	1.0535	0.9668
140141	08/01/92	07/31/93	1.0038	0.9738
140143	10/01/92	09/30/93	1.0716	0.9865
140147	12/01/92	11/30/93	1.2099	0.9856
140148	10/01/92	09/30/93	1.6497	0.9990
140152	01/01/93	12/31/93	1.0651	0.9938
140155	01/01/93	12/31/93	1.1722	0.9897
140160	08/01/92	07/31/93	1.1817	0.9806
140161	10/01/92	09/30/93	1.0966	0.9651
140162	10/01/92	09/30/93	1.6837	0.9965
140167	10/01/92	09/30/93	1.1207	0.9864
140180	01/01/93	12/31/93	1.5142	0.9976
140181	01/01/93	12/31/93	1.2841	0.9922
140182	11/01/92	10/31/93	1.2731	0.9952
140185	01/01/93	12/31/93	1.4267	0.9885
140186	01/01/93	12/31/93	1.2155	0.9855
140188	09/01/92	08/31/93	0.9984	0.9194
140191	01/01/93	12/31/93	1.4129	0.9980
140192	10/01/92	09/30/93	1.0694	0.9953
140202	01/01/93	12/31/93	1.2811	0.9868
140203	10/01/92	09/30/93	1.2195	0.9890
140206	10/01/92	09/30/93	1.0507	0.9878
140207	01/01/93	12/31/93	1.4058	0.9955
140208	01/01/93	12/31/93	1.5200	0.9979
140209	01/01/93	12/31/93	1.6340	0.9992
140211	09/01/92	08/31/93	1.1900	0.9680
140212	01/01/93	12/31/93	1.1730	0.9959
140217	09/01/92	08/31/93	1.2439	0.9958
140220	10/01/92	09/30/93	1.1770	0.9785
140233	10/01/92	09/30/93	1.7202	0.9983
140236	10/01/92	09/30/93	1.0024	0.9854
140240	01/01/93	12/31/93	1.3935	0.9986
140252	11/01/92	10/31/93	1.3562	0.9940
140258	01/01/93	12/31/93	1.4282	0.9977
140271	01/01/93	12/31/93	0.9901	0.9449
140280	01/01/93	12/31/93	1.2417	0.9953
140281	09/01/92	08/31/93	1.5815	0.9960
140285	01/01/93	12/31/93	1.2650	0.9875
140288	01/01/93	12/31/93	1.6552	0.9965
140289	01/01/93	12/31/93	1.2742	0.9829
140291	01/01/93	12/31/93	1.3370	0.9812
140292	01/01/93	12/31/93	1.2059	0.9676
140294	01/01/93	12/31/93	1.1473	0.9749
150001	01/01/93	12/31/93	1.0434	0.9806
150002	01/01/93	12/31/93	1.4049	0.9956
150003	01/01/93	12/31/93	1.6940	0.9967
150004	01/01/93	12/31/93	1.4887	0.9965
150005	01/01/93	12/31/93	1.1912	0.9772
150006	01/01/93	12/31/93	1.2169	0.9833
150007	01/01/93	12/31/93	1.2363	0.9823
150008	01/01/93	12/31/93	1.3292	0.9991
150009	01/01/93	12/31/93	1.2706	0.9938
150010	01/01/93	12/31/93	1.1525	0.9823
150013	01/01/93	12/31/93	1.1662	0.9702
150014	09/01/92	08/31/93	1.3837	0.9981
150015	01/01/93	12/31/93	1.2502	0.9878
150017	01/01/93	12/31/93	1.7697	0.9997
150018	01/01/93	12/31/93	1.3025	0.9836
150020	10/01/92	09/30/93	1.0935	0.9913
150021	01/01/93	12/31/93	1.6339	0.9970
150022	01/01/93	12/31/93	1.1312	0.9744
150023	09/01/92	08/31/93	1.4019	0.9959
150024	01/01/93	12/31/93	1.2413	0.9946
150026	01/01/93	12/31/93	1.1969	0.9691
150027	01/01/93	12/31/93	1.0322	0.9625
150029	01/01/93	12/31/93	1.2912	0.9905
150030	01/01/93	12/31/93	1.0935	0.9736
150031	10/01/92	09/30/93	1.0914	0.9590
150033	01/01/93	12/31/93	1.5849	0.9988
150034	01/01/93	12/31/93	1.3023	0.9926
150035	01/01/93	12/31/93	1.4228	0.9983
150036	01/01/93	12/31/93	1.0226	0.9707
150037	01/01/93	12/31/93	1.1957	0.9791
150038	01/01/93	12/31/93	1.2139	0.9833
150039	10/01/92	09/30/93	0.9116	0.9511
150042	01/01/93	12/31/93	1.1979	0.9933

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
150044	01/01/93	12/31/93	1.2643	0.9912
150045	10/01/92	09/30/93	1.1682	0.9685
150046	09/01/92	08/31/93	1.5496	0.9954
150047	01/01/93	12/31/93	1.6979	0.9983
150048	01/01/93	12/31/93	1.1690	0.9853
150049	01/01/93	12/31/93	1.1411	0.9753
150050	01/01/93	12/31/93	1.1582	0.9748
150051	10/01/92	09/30/93	1.3424	0.9925
150052	01/01/93	12/31/93	1.1083	0.9377
150053	01/01/93	12/31/93	1.0186	0.9627
150054	01/01/93	12/31/93	1.0499	0.9573
150057	01/01/93	12/31/93	2.4033	0.9953
150058	01/01/93	12/31/93	1.6169	0.9983
150059	01/01/93	12/31/93	1.2215	0.9845
150060	01/01/93	12/31/93	1.1232	0.9730
150061	01/01/93	12/31/93	1.1855	0.9688
150062	01/01/93	12/31/93	1.0357	0.9696
150063	01/01/93	12/31/93	1.1019	0.9790
150064	10/01/92	09/30/93	1.0632	0.9709
150065	01/01/93	12/31/93	1.0943	0.9795
150066	01/01/93	12/31/93	1.0257	0.9701
150067	01/01/93	12/31/93	1.0959	0.9677
150069	01/01/93	12/31/93	1.2250	0.9743
150070	01/01/93	12/31/93	1.0001	0.9505
150071	01/01/93	12/31/93	1.2005	0.9482
150072	01/01/93	12/31/93	1.2055	0.9744
150073	01/01/93	12/31/93	0.9571	0.9699
150074	10/01/92	09/30/93	1.5558	0.9996
150075	10/01/92	09/30/93	1.2025	0.9892
150078	01/01/93	12/31/93	1.0864	0.9793
150079	10/01/92	09/30/93	1.1015	0.9673
150086	01/01/93	12/31/93	1.3036	0.9789
150090	01/01/93	12/31/93	1.2819	0.9914
150091	01/01/93	12/31/93	1.0737	0.9679
150092	01/01/93	12/31/93	1.0280	0.9395
150094	01/01/93	12/31/93	0.9955	0.9868
150095	10/01/92	09/30/93	1.0839	0.9701
150096	01/01/93	12/31/93	1.0470	0.9686
150097	01/01/93	12/31/93	1.0966	0.9730
150098	01/01/93	12/31/93	1.1611	0.9600
150101	01/01/93	12/31/93	1.1371	0.9621
150102	01/01/93	12/31/93	1.0153	0.9706
150104	01/01/93	12/31/93	1.0699	0.9675
150105	01/01/93	12/31/93	1.1759	0.9705
150106	01/01/93	12/31/93	1.0527	0.9690
150109	01/01/93	12/31/93	1.4059	0.9725
150111	01/01/93	12/31/93	1.1608	0.9801
150112	01/01/93	12/31/93	1.2131	0.9840
150113	01/01/93	12/31/93	1.1580	0.9826
150114	01/01/93	12/31/93	0.9890	0.9612
150122	01/01/93	12/31/93	1.1182	0.9381
150123	08/01/92	07/31/93	1.0380	0.9957
150124	10/01/92	09/30/93	1.1259	0.9737
150127	10/01/92	09/30/93	1.2022	0.9659
150128	10/01/92	09/30/93	1.2209	0.9887
150129	09/01/92	08/31/93	1.2318	0.9896
150132	01/01/93	12/31/93	1.3650	0.9988
150133	01/01/93	12/31/93	1.1785	0.9722
150134	01/01/93	12/31/93	1.1312	0.9716
150136	09/01/92	08/31/93	0.8467	0.9934
160001	11/01/92	10/31/93	1.1894	0.9775
160002	10/01/92	09/30/93	1.1645	0.9704
160003	01/01/93	12/31/93	1.0305	0.9630
160008	10/01/92	09/30/93	1.1467	0.9756
160044	01/01/93	12/31/93	1.1540	0.9755
160045	09/01/92	08/31/93	1.6701	0.9985
160047	10/01/92	09/30/93	1.3707	0.9846
160072	01/01/93	12/31/93	1.1353	0.9788
160082	08/01/92	07/31/93	1.6784	0.9994
160092	01/01/93	12/31/93	0.9724	0.9567
160099	10/01/92	09/30/93	1.0425	0.9820
160104	12/01/92	11/30/93	1.1878	0.9871
160110	01/01/93	12/31/93	1.4623	0.9960
160111	09/01/92	08/31/93	1.0316	0.9754
160122	10/01/92	09/30/93	1.1663	0.9614
160129	01/01/93	12/31/93	1.0179	0.9483
160130	10/01/92	09/30/93	1.0460	0.9689
160131	01/01/93	12/31/93	1.1464	0.9849
160133	01/01/93	12/31/93	1.1511	0.9898
160138	01/01/93	12/31/93	1.1225	0.9753
160147	01/01/93	12/31/93	1.1641	0.9742
170001	01/01/93	12/31/93	1.2268	0.9753
170004	01/01/93	12/31/93	1.0697	0.9774
170006	10/01/92	09/30/93	1.1820	0.9891

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
170008	01/01/93	12/31/93	1.0576	0.9881
170012	10/01/92	09/30/93	1.3788	0.9842
170014	01/01/93	12/31/93	1.0555	0.9654
170017	01/01/93	12/31/93	1.1765	0.9703
170018	01/01/93	12/31/93	1.0218	0.9688
170019	01/01/93	12/31/93	1.1438	0.9806
170022	10/01/92	09/30/93	1.2274	0.9712
170023	01/01/93	12/31/93	1.3875	0.9894
170024	10/01/92	09/30/93	1.1883	0.9844
170026	10/01/92	09/30/93	1.0150	0.9881
170027	10/01/92	09/30/93	1.1866	0.9623
170031	01/01/93	12/31/93	0.9008	0.9882
170032	10/01/92	09/30/93	1.0352	0.9858
170033	01/01/93	12/31/93	1.2619	0.9802
170034	01/01/93	12/31/93	0.9618	0.9685
170035	01/01/93	12/31/93	0.8747	0.9107
170036	01/01/93	12/31/93	0.9076	0.9893
170038	01/01/93	12/31/93	0.9483	0.9423
170039	01/01/93	12/31/93	1.0812	0.9760
170041	01/01/93	12/31/93	1.0414	0.9655
170043	01/01/93	12/31/93	1.0088	0.9582
170049	01/01/93	12/31/93	1.3082	0.9814
170050	01/01/93	12/31/93	0.9680	1.0000
170054	01/01/93	12/31/93	1.0697	0.9728
170055	01/01/93	12/31/93	0.9956	0.9615
170060	01/01/93	12/31/93	1.0761	0.9766
170062	10/01/92	09/30/93	0.9398	0.9544
170063	01/01/93	12/31/93	0.9285	0.9495
170064	01/01/93	12/31/93	0.9789	0.9734
170066	01/01/93	12/31/93	0.9071	0.8999
170068	01/01/93	12/31/93	1.2458	0.9832
170070	01/01/93	12/31/93	0.9890	0.9670
170073	01/01/93	12/31/93	1.0730	0.9730
170075	10/01/92	09/30/93	0.8338	0.9546
170076	01/01/93	12/31/93	1.1032	0.9842
170077	01/01/93	12/31/93	0.9425	0.9661
170079	01/01/93	12/31/93	1.0316	0.9758
170080	01/01/93	12/31/93	1.0366	0.9525
170081	01/01/93	12/31/93	1.0118	0.9417
170082	01/01/93	12/31/93	1.0558	0.9627
170086	10/01/92	09/30/93	1.7032	0.9994
170087	10/01/92	09/30/93	1.3935	0.9985
170090	01/01/93	12/31/93	1.0208	0.9415
170092	01/01/93	12/31/93	0.8006	0.9401
170094	01/01/93	12/31/93	1.0673	0.9696
170097	01/01/93	12/31/93	0.9947	0.9596
170098	01/01/93	12/31/93	1.0396	0.9891
170099	01/01/93	12/31/93	1.2450	1.0000
170101	10/01/92	09/30/93	0.9597	0.9877
170102	01/01/93	12/31/93	1.0193	0.9571
170104	01/01/93	12/31/93	1.4367	0.9978
170106	09/01/92	08/31/93	0.9259	0.9418
170108	01/01/93	12/31/93	0.8880	0.9331
170109	01/01/93	12/31/93	1.0585	0.9768
170110	01/01/93	12/31/93	0.9466	0.9756
170112	01/01/93	12/31/93	0.9179	0.9583
170113	01/01/93	12/31/93	1.1512	0.9777
170114	01/01/93	12/31/93	1.0603	0.9690
170116	01/01/93	12/31/93	1.0909	0.9665
170117	01/01/93	12/31/93	0.9802	0.9401
170119	01/01/93	12/31/93	1.0084	0.9479
170120	01/01/93	12/31/93	1.3223	0.9650
170121	01/01/93	12/31/93	0.9169	0.9735
170122	10/01/92	09/30/93	1.8156	0.9987
170123	01/01/93	12/31/93	1.7336	0.9981
170124	01/01/93	12/31/93	0.9575	0.9596
170126	10/01/92	09/30/93	0.9147	0.9774
170128	01/01/93	12/31/93	0.9661	0.9047
170131	01/01/93	12/31/93	1.1335	0.9814
170134	01/01/93	12/31/93	1.0307	0.9772
170137	01/01/93	12/31/93	1.1369	0.9803
170139	01/01/93	12/31/93	1.0898	0.9820
170143	01/01/93	12/31/93	1.1408	0.9612
170144	10/01/92	09/30/93	1.4733	0.9931
170145	01/01/93	12/31/93	1.1990	0.9850
170146	01/01/93	12/31/93	1.3529	0.9975
170147	10/01/92	09/30/93	1.1322	0.9827
170148	10/01/92	09/30/93	1.4019	0.9974
170150	01/01/93	12/31/93	1.1050	0.9796
170151	01/01/93	12/31/93	1.0078	0.9635
170152	01/01/93	12/31/93	0.9657	0.9795
170160	01/01/93	12/31/93	1.0041	0.9600
170164	01/01/93	12/31/93	0.9596	0.9715
170166	01/01/93	12/31/93	1.0524	0.9883

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
170168	01/01/93	12/31/93	0.8824	1.0000
170172	01/01/93	12/31/93	0.9648	0.9298
170174	01/01/93	12/31/93	0.8689	0.9200
170175	09/01/92	08/31/93	1.2882	0.9680
180001	01/01/93	12/31/93	1.2013	0.9959
180004	10/01/92	09/30/93	1.1783	0.9743
180009	10/01/92	09/30/93	1.2786	0.9956
180010	09/01/92	08/31/93	1.7993	0.9986
180011	09/01/92	08/31/93	1.1957	0.9619
180014	09/01/92	08/31/93	1.5098	0.9990
180015	01/01/93	12/31/93	1.1233	0.9898
180016	01/01/93	12/31/93	1.2661	0.9904
180017	10/01/92	09/30/93	1.3010	0.9898
180019	12/01/92	11/30/93	1.3053	0.9794
180025	09/01/92	08/31/93	1.1002	0.9638
180026	01/01/93	12/31/93	1.1669	0.9851
180030	10/01/92	09/30/93	1.1342	0.9862
180031	10/01/92	09/30/93	0.9958	0.9883
180035	01/01/93	12/31/93	1.5246	0.9992
180036	01/01/93	12/31/93	1.1703	0.9848
180037	09/01/92	08/31/93	1.2557	0.9921
180040	01/01/93	12/31/93	1.9360	0.9989
180041	10/01/92	09/30/93	1.0426	0.9521
180043	10/01/92	09/30/93	1.1205	0.9656
180044	10/01/92	09/30/93	1.0432	0.9766
180045	01/01/93	12/31/93	1.2014	0.9919
180048	10/01/92	09/30/93	1.1443	0.9834
180051	12/01/92	11/30/93	1.3077	0.9783
180058	01/01/93	12/31/93	0.8935	0.9537
180059	01/01/93	12/31/93	0.8767	0.9710
180060	01/01/93	12/31/93	0.8393	0.6199
180063	10/01/92	09/30/93	1.0500	0.9706
180064	10/01/92	09/30/93	1.0977	0.9646
180072	10/01/92	09/30/93	1.0733	0.9766
180078	10/01/92	09/30/93	1.0779	0.9685
180079	10/01/92	09/30/93	0.9802	0.9717
180080	09/01/92	08/31/93	1.1098	0.9819
180081	01/01/93	12/31/93	1.5286	0.9959
180085	01/01/93	12/31/93	1.3367	0.9970
180088	01/01/93	12/31/93	1.6403	0.9979
180093	01/01/93	12/31/93	1.3668	0.9997
180094	01/01/93	12/31/93	0.9417	0.9828
180095	10/01/92	09/30/93	1.1227	0.9728
180099	10/01/92	09/30/93	1.0729	0.9728
180102	01/01/93	12/31/93	1.4441	0.9983
180103	09/01/92	08/31/93	1.9696	0.9975
180104	09/01/92	08/31/93	1.4520	0.9987
180106	09/01/92	08/31/93	0.8987	0.9801
180115	11/01/92	10/31/93	1.0922	0.9705
180116	09/01/92	08/31/93	1.3719	0.9880
180120	01/01/93	12/31/93	0.9597	0.9708
180121	01/01/93	12/31/93	1.1363	0.9781
180124	10/01/92	09/30/93	1.3515	0.9943
180126	11/01/92	10/31/93	1.0153	0.9668
180127	08/01/92	07/31/93	1.2277	0.9824
180130	09/01/92	08/31/93	1.4180	0.9977
190002	10/01/92	09/30/93	1.5678	0.9985
190003	09/01/92	08/31/93	1.4229	0.9748
190004	10/01/92	09/30/93	1.3257	0.9885
190013	01/01/93	12/31/93	1.2651	0.9882
190014	01/01/93	12/31/93	1.0681	0.9731
190018	10/01/92	09/30/93	1.2854	0.9725
190025	10/01/92	09/30/93	1.2403	0.9856
190026	10/01/92	09/30/93	1.3921	0.9976
190034	01/01/93	12/31/93	1.1939	0.9792
190039	01/01/93	12/31/93	1.4730	0.9995
190040	10/01/92	09/30/93	1.4215	0.9980
190044	10/01/92	09/30/93	1.0829	0.9750
190046	01/01/93	12/31/93	1.5033	0.9989
190049	01/01/93	12/31/93	1.0118	0.9714
190050	11/01/92	10/31/93	1.0946	0.9756
190053	12/01/92	11/30/93	1.0586	0.9508
190054	10/01/92	09/30/93	1.4413	0.9696
190059	11/01/92	10/31/93	0.9524	0.9561
190060	01/01/93	12/31/93	1.4417	0.9983
190065	10/01/92	09/30/93	1.4856	0.9985
190077	01/01/93	12/31/93	0.9310	0.9626
190078	01/01/93	12/31/93	1.2825	0.9787
190079	08/01/92	07/31/93	1.2513	0.9935
190083	10/01/92	09/30/93	0.9042	0.9603
190088	09/01/92	08/31/93	1.2481	0.9744
190089	10/01/92	09/30/93	1.0469	0.9819
190095	10/01/92	09/30/93	1.0271	0.9749
190103	11/01/92	10/31/93	0.8556	0.9681

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
190109	10/01/92	09/30/93	1.2015	0.9780
190111	10/01/92	09/30/93	1.5617	0.9986
190113	01/01/93	12/31/93	1.3109	0.9993
190115	01/01/93	12/31/93	1.3003	0.9958
190116	01/01/93	12/31/93	1.2292	0.9853
190118	10/01/92	09/30/93	1.0439	0.9629
190120	09/01/92	08/31/93	0.9145	0.9331
190127	10/01/92	09/30/93	1.4300	0.9936
190128	10/01/92	09/30/93	0.9131	1.0000
190130	10/01/92	09/30/93	0.9996	0.9601
190131	01/01/93	12/31/93	1.2978	0.9870
190134	10/01/92	09/30/93	0.9885	0.9803
190135	10/01/92	09/30/93	1.3917	0.9996
190136	10/01/92	09/30/93	1.0509	0.9686
190142	11/01/92	10/31/93	0.9707	0.9838
190144	09/01/92	08/31/93	1.1478	0.9792
190145	10/01/92	09/30/93	0.9373	0.9930
190146	01/01/93	12/31/93	1.5698	0.9992
190147	10/01/92	09/30/93	0.9831	0.9746
190149	10/01/92	09/30/93	0.9744	0.9770
190151	10/01/92	09/30/93	1.0885	0.9854
190160	09/01/92	08/31/93	1.1447	0.9967
190162	01/01/93	12/31/93	1.2312	0.9951
190167	09/01/92	08/31/93	1.2631	0.9731
190175	01/01/93	12/31/93	0.8972	1.0000
190177	01/01/93	12/31/93	1.5220	0.9969
190178	09/01/92	08/31/93	0.9770	0.9674
190184	10/01/92	09/30/93	0.9820	0.9759
190185	01/01/93	12/31/93	1.2561	0.9965
190186	10/01/92	09/30/93	0.9017	0.9706
190187	01/01/93	12/31/93	0.8581	0.9774
190189	01/01/93	12/31/93	0.4742	0.8735
190190	01/01/93	12/31/93	0.9721	0.9805
190191	01/01/93	12/31/93	1.2381	0.9838
190193	01/01/93	12/31/93	1.2671	0.9799
190194	10/01/92	09/30/93	1.1245	0.9748
190197	01/01/93	12/31/93	1.2877	0.9936
190200	09/01/92	08/31/93	1.5276	0.9990
190201	09/01/92	08/31/93	1.4347	0.9868
190202	09/01/92	08/31/93	1.4769	0.9941
190203	01/01/93	12/31/93	1.5417	0.9992
190205	09/01/92	08/31/93	1.7737	0.9934
190206	09/01/92	08/31/93	1.4321	0.9995
190207	09/01/92	08/31/93	1.1983	0.9830
190208	01/01/93	12/31/93	0.8247	0.9224
190211	01/01/93	12/31/93	0.6060	0.9575
190213	01/01/93	12/31/93	5.3328	1.0000
200001	01/01/93	12/31/93	1.2774	0.9932
200006	10/01/92	09/30/93	1.1658	0.9848
200007	11/01/92	10/31/93	1.0220	0.9662
200009	10/01/92	09/30/93	1.6692	0.9973
200017	09/01/92	08/31/93	1.2738	0.9955
200018	01/01/93	12/31/93	1.1588	0.9906
200021	10/01/92	09/30/93	1.1373	0.9853
200025	01/01/93	12/31/93	1.1708	0.9904
200026	10/01/92	09/30/93	1.0485	0.9846
200027	01/01/93	12/31/93	1.2471	0.9695
200028	12/01/92	11/30/93	0.9616	0.9691
200031	01/01/93	12/31/93	1.2693	0.9916
200032	01/01/93	12/31/93	1.2540	0.9770
200033	09/27/92	09/25/93	1.6698	0.9966
200034	01/01/93	12/31/93	1.2208	0.9883
200041	01/01/93	12/31/93	1.1833	0.9846
200043	01/01/93	12/31/93	0.6249	0.9903
200052	10/01/92	09/30/93	1.0205	0.9900
200055	01/01/93	12/31/93	1.0726	0.9739
200062	01/01/93	12/31/93	0.9534	0.9675
200066	10/01/92	09/30/93	1.1910	0.9786
210006	01/01/93	12/31/93	1.1125	0.9856
210011	01/01/93	12/31/93	1.2705	0.9901
210046	01/01/93	12/31/93	1.1298	0.9677
210049	01/01/93	12/31/93	1.1280	0.9794
220001	10/01/92	09/30/93	1.1847	0.9857
220002	10/01/92	09/30/93	1.4344	0.9965
220003	10/01/92	09/30/93	1.0773	0.9828
220004	10/01/92	09/30/93	1.2344	0.9901
220006	10/01/92	09/30/93	1.3043	0.9893
220008	10/01/92	09/30/93	1.1496	0.9853
220010	10/01/92	09/30/93	1.2177	0.9905
220012	10/01/92	09/30/93	1.3111	0.9732
220015	10/01/92	09/30/93	1.1865	0.9901
220016	10/01/92	09/30/93	1.2529	0.9813
220017	10/01/92	09/30/93	1.2584	0.9936
220019	10/01/92	09/30/93	1.0791	0.9862

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
220020	10/01/92	09/30/93	1.1750	0.9912
220021	10/01/92	09/30/93	1.2664	0.9922
220023	10/01/92	09/30/93	1.1631	0.9948
220024	10/01/92	09/30/93	1.1751	0.9936
220025	10/01/92	09/30/93	1.0964	0.9880
220026	10/01/92	09/30/93	1.3788	0.9888
220028	10/01/92	09/30/93	1.4017	0.9978
220029	10/01/92	09/30/93	1.1421	0.9881
220030	10/01/92	09/30/93	1.0916	0.9794
220031	09/27/92	09/25/93	1.6523	0.9974
220033	10/01/92	09/30/93	1.3330	0.9930
220035	10/01/92	09/30/93	1.2150	0.9918
220036	10/01/92	09/30/93	1.5936	0.9968
220038	10/01/92	09/30/93	1.2409	0.9813
220042	10/01/92	09/30/93	1.2687	0.9835
220045	10/01/92	09/30/93	1.2562	0.9951
220046	10/01/92	09/30/93	1.3798	0.9941
220048	10/01/92	09/30/93	0.7353	1.0000
220049	10/01/92	09/30/93	1.2306	0.9794
220050	10/01/92	09/30/93	0.9597	0.9753
220051	10/01/92	09/30/93	1.1952	0.9933
220052	10/01/92	09/30/93	1.2007	0.9881
220053	10/01/92	09/30/93	1.2856	0.9832
220055	10/01/92	09/30/93	1.1976	0.9892
220057	10/01/92	09/30/93	1.2912	0.9922
220058	10/01/92	09/30/93	1.1249	0.9770
220060	10/01/92	09/30/93	1.1434	0.9800
220062	10/01/92	09/30/93	0.7216	0.9874
220063	10/01/92	09/30/93	1.2084	0.9902
220064	10/01/92	09/30/93	1.1970	0.9867
220065	10/01/92	09/30/93	1.2448	0.9790
220066	10/01/92	09/30/93	1.3006	0.9949
220067	10/01/92	09/30/93	1.2468	0.9910
220068	10/01/92	09/30/93	0.5923	0.9887
220070	10/01/92	09/30/93	1.1605	0.9854
220071	10/01/92	09/30/93	1.8220	0.9987
220073	10/01/92	09/30/93	1.3085	0.9884
220074	10/01/92	09/30/93	1.2420	0.9787
220075	10/01/92	09/30/93	1.1746	0.9883
220076	10/01/92	09/30/93	1.2116	0.9826
220077	10/01/92	09/30/93	1.6498	0.9987
220079	10/01/92	09/30/93	1.1464	0.9901
220080	10/01/92	09/30/93	1.2230	0.9920
220081	10/01/92	09/30/93	0.9662	0.9696
220082	10/01/92	09/30/93	1.2112	0.9916
220084	10/01/92	09/30/93	1.2142	0.9643
220086	09/27/92	09/25/93	1.5724	0.9988
220088	10/01/92	09/30/93	1.5477	0.9888
220089	10/01/92	09/30/93	1.2473	0.9907
220090	10/01/92	09/30/93	1.1875	0.9820
220092	10/01/92	09/30/93	1.2704	0.9818
220094	10/01/92	09/30/93	1.2235	0.9859
220095	10/01/92	09/30/93	1.1885	0.9827
220097	10/01/92	09/30/93	1.0484	0.9750
220098	10/01/92	09/30/93	1.2236	0.9826
220099	10/01/92	09/30/93	1.1621	0.9858
220100	10/01/92	09/30/93	1.2430	0.9830
220101	10/01/92	09/30/93	1.3982	0.9899
220102	10/01/92	09/30/93	0.6305	1.0000
220104	10/01/92	09/30/93	1.2353	0.9907
220105	10/01/92	09/30/93	1.1450	0.9854
220106	10/01/92	09/30/93	1.1355	0.9829
220107	10/01/92	09/30/93	1.1133	0.9905
220108	10/01/92	09/30/93	1.1529	0.9873
220110	10/01/92	09/30/93	1.9831	0.9968
220111	10/01/92	09/30/93	1.1966	0.9762
220116	09/27/92	09/25/93	1.8075	0.9993
220118	10/01/92	09/30/93	2.0766	0.9988
220119	10/01/92	09/30/93	1.3325	0.9901
220120	10/01/92	09/30/93	1.1828	0.9965
220123	10/01/92	09/30/93	1.0257	0.9582
220126	10/01/92	09/30/93	1.2285	0.9728
220128	10/01/92	09/30/93	1.0833	0.9888
220135	10/01/92	09/30/93	1.1575	0.9760
220156	10/01/92	09/30/93	1.3047	0.9853
220171	10/01/92	09/30/93	1.6778	0.9966
230003	10/01/92	09/30/93	1.1351	0.9871
230007	01/01/93	12/31/93	1.0475	0.9717
230012	01/01/93	12/31/93	0.6678	0.9838
230013	01/01/93	12/31/93	1.3410	0.9933
230014	01/01/93	12/31/93	0.8897	0.9225
230015	01/01/93	12/31/93	1.2185	0.9842
230017	01/01/93	12/31/93	1.5244	0.9994
230020	01/01/93	12/31/93	1.6400	0.9952

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
230021	10/01/92	09/30/93	1.5763	0.9977
230022	01/01/93	12/31/93	1.2896	0.9795
230040	10/01/92	09/30/93	1.2454	0.9804
230042	01/01/93	12/31/93	1.1462	0.9767
230043	01/01/93	12/31/93	0.4818	0.9762
230053	01/01/93	12/31/93	1.4729	0.9982
230055	01/01/93	12/31/93	1.2027	0.9879
230056	10/01/92	09/30/93	0.9529	0.9689
230063	01/01/93	12/31/93	1.3529	0.9922
230065	01/01/93	12/31/93	1.5134	0.9961
230071	11/01/92	10/31/93	0.6167	0.9979
230076	01/01/93	12/31/93	1.3137	0.9973
230078	10/01/92	09/30/93	1.1495	0.9823
230080	10/01/92	09/30/93	1.1798	0.9854
230087	01/01/93	12/31/93	0.9959	0.9779
230089	09/01/92	08/31/93	1.3512	0.9954
230096	10/01/92	09/30/93	1.2437	0.9772
230101	10/01/92	09/30/93	1.1119	0.9653
230103	01/01/93	12/31/93	1.0108	0.9878
230104	01/01/93	12/31/93	1.6217	0.9981
230105	01/01/93	12/31/93	1.5885	0.9979
230107	01/01/93	12/31/93	0.8731	0.9578
230110	10/01/92	09/30/93	1.2649	0.9889
230114	01/01/93	12/31/93	0.6498	1.0000
230115	01/01/93	12/31/93	0.9760	0.9484
230118	10/01/92	09/30/93	1.2737	0.9649
230119	10/01/92	09/30/93	1.2364	0.9942
230121	01/01/93	12/31/93	1.3072	0.9740
230122	10/01/92	09/30/93	1.3009	0.9929
230125	10/01/92	09/30/93	1.4049	0.9820
230128	01/01/93	12/31/93	1.4204	0.9969
230129	01/01/93	12/31/93	1.9582	0.9974
230130	01/01/93	12/31/93	1.6450	0.9994
230134	01/01/93	12/31/93	1.2139	0.9745
230135	01/01/93	12/31/93	1.2738	0.9873
230137	10/01/92	09/30/93	1.1502	0.9880
230141	10/01/92	09/30/93	1.6084	0.9978
230142	01/01/93	12/31/93	1.1769	0.9881
230143	01/01/93	12/31/93	1.1728	0.9841
230144	01/01/93	12/31/93	1.1783	0.9828
230145	10/01/92	09/30/93	1.1690	0.9897
230146	01/01/93	12/31/93	1.2918	0.9803
230149	01/01/93	12/31/93	1.2449	0.9578
230151	01/01/93	12/31/93	1.3534	0.9907
230155	01/01/93	12/31/93	1.1572	0.9740
230167	01/01/93	12/31/93	1.2130	0.9940
230169	10/01/92	09/30/93	1.3441	0.9858
230171	01/01/93	12/31/93	1.0580	0.9767
230175	10/01/92	09/30/93	2.6575	1.0000
230176	01/01/93	12/31/93	1.1940	0.9818
230184	10/01/92	09/30/93	1.1275	0.9777
230186	01/01/93	12/31/93	1.1192	0.9865
230190	01/01/93	12/31/93	1.3386	0.9522
230191	01/01/93	12/31/93	0.8775	0.9654
230193	10/01/92	09/30/93	1.2672	0.9875
230194	01/01/93	12/31/93	1.1651	0.9644
230195	10/01/92	09/30/93	1.2963	0.9862
230197	10/01/92	09/30/93	1.2684	0.9896
230204	10/01/92	09/30/93	1.2856	0.9925
230205	10/01/92	09/30/93	1.0832	0.9478
230208	01/01/93	12/31/93	1.2252	0.9726
230211	01/01/93	12/31/93	0.9921	0.9431
230213	01/01/93	12/31/93	1.0421	0.9762
230216	01/01/93	12/31/93	1.3452	0.9965
230217	01/01/93	12/31/93	1.1336	0.9660
230223	01/01/93	12/31/93	1.3363	0.9907
230227	01/01/93	12/31/93	1.4427	0.9970
230228	01/01/93	12/31/93	1.3167	0.9901
230230	01/01/93	12/31/93	1.3509	0.9884
230235	01/01/93	12/31/93	0.9343	0.9696
230236	10/01/92	09/30/93	1.3266	0.9996
230237	10/01/92	09/30/93	1.1151	0.9947
230239	10/01/92	09/30/93	1.1803	0.9701
230244	10/01/92	09/30/93	1.4492	0.9853
230253	10/01/92	09/30/93	1.2354	0.9631
230254	01/01/93	12/31/93	1.2244	0.9914
230259	01/01/93	12/31/93	1.2010	0.9811
230269	01/01/93	12/31/93	1.2254	0.9940
230270	01/01/93	12/31/93	1.2425	0.9809
230273	01/01/93	12/31/93	1.6591	0.9990
230276	01/01/93	12/31/93	0.9342	0.9944
230277	01/01/93	12/31/93	1.2276	0.9870
240001	01/01/93	12/31/93	1.5247	0.9984
240003	09/01/92	08/31/93	1.2232	0.9790

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
240004	01/01/93	12/31/93	1.4388	0.9855
240006	01/01/93	12/31/93	1.1071	0.9627
240007	10/01/92	09/30/93	1.0696	0.9577
240008	10/01/92	09/30/93	1.0377	0.9567
240010	01/01/93	12/31/93	1.9604	0.9945
240011	10/01/92	09/30/93	1.1065	0.9801
240013	10/01/92	09/30/93	1.2215	0.9670
240014	01/01/93	12/31/93	1.0700	0.9447
240016	10/01/92	09/30/93	1.3929	0.9696
240018	10/01/92	09/30/93	1.2090	0.9728
240019	01/01/93	12/31/93	1.2947	0.9994
240020	10/01/92	09/30/93	1.1820	0.9757
240021	10/01/92	09/30/93	1.1335	0.9511
240022	01/01/93	12/31/93	1.0848	0.9577
240023	01/01/93	12/31/93	1.1045	0.9557
240025	01/01/93	12/31/93	1.1706	0.9735
240027	10/01/92	09/30/93	1.0193	0.9730
240028	10/01/92	09/30/93	1.1021	0.9795
240029	10/01/92	09/30/93	1.2072	0.9740
240030	01/01/93	12/31/93	1.3503	0.9807
240031	01/01/93	12/31/93	1.0285	0.9263
240038	01/01/93	12/31/93	1.4854	0.9975
240041	10/01/92	09/30/93	1.2725	0.9740
240043	01/01/93	12/31/93	1.2232	0.9628
240045	10/01/92	09/30/93	1.0138	0.9514
240047	01/01/93	12/31/93	1.3857	0.9976
240048	09/01/92	08/31/93	1.3038	0.9887
240050	09/01/92	08/31/93	1.1469	0.9492
240051	10/01/92	09/30/93	0.9263	0.9330
240052	10/01/92	09/30/93	1.2131	0.9813
240053	01/01/93	12/31/93	1.4890	0.9969
240056	01/01/93	12/31/93	1.2676	0.9848
240058	10/01/92	09/30/93	1.0014	0.9534
240059	10/01/92	09/30/93	1.2157	0.9668
240061	01/01/93	12/31/93	1.5889	0.9940
240063	09/01/92	08/31/93	1.5326	0.9919
240064	01/01/93	12/31/93	1.1658	0.9686
240065	10/01/92	09/30/93	0.9523	0.9624
240066	09/01/92	09/30/93	1.3626	0.9814
240069	01/01/93	12/31/93	1.1535	0.9645
240071	01/01/93	12/31/93	1.1366	0.9700
240072	01/01/93	12/31/93	1.0440	0.9354
240073	01/01/93	12/31/93	1.0083	0.9457
240076	01/01/93	12/31/93	1.0925	0.9610
240078	01/01/93	12/31/93	1.4016	0.9962
240079	10/01/92	09/30/93	1.0462	0.9693
240080	01/01/93	12/31/93	1.3969	0.9958
240082	01/01/93	12/31/93	1.1828	0.9851
240083	01/01/93	12/31/93	1.3415	0.9597
240084	01/01/93	12/31/93	1.3799	0.9618
240085	01/01/93	12/31/93	0.8955	0.9550
240086	10/01/92	09/30/93	1.1710	0.9530
240087	01/01/93	12/31/93	1.0765	0.9797
240088	01/01/93	12/31/93	1.4722	0.9720
240090	10/01/92	09/30/93	1.0895	0.9628
240091	01/01/93	12/31/93	0.9828	0.9350
240093	10/01/92	09/30/93	1.2779	0.9816
240094	10/01/92	09/30/93	0.9767	0.9484
240096	01/01/93	12/31/93	1.1305	0.9726
240097	01/01/93	12/31/93	1.0910	0.9763
240098	10/01/92	09/30/93	1.0135	0.9703
240100	12/01/92	11/30/93	1.2730	0.9795
240102	01/01/93	12/31/93	1.0488	0.9680
240103	10/01/92	09/30/93	1.1250	0.9565
240105	10/01/92	09/30/93	0.9282	0.9558
240106	01/01/93	12/31/93	1.2197	0.9936
240107	01/01/93	12/31/93	0.9093	0.9800
240108	10/01/92	09/30/93	1.0243	0.9570
240109	01/01/93	12/31/93	0.9307	0.9733
240111	01/01/93	12/31/93	1.0282	0.9485
240112	01/01/93	12/31/93	1.0339	0.9885
240114	01/01/93	12/31/93	1.0300	0.9028
240115	01/01/93	12/31/93	1.6475	0.9966
240116	10/01/92	09/30/93	0.9114	0.9293
240117	11/01/92	10/31/93	1.1158	0.9532
240119	01/01/93	12/31/93	0.9083	0.9582
240121	10/01/92	09/30/93	0.9012	0.9539
240122	10/01/92	09/30/93	1.0913	0.9546
240123	01/01/93	12/31/93	1.0234	0.9498
240124	01/01/93	12/31/93	1.0606	0.9707
240127	01/01/93	12/31/93	1.0061	0.9841
240128	01/01/93	12/31/93	1.1426	0.9627
240130	01/01/93	12/31/93	0.9629	0.9454
240132	01/01/93	12/31/93	1.1894	0.9881

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
240133	01/01/93	12/31/93	1.1246	0.9543
240135	10/01/92	09/30/93	0.9478	0.9943
240138	10/01/92	09/30/93	0.8781	0.9699
240139	10/01/92	09/30/93	0.9635	0.9567
240140	01/01/93	12/31/93	0.9138	0.9348
240141	01/01/93	12/31/93	1.0246	0.9460
240142	01/01/93	12/31/93	1.0423	0.9486
240143	10/01/92	09/30/93	0.9227	0.9554
240144	01/01/93	12/31/93	0.9547	0.9552
240146	10/01/92	09/30/93	0.9767	0.9466
240148	01/01/93	12/31/93	0.9088	0.9552
240150	10/01/92	09/30/93	0.9295	1.0000
240152	01/01/93	12/31/93	0.9754	0.9400
240153	10/01/92	09/30/93	1.0222	0.9635
240154	01/01/93	12/31/93	1.0074	0.9768
240155	10/01/92	09/30/93	0.9662	0.9246
240157	09/01/92	08/31/93	1.0315	0.9309
240161	10/01/92	09/30/93	0.9934	0.9694
240162	01/01/93	12/31/93	0.9867	0.9517
240163	01/01/93	12/31/93	0.9341	0.9557
240166	10/01/92	09/30/93	1.1512	0.9532
240169	01/01/93	12/31/93	0.9553	0.9585
240170	01/01/93	12/31/93	1.0703	0.9768
240172	01/01/93	12/31/93	1.1111	0.9735
240173	01/01/93	12/31/93	0.9845	0.9621
240179	01/01/93	12/31/93	0.9853	0.9729
240180	01/01/93	12/31/93	0.9140	0.9456
240184	10/01/92	09/30/93	0.9985	0.9792
240187	01/01/93	12/31/93	1.2825	0.9615
240192	01/01/93	12/31/93	1.0835	0.9796
240193	10/01/92	09/30/93	1.1249	0.9900
240196	01/01/93	12/31/93	0.6006	0.9976
240200	01/01/93	12/31/93	0.8504	0.8770
240207	01/01/93	12/31/93	1.1868	0.9792
240210	09/01/92	08/31/93	1.2920	0.9832
250002	10/01/92	09/30/93	0.8115	0.9597
250003	10/01/92	09/30/93	0.9249	0.9650
250004	10/01/92	09/30/93	1.4356	0.9987
250005	10/01/92	09/30/93	0.9891	0.9805
250007	10/01/92	09/30/93	1.2262	0.9925
250008	10/01/92	09/30/93	0.9914	0.9410
250009	10/01/92	09/30/93	1.1391	0.9841
250010	10/01/92	09/30/93	1.0673	0.9621
250015	10/01/92	09/30/93	1.0511	0.9612
250018	10/01/92	09/30/93	0.9044	0.9900
250019	10/01/92	09/30/93	1.3892	0.9973
250020	10/01/92	09/30/93	0.9700	0.9571
250021	10/01/92	09/30/93	0.9405	0.9169
250023	01/01/93	12/31/93	0.8434	0.9634
250024	10/01/92	09/30/93	1.0274	0.9549
250025	10/01/92	09/30/93	1.0165	0.9612
250027	10/01/92	09/30/93	1.0457	0.9437
250029	01/01/93	12/31/93	0.9426	0.9495
250030	01/01/93	12/31/93	0.9985	0.9567
250035	10/01/92	09/30/93	0.8637	0.9585
250036	10/01/92	09/30/93	0.9948	0.9593
250037	10/01/92	09/30/93	0.8926	0.9569
250038	10/01/92	09/30/93	0.9992	0.9701
250039	10/01/92	09/30/93	0.9749	0.9684
250040	10/01/92	09/30/93	1.3054	0.9909
250042	10/01/92	09/30/93	1.1621	0.9808
250043	10/01/92	09/30/93	0.8795	0.9434
250045	10/01/92	09/30/93	1.1894	0.9586
250047	10/01/92	09/30/93	0.9733	0.9610
250048	01/01/93	12/31/93	1.4279	0.9987
250049	10/01/92	09/30/93	0.9192	0.9814
250050	10/01/92	09/30/93	1.2378	0.9828
250051	10/01/92	09/30/93	0.9019	0.9700
250057	10/01/92	09/30/93	1.1381	0.9694
250058	10/01/92	09/30/93	1.1707	0.9880
250059	10/01/92	09/30/93	1.0218	0.9529
250060	10/01/92	09/30/93	0.8038	0.9701
250061	10/01/92	09/30/93	0.8702	0.9876
250063	10/01/92	09/30/93	0.8589	0.9604
250065	10/01/92	09/30/93	0.8975	0.9768
250066	10/01/92	09/30/93	0.9681	0.9740
250067	10/01/92	09/30/93	0.9652	0.9756
250068	10/01/92	09/30/93	0.8931	0.9620
250069	01/01/93	12/31/93	1.2353	0.9961
250071	10/01/92	09/30/93	1.0498	0.9620
250072	01/01/93	12/31/93	1.3433	0.9948
250076	10/01/92	09/30/93	0.9524	0.9366
250077	10/01/92	09/30/93	0.9294	0.9768
250078	10/01/92	09/30/93	1.3944	0.9981
250079	10/01/92	09/30/93	0.8712	0.9527
250081	10/01/92	09/30/93	1.2175	0.9966
250092	10/01/92	09/30/93	1.2190	0.9925
250083	01/01/93	12/31/93	0.9690	0.9766
250084	10/01/92	09/30/93	1.1229	0.9965
250085	10/01/92	09/30/93	1.0480	0.9700
250086	10/01/92	09/30/93	0.9588	0.8833
250088	10/01/92	09/30/93	0.9833	0.9583
250089	01/01/93	12/31/93	1.0563	0.9892
250093	10/01/92	09/30/93	1.1483	0.9859
250095	10/01/92	09/30/93	1.0351	0.9835
250096	10/01/92	09/30/93	1.1164	0.9907
250097	10/01/92	09/30/93	1.2123	0.9787
250098	10/01/92	09/30/93	0.8663	0.9638
250099	10/01/92	09/30/93	1.2529	0.9839
250100	10/01/92	09/30/93	1.2450	0.9870
250101	10/01/92	09/30/93	0.8787	0.9757
250104	10/01/92	09/30/93	1.3333	0.9988
250105	10/01/92	09/30/93	0.8909	0.9545
250107	10/01/92	09/30/93	0.9495	0.9745
250109	10/01/92	09/30/93	0.9585	0.9612
250112	10/01/92	09/30/93	0.9542	0.9486
250117	01/01/93	12/31/93	1.0534	0.9632
250119	10/01/92	09/30/93	1.0904	0.9694
250120	10/01/92	09/30/93	0.9979	0.9862
250122	09/01/92	08/31/93	1.2097	0.9939
250124	01/01/93	12/31/93	0.8952	0.9762
250125	01/01/93	12/31/93	1.3094	0.9869
250131	01/01/93	12/31/93	1.0301	0.9704
250136	01/01/93	12/31/93	0.8105	1.0000
250140	10/01/92	09/30/93	0.9054	0.9893
260003	09/01/92	08/31/93	1.0188	0.9625
260004	01/01/93	12/31/93	1.0429	0.9842
260005	01/01/93	12/31/93	1.5596	0.9747
260011	01/01/93	12/31/93	1.5829	0.9959
260012	10/01/92	10/31/93	1.0807	0.9669
260014	01/01/93	12/31/93	1.7307	0.9988
260015	01/01/93	12/31/93	1.1876	0.9559
260017	01/01/93	12/31/93	1.2216	0.9752
260018	10/01/92	09/30/93	0.9459	0.9523
260019	01/01/93	12/31/93	1.0602	0.9611
260021	10/01/92	09/30/93	1.4496	0.9958
260023	10/01/92	09/30/93	1.2373	0.9898
260024	12/01/92	11/30/93	1.0361	0.9810
260025	10/01/92	09/30/93	1.2413	0.9814
260027	01/01/93	12/31/93	1.5856	0.9990
260029	10/01/92	09/30/93	1.1960	0.9707
260030	10/01/92	09/30/93	1.1694	0.9684
260031	01/01/93	12/31/93	1.4977	0.9992
260032	01/01/93	12/31/93	1.6378	0.9975
260034	01/01/93	12/31/93	1.0071	0.9650
260035	12/01/92	11/30/93	1.0866	0.9745
260036	01/01/93	12/31/93	1.0771	0.9650
260039	09/01/92	08/31/93	1.2078	0.9774
260040	10/01/92	09/30/93	1.4935	0.9986
260044	01/01/93	12/31/93	1.0825	0.9766
260047	10/01/92	09/30/93	1.2892	0.9903
260050	01/01/93	12/31/93	1.1236	0.9666
260053	10/01/92	09/30/93	1.1332	0.9929
260054	01/01/93	12/31/93	1.2744	0.9931
260057	10/01/92	09/30/93	1.2139	0.9756
260062	01/01/93	12/31/93	1.1922	0.9866
260063	01/01/93	12/31/93	1.1379	0.9604
260064	01/01/93	12/31/93	1.3724	0.9843
260068	01/01/93	12/31/93	1.7650	0.9991
260070	01/01/93	12/31/93	1.2671	0.9222
260073	01/01/93	12/31/93	1.0478	0.9814
260074	01/01/93	12/31/93	1.2061	0.9651
260078	01/01/93	12/31/93	1.1163	0.9725
260080	09/01/92	08/31/93	1.0641	0.9332
260089	01/01/93	12/31/93	1.0112	0.9936
260091	01/01/93	12/31/93	1.6333	0.9982
260092	01/01/93	12/31/93	1.0357	0.9422
260097	10/01/92	09/30/93	1.1333	0.9630
260100	10/01/92	09/30/93	1.0482	0.9549
260102	01/01/93	12/31/93	1.0949	0.9733
260103	01/01/93	12/31/93	1.3779	0.9933
260107	01/01/93	12/31/93	1.4071	0.9984
260110	01/01/93	12/31/93	1.6000	0.9962
260113	10/01/92	09/30/93	1.1617	0.9868
260116	01/01/93	12/31/93	1.1483	0.9891
260119	01/01/93	12/31/93	1.2329	0.9797
260120	12/01/92	11/30/93	1.2443	0.9694
260122	11/01/92	10/31/93	1.1865	0.9682
260123	01/01/93	12/31/93	1.0381	0.9786
260134	01/01/93	12/31/93	1.2447	0.9695
260138	01/01/93	12/31/93	1.8623	0.9989
260148	11/01/92	10/31/93	0.9853	0.9646
260158	01/01/93	12/31/93	1.1132	0.9801
260159	01/01/93	12/31/93	1.2136	0.9671
260160	01/01/93	12/31/93	1.1338	0.9750
260162	01/01/93	12/31/93	1.1511	0.9750
260166	01/01/93	12/31/93	1.2129	0.9834
260176	10/01/92	09/30/93	1.5583	0.9976
260178	01/01/93	12/31/93	1.5136	0.9962
260179	01/01/93	12/31/93	1.5216	0.9968
260180	01/01/93	12/31/93	1.5886	0.9976
260188	01/01/93	12/31/93	1.3886	0.9825
260190	01/01/93	12/31/93	1.2047	0.9860
260191	01/01/93	12/31/93	1.2010	0.9794
260193	01/01/93	12/31/93	1.2639	0.9645
260195	09/25/92	09/30/93	1.1455	0.9858
260198	01/01/93	12/31/93	1.2514	0.9871
260200	01/01/93	12/31/93	1.1825	0.9712
270002	10/01/92	09/30/93	1.1974	0.9797
270006	10/01/92	09/30/93	0.9936	1.0000
270007	10/01/92	09/30/93	0.9365	0.9776
270013	01/01/93	12/31/93	1.2805	0.9929
270019	01/01/93	12/31/93	0.9766	0.9767
270021	10/01/92	09/30/93	1.1272	0.9854
270033	01/01/93	12/31/93	0.9279	0.9817
270039	01/01/93	12/31/93	0.9478	0.9790
270048	11/01/92	10/31/93	1.0678	0.9688
270057	01/01/93	12/31/93	1.1725	0.9778
270059	11/01/92	10/31/93	0.8529	0.9620
270063	10/01/92	09/30/93	0.8679	0.9383
270083	01/01/93	12/31/93	1.0133	0.9245
270084	01/01/93	12/31/93	0.9094	0.9392
280001	10/01/92	09/30/93	1.0435	0.9578
280005	09/01/92	08/31/93	1.4358	0.9919
280012	01/01/93	12/31/93	1.2119	0.9793
280015	10/01/92	09/30/93	1.0988	0.9663
280017	08/01/92	07/31/93	1.1135	0.9651
280025	09/01/92	08/31/93	1.0221	0.9607
280030	09/01/92	08/31/93	1.8653	0.9992
280031	10/01/92	09/30/93	1.0504	0.9754
280032	01/01/93	12/31/93	1.2422	0.9848
280038	10/01/92	09/30/93	1.0935	0.9739
280039	10/01/92	09/30/93	1.1519	0.9703
280040	01/01/93	12/31/93	1.5815	0.9976
280041	01/01/93	12/31/93	1.0135	0.9827
280046	01/01/93	12/31/93	1.0352	0.9755
280047	01/01/93	12/31/93	1.0863	0.9682
280048	10/01/92	09/30/93	1.0501	0.9951
280054	10/01/92	09/30/93	1.2418	0.9683
280057	10/01/92	09/30/93	1.0036	0.9628
280058	10/01/92	09/30/93	1.2692	0.9609
280061	01/01/93	12/31/93	1.3800	0.9857
280065	01/01/93	12/31/93	1.2418	0.9843
280074	10/01/92	09/30/93	1.0865	0.9517
280076	08/01/92	07/31/93	1.0690	0.9674
280079	08/01/92	07/31/93	1.0206	0.9505
280081	10/01/92	09/30/93	1.4825	0.9966
280083	11/01/92	10/31/93	1.0274	0.9608
280085	01/01/93	12/31/93	0.7308	0.9156
280088	09/21/92	09/19/93	1.6797	0.9996
280089	10/01/92	09/30/93	1.0480	0.9849
280101	10/01/92	09/30/93	1.1423	0.9719
280102	01/01/93	12/31/93	0.9800	0.9422
280106	08/01/92	07/31/93	1.0414	0.9934
280107	11/01/92	10/31/93	1.0248	0.9501
280108	01/01/93	12/31/93	1.0895	0.9875
280109	08/01/92	07/31/93	0.8698	0.9725
280114	08/01/92	07/31/93	0.9779	0.9786
280115	01/01/93	12/31/93	1.0278	0.9723
290005	09/01/92	08/31/93	1.2468	0.9949
290006	01/01/93	12/31/93	1.0345	0.9616
290009	01/01/93	12/31/93	1.4954	0.9974
290010	01/01/93	12/31/93	1.1698	0.9837
290018	01/01/93	12/31/93	1.2225	1.0000
290021	01/01/93	12/31/93	1.5628	0.9982
290022	10/01/92	09/30/93	1.5905	0.9994
290032	01/01/93	12/31/93	1.3820	0.9837
300001	10/01/92	09/30/93	1.3449	0.9947
300005	10/01/92	09/30/93	1.2758	0.9863
300006	10/01/92	09/30/93	1.1356	0.9714
300007	10/01/92	09/30/93	1.1491	0.9675
300008	10/01/92	09/30/93	1.2686	0.9801

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
300009	10/01/92	09/30/93	1.1578	0.9560
300011	01/01/93	12/31/93	1.2868	0.9904
300012	10/01/92	09/30/93	1.2868	0.9850
300013	10/01/92	09/30/93	1.2088	0.9837
300014	10/01/92	09/30/93	1.2562	0.9899
300016	10/01/92	09/30/93	1.2416	0.9884
300017	07/31/92	07/31/93	1.1895	0.9810
300018	01/01/93	12/31/93	1.2283	0.9925
300020	10/01/92	09/30/93	1.2375	0.9930
300021	10/01/92	09/30/93	1.1571	0.9834
300022	01/01/93	12/31/93	1.1281	0.9643
300023	10/01/92	09/30/93	1.2309	0.9880
300024	10/01/92	09/30/93	1.2281	0.9739
300028	10/01/92	09/30/93	1.2007	0.9737
300033	10/01/92	09/30/93	1.0753	0.9760
310001	01/01/93	12/31/93	1.6601	0.9984
310002	01/01/93	12/31/93	1.7188	0.9983
310003	01/01/93	12/31/93	1.1961	0.9939
310005	01/01/93	12/31/93	1.1841	0.9864
310006	01/01/93	12/31/93	1.2077	0.9952
310008	01/01/93	12/31/93	1.3034	0.9950
310009	01/01/93	12/31/93	1.1636	0.9964
310010	01/01/93	12/31/93	1.2662	0.9898
310011	01/01/93	12/31/93	1.2502	0.9833
310012	01/01/93	12/31/93	1.5408	0.9992
310013	01/01/93	12/31/93	1.3042	0.9971
310014	01/01/93	12/31/93	1.6315	0.9978
310015	01/01/93	12/31/93	1.7433	0.9990
310016	01/01/93	12/31/93	1.2310	0.9954
310017	01/01/93	12/31/93	1.3350	0.9930
310018	01/01/93	12/31/93	1.2533	0.9936
310019	01/01/93	12/31/93	1.6570	0.9981
310020	01/01/93	12/31/93	1.2237	0.9973
310021	01/01/93	12/31/93	1.3234	0.9919
310022	01/01/93	12/31/93	1.2308	0.9936
310024	01/01/93	12/31/93	1.2379	0.9912
310025	01/01/93	12/31/93	1.2022	0.9898
310026	01/01/93	12/31/93	1.2887	0.9959
310027	01/01/93	12/31/93	1.3380	0.9958
310028	01/01/93	12/31/93	1.1493	0.9859
310029	01/01/93	12/31/93	1.8047	0.9967
310031	01/01/93	12/31/93	2.5969	0.9979
310032	01/01/93	12/31/93	1.2714	0.9856
310034	01/01/93	12/31/93	1.2142	0.9933
310036	01/01/93	12/31/93	1.2142	0.9909
310037	01/01/93	12/31/93	1.2005	0.9927
310038	01/01/93	12/31/93	1.7473	0.9978
310039	01/01/93	12/31/93	1.2975	0.9948
310040	01/01/93	12/31/93	1.2419	0.9970
310041	01/01/93	12/31/93	1.2794	0.9937
310042	01/01/93	12/31/93	1.1522	0.9916
310043	01/01/93	12/31/93	1.2056	0.9950
310044	01/01/93	12/31/93	1.3228	0.9894
310045	01/01/93	12/31/93	1.2937	0.9982
310047	01/01/93	12/31/93	1.2872	0.9868
310048	01/01/93	12/31/93	1.2281	0.9931
310049	01/01/93	12/31/93	1.2820	0.9961
310050	10/01/92	09/30/93	1.1860	0.9931
310051	01/01/93	12/31/93	1.2962	0.9970
310052	01/01/93	12/31/93	1.2071	0.9930
310054	01/01/93	12/31/93	1.2667	0.9949
310056	01/01/93	12/31/93	1.1637	0.9800
310057	01/01/93	12/31/93	1.2793	0.9925
310058	01/01/93	12/31/93	1.1206	0.9980
310060	01/01/93	12/31/93	1.1934	0.9922
310061	01/01/93	12/31/93	1.1447	0.9901
310062	01/01/93	12/31/93	1.2960	0.9975
310063	01/01/93	12/31/93	1.3259	0.9939
310064	01/01/93	12/31/93	1.2609	0.9900
310067	01/01/93	12/31/93	1.2945	0.9919
310069	01/01/93	12/31/93	1.1915	0.9850
310070	01/01/93	12/31/93	1.3425	0.9951
310072	01/01/93	12/31/93	1.2493	0.9862
310073	01/01/93	12/31/93	1.4596	0.9968
310074	01/01/93	12/31/93	1.2697	0.9943
310075	01/01/93	12/31/93	1.2891	0.9948
310076	01/01/93	12/31/93	1.3475	0.9973
310077	01/01/93	12/31/93	1.5392	0.9983
310078	01/01/93	12/31/93	1.2881	0.9978
310081	01/01/93	12/31/93	1.2380	0.9894
310083	01/01/93	12/31/93	1.2318	0.9960
310084	01/01/93	12/31/93	1.2048	0.9917
310086	01/01/93	12/31/93	1.2036	0.9916
310087	01/01/93	12/31/93	1.2429	0.9864

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
310088	01/01/93	12/31/93	1.1668	0.9823
310090	01/01/93	12/31/93	1.2515	0.9927
310091	01/01/93	12/31/93	1.2144	0.9854
310092	01/01/93	12/31/93	1.3798	0.9947
310093	01/01/93	12/31/93	1.1664	0.9924
310096	01/01/93	12/31/93	1.8903	0.9985
310105	01/01/93	12/31/93	1.3134	0.9921
310108	01/01/93	12/31/93	1.3022	0.9958
310110	01/01/93	12/31/93	1.1705	0.9910
310111	01/01/93	12/31/93	1.2918	0.9911
310112	01/01/93	12/31/93	1.2939	0.9960
310113	01/01/93	12/31/93	1.2355	0.9846
310115	01/01/93	12/31/93	1.2001	0.9962
310116	01/01/93	12/31/93	1.2624	0.9931
310118	10/01/92	09/30/93	1.2920	0.9896
310120	01/01/93	12/31/93	1.0780	0.9907
310121	01/01/93	12/31/93	1.0903	0.9480
320019	09/01/92	08/31/93	1.3963	0.9994
320033	01/01/93	12/31/93	1.0754	0.9854
320035	01/01/93	12/31/93	1.3095	0.9681
320038	09/01/92	08/31/93	1.2472	0.9754
320048	01/01/93	12/31/93	1.2727	0.9897
320063	09/01/92	08/31/93	1.2869	0.9768
330001	01/01/93	12/31/93	1.1894	0.9870
330002	01/01/93	12/31/93	1.4559	0.9965
330003	01/01/93	12/31/93	1.3073	0.9958
330004	01/01/93	12/31/93	1.2743	0.9926
330005	01/01/93	12/31/93	1.7434	0.9988
330006	01/01/93	12/31/93	1.3305	0.9956
330007	01/01/93	12/31/93	1.3963	0.9940
330008	01/01/93	12/31/93	1.1339	0.9902
330009	01/01/93	12/31/93	1.2621	0.9980
330010	01/01/93	12/31/93	1.2285	0.9846
330011	01/01/93	12/31/93	1.2189	0.9918
330012	01/01/93	12/31/93	1.5956	0.9966
330013	01/01/93	12/31/93	2.0024	0.9973
330014	01/01/93	12/31/93	1.3963	0.9887
330016	01/01/93	12/31/93	1.0095	0.9831
330019	01/01/93	12/31/93	1.2534	0.9943
330020	01/01/93	12/31/93	1.0814	0.9808
330023	01/01/93	12/31/93	1.2102	0.9881
330024	01/01/93	12/31/93	1.8149	0.9992
330025	01/01/93	12/31/93	1.1072	0.9938
330027	01/01/93	12/31/93	1.5291	0.9891
330028	01/01/93	12/31/93	1.3393	0.9945
330029	01/01/93	12/31/93	1.1169	0.9906
330030	01/01/93	12/31/93	1.1617	0.9868
330033	01/01/93	12/31/93	1.1867	0.9702
330034	01/01/93	12/31/93	0.9912	0.9859
330036	01/01/93	12/31/93	1.2903	0.9922
330037	01/01/93	12/31/93	1.1241	0.9882
330038	01/01/93	12/31/93	1.1873	0.9851
330039	01/01/93	12/31/93	0.8384	0.9778
330041	01/01/93	12/31/93	1.3294	0.9964
330043	01/01/93	12/31/93	1.2433	0.9932
330044	01/01/93	12/31/93	1.1762	0.9940
330045	01/01/93	12/31/93	1.3898	0.9915
330046	01/01/93	12/31/93	1.5243	0.9986
330047	01/01/93	12/31/93	1.2286	0.9917
330048	01/01/93	12/31/93	1.2814	0.9904
330049	01/01/93	12/31/93	1.2592	0.9824
330053	01/01/93	12/31/93	1.1449	0.9860
330055	01/01/93	12/31/93	1.4212	0.9904
330056	01/01/93	12/31/93	1.4030	0.9963
330057	01/01/93	12/31/93	1.6012	0.9987
330058	01/01/93	12/31/93	1.2728	0.9941
330059	01/01/93	12/31/93	1.5704	0.9985
330061	01/01/93	12/31/93	1.3280	0.9943
330062	01/01/93	12/31/93	1.0201	0.9764
330064	01/01/93	12/31/93	1.4153	0.9945
330065	01/01/93	12/31/93	1.2079	0.9914
330066	01/01/93	12/31/93	1.2260	0.9960
330067	01/01/93	12/31/93	1.3175	0.9881
330072	01/01/93	12/31/93	1.3479	0.9960
330073	01/01/93	12/31/93	1.2028	0.9842
330074	01/01/93	12/31/93	1.2323	0.9879
330075	01/01/93	12/31/93	1.0670	0.9872
330078	01/01/93	12/31/93	1.3908	0.9975
330079	01/01/93	12/31/93	1.2888	0.9935
330082	01/01/93	12/31/93	1.2319	0.9936
330084	01/01/93	12/31/93	0.9486	0.9680
330085	01/01/93	12/31/93	1.3435	0.9899
330086	01/01/93	12/31/93	1.2299	0.9966
330088	01/01/93	12/31/93	1.0911	0.9742

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
330090	01/01/93	12/31/93	1.5912	0.9961
330091	01/01/93	12/31/93	1.3674	0.9957
330092	01/01/93	12/31/93	0.9944	0.9762
330094	01/01/93	12/31/93	1.1908	0.9873
330095	01/01/93	12/31/93	1.2007	0.9964
330096	01/01/93	12/31/93	1.0627	0.9837
330097	01/01/93	12/31/93	1.1617	0.9864
330100	01/01/93	12/31/93	0.6958	0.9974
330101	01/01/93	12/31/93	1.7564	0.9985
330102	01/01/93	12/31/93	1.2866	0.9975
330103	01/01/93	12/31/93	1.2142	0.9759
330104	01/01/93	12/31/93	1.3804	0.9931
330106	01/01/93	12/31/93	1.5648	0.9989
330107	01/01/93	12/31/93	1.1988	0.9764
330108	01/01/93	12/31/93	1.1914	0.9949
330111	01/01/93	12/31/93	1.1351	0.9786
330114	01/01/93	12/31/93	0.9654	0.9770
330115	01/01/93	12/31/93	1.2261	0.9777
330118	01/01/93	12/31/93	1.5846	0.9966
330119	01/01/93	12/31/93	1.7654	0.9989
330121	01/01/93	12/31/93	1.0023	0.9681
330122	01/01/93	12/31/93	1.2258	0.9954
330125	01/01/93	12/31/93	1.7087	0.9985
330126	01/01/93	12/31/93	1.2031	0.9902
330132	01/01/93	12/31/93	1.0897	0.9743
330133	01/01/93	12/31/93	1.3627	0.9965
330135	01/01/93	12/31/93	1.2331	0.9799
330136	01/01/93	12/31/93	1.2828	0.9924
330140	01/01/93	12/31/93	1.6770	0.9993
330141	01/01/93	12/31/93	1.3075	0.9945
330144	01/01/93	12/31/93	1.0658	0.9852
330148	01/01/93	12/31/93	0.9870	0.9644
330151	01/01/93	12/31/93	1.0803	0.9791
330152	01/01/93	12/31/93	1.3840	0.9959
330153	01/01/93	12/31/93	1.6352	0.9987
330157	01/01/93	12/31/93	1.2567	0.9929
330158	01/01/93	12/31/93	1.3014	0.9969
330159	01/01/93	12/31/93	1.3249	0.9937
330160	01/01/93	12/31/93	1.4099	0.9967
330161	01/01/93	12/31/93	0.9059	0.9927
330162	01/01/93	12/31/93	1.2970	0.9906
330163	01/01/93	12/31/93	1.1479	0.9898
330164	01/01/93	12/31/93	1.3437	0.9929
330166	01/01/93	12/31/93	0.9855	0.9524
330167	01/01/93	12/31/93	1.5754	0.9978
330169	01/01/93	12/31/93	1.4175	0.9960
330171	01/01/93	12/31/93	1.3259	0.9901
330175	01/01/93	12/31/93	1.0948	0.9949
330177	01/01/93	12/31/93	1.0171	0.9691
330179	01/01/93	12/31/93	0.8781	0.9674
330180	01/01/93	12/31/93	1.2009	0.9943
330181	01/01/93	12/31/93	1.2403	0.9904
330182	01/01/93	12/31/93	2.3782	0.9979
330183	01/01/93	12/31/93	1.3794	0.9922
330184	01/01/93	12/31/93	1.3702	0.9896
330185	01/01/93	12/31/93	1.1881	0.9878
330186	01/01/93	12/31/93	1.0021	0.9908
330188	01/01/93	12/31/93	1.2072	0.9945
330189	01/01/93	12/31/93	0.8028	0.9907
330191	01/01/93	12/31/93	1.3034	0.9961
330193	01/01/93	12/31/93	1.3739	0.9952
330194	01/01/93	12/31/93	1.8101	0.9987
330195	01/01/93	12/31/93	1.5801	0.9980
330197	01/01/93	12/31/93	1.0444	0.9960
330198	01/01/93	12/31/93	1.3225	0.9950
330201	01/01/93	12/31/93	1.4601	0.9987
330203	01/01/93	12/31/93	1.3416	0.9981
330205	01/01/93	12/31/93	1.1914	0.9786
330208	01/01/93	12/31/93	1.2131	0.9927
330209	01/01/93	12/31/93	1.2105	0.9869
330211	01/01/93	12/31/93	1.2504	0.9866
330212	01/01/93	12/31/93	1.2120	0.9969
330213	01/01/93	12/31/93	1.1238	0.9714
330214	01/01/93	12/31/93	1.7401	0.9999
330215	01/01/93	12/31/93	1.1501	0.9920
330218	01/01/93	12/31/93	1.2029	0.9913
330219	01/01/93	12/31/93	1.6567	0.9974
330221	01/01/93	12/31/93	1.3191	0.9964
330222	01/01/93	12/31/93	1.2196	0.9826
330223	01/01/93	12/31/93	1.0789	0.9692
330224	01/01/93	12/31/93	1.3020	0.9898
330225	01/01/93	12/31/93	1.1726	0.9946
330226	01/01/93	12/31/93	1.2814	0.9900
330229	01/01/93	12/31/93	1.3639	0.9846

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
330230	01/01/93	12/31/93	1.5616	0.9950
330232	01/01/93	12/31/93	1.2514	0.9947
330233	01/01/93	12/31/93	1.5212	0.9960
330235	01/01/93	12/31/93	1.1352	0.9966
330236	01/01/93	12/31/93	1.3332	0.9947
330238	01/01/93	12/31/93	1.1025	0.9828
330239	01/01/93	12/31/93	1.2427	0.9951
330241	01/01/93	12/31/93	1.8532	0.9977
330242	01/01/93	12/31/93	1.3939	0.9956
330245	01/01/93	12/31/93	1.2160	0.9868
330246	01/01/93	12/31/93	1.2319	0.9946
330247	01/01/93	12/31/93	0.7018	0.9952
330249	01/01/93	12/31/93	1.1765	0.9836
330250	01/01/93	12/31/93	1.2628	0.9933
330252	01/01/93	12/31/93	0.9389	0.9233
330254	01/01/93	12/31/93	0.9941	0.9823
330258	01/01/93	12/31/93	1.3795	0.9914
330259	01/01/93	12/31/93	1.4018	0.9905
330261	01/01/93	12/31/93	1.2622	0.9924
330263	01/01/93	12/31/93	1.0248	0.9738
330264	01/01/93	12/31/93	1.1798	0.9870
330265	01/01/93	12/31/93	1.2755	0.9958
330267	01/01/93	12/31/93	1.3114	0.9922
330268	01/01/93	12/31/93	1.0965	0.9423
330270	01/01/93	12/31/93	1.9337	0.9944
330273	01/01/93	12/31/93	1.3635	0.9896
330275	01/01/93	12/31/93	1.2271	0.9969
330276	01/01/93	12/31/93	1.2167	0.9835
330277	01/01/93	12/31/93	1.1664	0.9762
330279	01/01/93	12/31/93	1.3076	0.9967
330281	01/01/93	12/31/93	0.5646	0.9970
330285	01/01/93	12/31/93	1.7124	0.9976
330286	01/01/93	12/31/93	1.3459	0.9927
330288	01/01/93	12/31/93	1.0464	0.9769
330290	01/01/93	12/31/93	1.6767	0.9993
330293	01/01/93	12/31/93	1.1766	0.9835
330304	01/01/93	12/31/93	1.2789	0.9911
330306	01/01/93	12/31/93	1.4296	0.9943
330307	01/01/93	12/31/93	1.2056	0.9862
330309	01/01/93	12/31/93	1.1831	0.9897
330314	01/01/93	12/31/93	1.3382	0.9956
330315	01/01/93	12/31/93	1.1681	0.9876
330316	01/01/93	12/31/93	1.3027	0.9952
330327	01/01/93	12/31/93	0.9053	0.9572
330331	01/01/93	12/31/93	1.1843	0.9909
330332	01/01/93	12/31/93	1.2501	0.9916
330333	01/01/93	12/31/93	1.3022	0.9995
330336	01/01/93	12/31/93	1.3303	0.9799
330338	01/01/93	12/31/93	1.1762	0.9891
330339	01/01/93	12/31/93	0.8046	0.9894
330340	01/01/93	12/31/93	1.1780	0.9757
330350	01/01/93	12/31/93	1.7709	0.9974
330353	01/01/93	12/31/93	1.2943	0.9938
330357	01/01/93	12/31/93	1.3589	0.9882
330359	01/01/93	12/31/93	0.9238	0.9734
330372	01/01/93	12/31/93	1.2708	0.9907
330381	01/01/93	12/31/93	1.2770	0.9967
330386	01/01/93	12/31/93	1.1750	0.9753
330387	01/01/93	12/31/93	0.8423	0.9787
330389	01/01/93	12/31/93	1.9113	0.9958
330390	01/01/93	12/31/93	1.2556	0.9976
330393	01/01/93	12/31/93	1.6160	0.9980
330394	01/01/93	12/31/93	1.4328	0.9988
330395	01/01/93	12/31/93	1.3564	0.9915
330397	01/01/93	12/31/93	1.5229	0.9959
330398	01/01/93	12/31/93	1.2836	0.9807
330399	01/01/93	12/31/93	1.3668	0.9955
340001	10/01/92	09/30/93	1.3629	0.9899
340002	10/01/92	09/30/93	1.8306	0.9977
340003	10/01/92	09/30/93	1.1793	0.9573
340004	10/01/92	09/30/93	1.4919	0.9978
340005	10/01/92	09/30/93	1.1679	0.9691
340006	10/01/92	09/30/93	1.2412	0.9596
340007	10/01/92	09/30/93	1.1651	0.9773
340008	10/01/92	09/30/93	1.1796	0.9760
340009	10/01/92	09/30/93	1.5066	0.9777
340010	10/04/92	10/02/93	1.3159	0.9836
340011	10/01/92	09/30/93	1.0639	0.9730
340012	10/01/92	09/30/93	1.1393	0.9845
340013	10/01/92	09/30/93	1.2035	0.9743
340015	10/01/92	09/30/93	1.2381	0.9750
340016	10/01/92	09/30/93	1.1056	0.9892
340017	10/01/92	09/30/93	1.2652	0.9654
340018	10/01/92	09/30/93	1.1934	0.9772

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
340021	10/01/92	09/30/93	1.3176	0.9871
340022	10/01/92	09/30/93	1.0840	0.9652
340023	01/01/93	12/31/93	1.3259	0.9890
340024	10/01/92	09/30/93	1.2481	0.9630
340025	10/01/92	09/30/93	1.1573	0.9853
340027	10/01/92	09/30/93	1.2165	0.9970
340028	10/01/92	09/30/93	1.4172	0.9951
340031	10/01/92	09/30/93	1.0153	0.9512
340034	10/01/92	09/30/93	1.2717	0.9628
340035	10/01/92	09/30/93	1.1569	0.9646
340036	10/01/92	09/30/93	1.1793	0.9763
340037	10/01/92	09/30/93	1.2314	0.9840
340038	10/01/92	09/30/93	1.1357	0.9792
340039	10/01/92	09/30/93	1.2816	0.9815
340040	10/01/92	09/30/93	1.8038	0.9993
340041	10/01/92	09/30/93	1.2549	0.9680
340042	10/01/92	09/30/93	1.1501	0.9794
340044	10/01/92	09/30/93	1.0440	0.9626
340045	10/01/92	09/30/93	1.0232	0.9605
340048	10/01/92	09/30/93	1.2551	1.0000
340049	10/01/92	09/30/93	0.6445	1.0000
340050	10/01/92	09/30/93	1.1695	0.9668
340051	10/01/92	09/30/93	1.2050	0.9777
340053	10/01/92	09/30/93	1.5869	0.9983
340054	10/01/92	09/30/93	1.0732	0.9682
340055	10/01/92	09/30/93	1.2086	0.9882
340060	10/01/92	09/30/93	1.1183	0.9616
340063	10/01/92	09/30/93	1.0139	0.9598
340064	10/01/92	09/30/93	1.1725	0.9762
340065	10/01/92	09/30/93	1.1391	0.9580
340067	10/01/92	09/30/93	1.1634	0.9466
340068	10/01/92	09/30/93	1.3548	0.9724
340069	10/01/92	09/30/93	1.7566	0.9952
340070	10/01/92	09/30/93	1.2694	0.9687
340071	10/01/92	09/30/93	1.0301	0.9481
340072	10/01/92	09/30/93	1.0980	0.9839
340075	10/01/92	09/30/93	1.1543	0.9841
340080	10/01/92	09/30/93	1.1411	0.9822
340084	10/01/92	09/30/93	1.0582	0.9827
340085	10/01/92	09/30/93	1.1942	0.9879
340087	10/01/92	09/30/93	1.1740	0.9870
340088	10/01/92	09/30/93	1.1213	0.9759
340089	10/01/92	09/30/93	0.9657	0.9729
340090	10/01/92	09/30/93	1.0747	0.9577
340091	10/01/92	09/30/93	1.6453	0.9989
340093	10/01/92	09/30/93	1.1232	0.9786
340094	10/01/92	09/30/93	1.3301	0.9847
340096	10/01/92	09/30/93	1.2399	0.9646
340097	10/01/92	09/30/93	1.1151	0.9671
340098	09/27/92	09/25/93	1.6286	0.9979
340099	10/01/92	09/30/93	1.1369	0.9684
340100	10/01/92	09/30/93	1.2221	1.0000
340101	01/01/93	12/31/93	1.0349	0.9874
340104	10/01/92	09/30/93	1.0167	0.9775
340105	10/01/92	09/30/93	1.3463	0.9959
340106	10/01/92	09/30/93	1.1316	0.9806
340107	01/01/93	12/31/93	1.2560	0.9762
340109	10/01/92	09/30/93	1.3000	0.9867
340111	10/01/92	09/30/93	1.1302	0.9581
340112	10/01/92	09/30/93	1.0452	0.9269
340113	01/01/93	12/31/93	1.9406	0.9991
340114	10/01/92	09/30/93	1.4375	0.9987
340115	10/01/92	09/30/93	1.5009	0.9964
340119	10/01/92	09/30/93	1.2907	0.9784
340120	10/01/92	09/30/93	1.0983	0.9746
340121	10/01/92	09/30/93	1.0666	0.9643
340122	10/01/92	09/30/93	1.0123	0.9735
340123	10/01/92	09/30/93	1.1626	0.9633
340124	10/01/92	09/30/93	1.0939	0.9607
340125	10/01/92	09/30/93	1.4097	0.9918
340126	10/01/92	09/30/93	1.3418	0.9845
340127	10/01/92	09/30/93	1.2563	0.9731
340129	10/01/92	09/30/93	1.2567	0.9778
340130	10/01/92	09/30/93	1.3320	0.9736
340131	10/01/92	09/30/93	1.3182	0.9877
340132	10/01/92	09/30/93	1.2779	0.9634
340133	10/01/92	09/30/93	1.1506	0.9562
340141	10/01/92	09/30/93	1.5710	0.9975
340142	10/01/92	09/30/93	1.2220	0.9743
340145	10/01/92	09/30/93	1.2801	0.9512
340146	10/01/92	09/30/93	1.0441	0.9583
340147	10/04/92	10/02/93	1.3425	0.9948
340151	10/01/92	09/30/93	1.2034	0.9819
340159	10/01/92	09/30/93	1.1149	0.9765

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
340166	01/01/93	12/31/93	1.3753	0.9879
340168	10/01/92	09/30/93	0.5447	1.0000
350004	10/01/92	09/30/93	1.8723	0.9987
350007	10/01/92	09/30/93	1.0045	0.9554
350015	01/01/93	12/31/93	1.6193	0.9939
350016	01/01/93	12/31/93	0.9935	0.9883
350018	10/01/92	09/30/93	1.1459	0.9884
350019	01/01/93	12/31/93	1.5986	0.9959
350020	01/01/93	12/31/93	1.3682	0.9837
350023	01/01/93	12/31/93	0.8092	0.9572
350024	10/01/92	09/30/93	1.1536	0.9644
350027	10/01/92	09/30/93	0.9973	0.9879
350033	01/01/93	12/31/93	0.9214	0.9617
350036	07/01/92	07/31/93	0.8994	0.9341
350038	01/01/93	12/31/93	1.0108	0.9501
350041	01/01/93	12/31/93	1.0813	0.9744
350042	01/01/93	12/31/93	1.0496	0.9909
350051	01/01/93	12/31/93	0.9614	0.9685
350055	01/01/93	12/31/93	0.9295	0.9671
350066	10/01/92	09/30/93	0.6321	0.9741
360001	01/01/93	12/31/93	1.2264	0.9885
360002	01/01/93	12/31/93	1.1550	0.9755
360007	01/01/93	12/31/93	1.0658	0.9853
360009	01/01/93	12/31/93	1.3346	0.9858
360010	01/01/93	12/31/93	1.1682	0.9754
360012	01/01/93	12/31/93	1.2374	0.9873
360013	01/01/93	12/31/93	1.0975	0.9830
360016	01/01/93	12/31/93	1.5514	0.9987
360018	01/01/93	12/31/93	1.5419	0.9988
360019	01/01/93	12/31/93	1.2405	0.9844
360020	01/01/93	12/31/93	1.4449	0.9975
360021	01/01/93	12/31/93	1.2443	0.9814
360024	01/01/93	12/31/93	1.2697	0.9896
360025	01/01/93	12/31/93	1.1983	0.9778
360026	01/01/93	12/31/93	1.1596	0.9911
360027	01/01/93	12/31/93	1.5294	0.9978
360030	01/01/93	12/31/93	1.1469	0.9774
360031	01/01/93	12/31/93	1.2509	0.9837
360032	01/01/93	12/31/93	1.0799	0.9495
360034	01/01/93	12/31/93	1.2068	0.9595
360036	01/01/93	12/31/93	1.1787	0.9724
360037	01/01/93	12/31/93	2.0513	0.9923
360038	01/01/93	12/31/93	1.4670	0.9989
360039	01/01/93	12/31/93	1.2739	0.9919
360041	01/01/93	12/31/93	1.3489	0.9909
360042	01/01/93	12/31/93	1.1441	0.9569
360044	01/01/93	12/31/93	1.0655	0.9766
360046	01/01/93	12/31/93	1.1008	0.9710
360047	01/01/93	12/31/93	1.0611	0.9694
360049	01/01/93	12/31/93	1.3268	0.9933
360051	01/01/93	12/31/93	1.5044	0.9989
360055	01/01/93	12/31/93	1.1902	0.9870
360056	01/01/93	12/31/93	1.3361	0.9899
360057	01/01/93	12/31/93	1.0502	0.9638
360059	01/01/93	12/31/93	1.5065	0.9982
360062	01/01/93	12/31/93	1.5303	0.9935
360063	01/01/93	12/31/93	1.0271	0.9666
360064	01/01/93	12/31/93	1.4480	0.9965
360065	01/01/93	12/31/93	1.2464	0.9836
360066	01/01/93	12/31/93	1.2311	0.9853
360067	01/01/93	12/31/93	1.1145	0.9589
360068	01/01/93	12/31/93	1.5975	0.9988
360069	01/01/93	12/31/93	1.0290	0.9555
360070	01/01/93	12/31/93	1.5703	0.9938
360071	01/01/93	12/31/93	1.2675	0.9793
360072	01/01/93	12/31/93	1.2047	0.9712
360074	10/01/92	09/30/93	1.4118	0.9928
360075	01/01/93	12/31/93	1.4359	0.9964
360076	01/01/93	12/31/93	1.2892	0.9808
360077	01/01/93	12/31/93	1.4009	0.9969
360078	01/01/93	12/31/93	1.2753	0.9884
360079	01/01/93	12/31/93	1.6481	0.9986
360080	01/01/93	12/31/93	1.1169	0.9927
360081	01/01/93	12/31/93	1.3331	0.9938
360082	01/01/93	12/31/93	1.3029	0.9876
360083	01/01/93	12/31/93	1.2935	0.9848
360084	01/01/93	12/31/93	1.6169	0.9956
360086	01/01/93	12/31/93	1.4381	0.9838
360087	01/01/93	12/31/93	1.3196	0.9950
360088	01/01/93	12/31/93	1.1788	0.9713
360089	01/01/93	12/31/93	1.0998	0.9749
360091	01/01/93	12/31/93	1.2440	0.9849
360092	01/01/93	12/31/93	1.2249	0.9604
360093	01/01/93	12/31/93	1.2008	0.9717

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
360094	01/01/93	12/31/93	1.1841	0.9968
360095	01/01/93	12/31/93	1.2898	0.9817
360096	01/01/93	12/31/93	1.0954	0.9837
360098	01/01/93	12/31/93	1.3551	0.9842
360099	10/01/92	09/30/93	1.0586	0.9806
360100	01/01/93	12/31/93	1.2921	0.9825
360101	01/01/93	12/31/93	1.7626	0.9888
360102	01/01/93	12/31/93	1.2546	0.9943
360103	01/01/93	12/31/93	1.4047	0.9977
360104	01/01/93	12/31/93	0.9425	0.9920
360106	01/01/93	12/31/93	1.1227	0.9619
360107	09/01/92	08/31/93	1.1911	0.9764
360108	01/01/93	12/31/93	1.0609	0.9793
360109	01/01/93	12/31/93	1.0261	0.9694
360112	01/01/93	12/31/93	1.7627	0.9976
360113	01/01/93	12/31/93	1.3625	0.9894
360114	01/01/93	12/31/93	1.0742	0.9707
360115	01/01/93	12/31/93	1.2036	0.9882
360116	01/01/93	12/31/93	1.0762	0.9529
360118	01/01/93	12/31/93	1.3112	0.9853
360119	01/01/93	12/31/93	1.2381	0.9909
360120	01/01/93	12/31/93	0.6543	0.9709
360121	10/01/92	09/30/93	1.2414	0.9793
360122	01/01/93	12/31/93	1.3423	0.9890
360123	01/01/93	12/31/93	1.2333	0.9907
360124	01/01/93	12/31/93	1.2156	0.9784
360125	01/01/93	12/31/93	1.1263	0.9787
360126	01/01/93	12/31/93	1.2973	0.9863
360127	01/01/93	12/31/93	1.0982	0.9694
360128	01/01/93	12/31/93	1.1371	0.9735
360129	01/01/93	12/31/93	0.9950	0.9543
360130	01/01/93	12/31/93	1.0580	0.9817
360131	01/01/93	12/31/93	1.1928	0.9787
360132	01/01/93	12/31/93	1.2901	0.9866
360133	01/01/93	12/31/93	1.4585	0.9955
360135	01/01/93	12/31/93	1.1777	0.9691
360136	01/01/93	12/31/93	1.1119	0.9432
360137	01/01/93	12/31/93	1.5705	0.9972
360140	01/01/93	12/31/93	1.0638	0.9612
360141	01/01/93	12/31/93	1.4207	0.9978
360142	01/01/93	12/31/93	0.9906	0.9520
360143	01/01/93	12/31/93	1.2845	0.9941
360144	01/01/93	12/31/93	1.2950	0.9926
360145	01/01/93	12/31/93	1.5210	0.9971
360147	10/01/92	09/30/93	1.2051	0.9667
360148	01/01/93	12/31/93	1.1115	0.9811
360149	01/01/93	12/31/93	1.0941	0.9897
360150	01/01/93	12/31/93	1.3046	0.9856
360151	01/01/93	12/31/93	1.3601	0.9854
360152	01/01/93	12/31/93	1.4961	0.9965
360153	01/01/93	12/31/93	1.1685	0.9830
360154	01/01/93	12/31/93	1.0315	0.9806
360155	01/01/93	12/31/93	1.3124	0.9935
360156	10/01/92	09/30/93	1.1318	0.9685
360159	01/01/93	12/31/93	1.1922	0.9721
360162	01/01/93	12/31/93	1.2868	0.9941
360163	01/01/93	12/31/93	1.7877	0.9950
360164	01/01/93	12/31/93	0.8772	0.9713
360165	11/01/92	10/31/93	1.1284	0.9662
360166	01/01/93	12/31/93	1.2007	0.9906
360169	01/01/93	12/31/93	1.0948	0.9379
360170	01/01/93	12/31/93	1.1145	0.9719
360172	01/01/93	12/31/93	1.3708	0.9864
360174	01/01/93	12/31/93	1.2169	0.9900
360175	01/01/93	12/31/93	1.1859	0.9657
360176	01/01/93	12/31/93	1.2106	0.9749
360177	01/01/93	12/31/93	1.2303	0.9546
360179	12/27/92	12/25/93	1.2854	0.9938
360180	01/01/93	12/31/93	2.2030	0.9986
360184	01/01/93	12/31/93	0.6334	1.0000
360186	01/01/93	12/31/93	1.2108	0.9670
360188	01/01/93	12/31/93	1.0393	0.9608
360189	01/01/93	12/31/93	1.0656	0.9872
360192	01/01/93	12/31/93	1.3360	0.9867
360193	01/01/93	12/31/93	1.2875	0.9928
360194	10/01/92	09/30/93	1.1413	0.9434
360195	01/01/93	12/31/93	1.1604	0.9546
360197	01/01/93	12/31/93	1.1537	0.9596
360200	01/01/93	12/31/93	1.1839	0.9559
360203	01/01/93	12/31/93	1.1371	0.9751
360204	01/01/93	12/31/93	1.2116	0.9903
360210	01/01/93	12/31/93	1.1593	0.9794
360211	01/01/93	12/31/93	1.1906	0.9908
360212	01/01/93	12/31/93	1.4069	0.9962

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
360213	01/01/93	12/31/93	1.1036	0.9814
360218	01/01/93	12/31/93	1.2293	0.9835
360230	01/01/93	12/31/93	1.2895	0.9895
360231	01/01/93	12/31/93	1.0878	0.9848
360232	01/01/93	12/31/93	1.1730	0.9712
360234	01/01/93	12/31/93	1.3079	0.9901
360236	01/01/93	12/31/93	1.2263	0.9861
360239	01/01/93	12/31/93	1.1463	0.9805
360240	01/01/93	12/31/93	0.5818	0.9722
360241	01/01/93	12/31/93	0.5907	0.9759
370001	01/01/93	12/31/93	1.6720	0.9977
370002	01/01/93	12/31/93	1.2297	0.9609
370006	10/01/92	09/30/93	1.1944	0.9840
370007	01/01/93	12/31/93	1.1134	0.9761
370014	10/01/92	09/30/93	1.2983	0.9759
370017	01/01/93	12/31/93	1.0811	0.9448
370018	11/01/92	10/31/93	1.3083	0.9884
370020	10/01/92	09/30/93	1.2848	0.9748
370021	09/01/92	08/31/93	0.9687	0.9409
370025	10/01/92	09/30/93	1.3960	0.9909
370032	11/01/92	10/31/93	1.4123	0.9986
370033	10/01/92	09/30/93	1.1169	0.9874
370037	01/01/93	12/31/93	1.5354	0.9991
370039	11/01/92	10/31/93	1.3192	0.9791
370040	10/01/92	09/30/93	1.0365	0.9797
370049	01/01/93	12/31/93	1.3617	0.9735
370051	10/01/92	09/30/93	1.0330	0.9544
370054	01/01/93	12/31/93	1.2740	0.9730
370057	01/01/93	12/31/93	1.1250	0.9742
370071	01/01/93	12/31/93	1.0728	0.9672
370077	01/01/93	12/31/93	1.3011	0.9852
370078	01/01/93	12/31/93	1.6361	0.9982
370092	10/01/92	09/30/93	1.1134	0.9542
370093	09/01/92	08/31/93	1.7856	0.9991
370094	01/01/93	12/31/93	1.4036	0.9957
370095	01/01/93	12/31/93	0.9035	0.9775
370105	10/01/92	09/30/93	2.0588	0.9940
370106	11/01/92	10/31/93	1.4729	0.9988
370108	10/01/92	09/30/93	1.1880	0.9595
370114	10/01/92	09/30/93	1.5704	0.9988
370121	09/01/92	08/31/93	1.3201	0.9664
370141	09/01/92	08/31/93	1.3981	0.9919
370146	01/01/93	12/31/93	1.1792	0.9306
370148	09/01/92	08/31/93	1.3489	0.9834
370149	10/01/92	09/30/93	1.1873	0.9758
370161	11/01/92	10/31/93	1.2069	0.9799
370165	10/01/92	09/30/93	1.1641	0.9751
370169	01/01/93	12/31/93	1.0176	0.9703
370176	01/01/93	12/31/93	1.2186	0.9750
370179	10/01/92	09/30/93	0.9611	0.9190
370189	01/01/93	12/31/93	1.0859	0.9952
370190	01/01/93	12/31/93	1.7244	1.0000
380004	01/01/93	12/31/93	1.6808	0.9795
380006	01/01/93	12/31/93	1.2953	0.9795
380010	01/01/93	12/31/93	1.0559	0.9862
380014	01/01/93	12/31/93	1.3367	0.9917
380018	10/01/92	09/30/93	1.7734	0.9978
380019	01/01/93	12/31/93	1.3578	0.9787
380021	10/01/92	09/30/93	1.2014	0.9883
380026	01/01/93	12/31/93	1.3569	0.9653
380029	10/01/92	09/30/93	1.1914	0.9810
380036	01/01/93	12/31/93	1.0826	0.9368
380038	08/01/92	07/31/93	1.2313	0.9773
380039	01/01/93	12/31/93	1.2889	0.9890
380042	01/01/93	12/31/93	1.1210	0.9694
380047	01/01/93	12/31/93	1.6608	0.9979
380050	10/01/92	09/30/93	1.2442	0.9858
380051	10/01/92	09/30/93	1.5093	0.9953
380052	01/01/93	12/31/93	1.2058	0.9819
380055	01/01/93	12/31/93	1.1902	0.9909
380056	01/01/93	12/31/93	1.0793	0.9777
380060	01/01/93	12/31/93	1.4558	0.9876
380061	01/01/93	12/31/93	1.5570	0.9982
380064	08/01/92	07/31/93	1.3134	0.9841
380068	10/01/92	09/30/93	1.0233	0.9296
380070	01/01/93	12/31/93	1.2442	0.9497
380075	01/01/93	12/31/93	1.4611	0.9945
380082	01/01/93	12/31/93	1.2131	0.9926
380091	01/01/93	12/31/93	1.1609	0.9839
390028	01/01/93	12/31/93	1.7552	0.9991
390054	01/01/93	12/31/93	1.1025	0.9815
390059	07/01/92	08/06/93	1.3245	0.9924
390060	01/01/93	12/31/93	1.0940	0.9907
390169	01/01/93	12/31/93	1.1971	0.9973

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
390186	01/01/93	12/31/93	1.0253	0.9756
390237	01/01/93	12/31/93	1.5243	0.9976
390272	09/01/92	08/31/93	0.5433	0.9850
400002	01/01/93	12/31/93	1.3882	0.9992
400005	01/01/93	12/31/93	1.0596	0.9995
400007	01/01/93	12/31/93	1.1966	0.9992
400008	01/01/93	12/31/93	1.1693	1.0000
400010	10/01/92	09/30/93	0.9384	0.9679
400011	01/01/93	12/31/93	1.0597	0.9976
400014	01/01/93	12/31/93	1.3737	0.9988
400016	10/01/92	09/30/93	1.3265	0.9995
400017	01/01/93	12/31/93	1.1709	0.9982
400019	01/01/93	12/31/93	1.5238	0.9990
400022	01/01/93	12/31/93	1.2971	0.9999
400024	01/01/93	12/31/93	1.0171	0.9951
400032	01/01/93	12/31/93	1.1280	0.9991
400094	01/01/93	12/31/93	1.0247	0.9897
400098	01/01/93	12/31/93	1.3015	0.9991
400106	10/01/92	09/30/93	1.1958	0.9997
400109	10/01/92	09/30/93	1.5764	0.9944
400111	01/01/93	12/31/93	1.1395	0.9982
400113	10/01/92	09/30/93	1.1788	0.9977
400115	01/01/93	12/31/93	0.9888	0.9980
400117	01/01/93	12/31/93	1.2070	0.9993
400118	01/01/93	12/31/93	1.1391	0.9976
400120	01/01/93	12/31/93	1.3350	0.9996
400122	09/01/92	08/31/93	0.9826	0.9876
410001	10/01/92	09/30/93	1.3195	0.9903
410004	10/01/92	09/30/93	1.4030	0.9944
410005	10/01/92	09/30/93	1.3467	0.9967
410006	10/01/92	09/30/93	1.2063	0.9836
410007	10/01/92	09/30/93	1.6561	0.9977
410008	10/01/92	09/30/93	1.2013	0.9842
410009	10/01/92	09/30/93	1.3174	0.9946
410010	10/01/92	09/30/93	1.0107	0.9846
410011	10/01/92	09/30/93	1.2098	0.9949
410012	10/01/92	09/30/93	1.6436	0.9983
410013	10/01/92	09/30/93	1.2322	0.9817
420005	01/01/93	12/31/93	1.1534	0.9724
420007	10/04/92	10/02/93	1.5331	0.9982
420009	10/01/92	09/30/93	1.2494	0.9627
420010	10/01/92	09/30/93	1.0665	0.9608
420011	10/01/92	09/30/93	1.0781	0.9689
420014	10/01/92	09/30/93	1.0232	0.9708
420015	10/01/92	09/30/93	1.3033	0.9867
420016	10/01/92	09/30/93	1.0799	0.9852
420018	09/27/92	09/25/93	1.5712	0.9978
420019	10/01/92	09/30/93	1.1517	0.9785
420020	10/01/92	09/30/93	1.2236	0.9688
420022	10/04/92	10/02/93	0.9916	0.9467
420023	01/01/93	12/31/93	1.3606	0.9962
420026	09/06/92	09/04/93	1.8690	0.9979
420027	09/27/92	09/25/93	1.3256	0.9922
420028	10/01/92	09/30/93	1.1069	0.9743
420029	10/01/92	09/30/93	1.7591	1.0000
420030	01/01/93	12/31/93	1.1906	0.9591
420031	10/01/92	09/30/93	1.0152	0.9303
420033	10/01/92	09/30/93	1.1551	0.9688
420036	10/01/92	09/30/93	1.2291	0.9693
420037	10/01/92	09/30/93	1.2544	0.9689
420038	10/01/92	09/30/93	1.2145	0.9735
420039	10/01/92	09/30/93	1.1045	0.9798
420040	10/01/92	09/30/93	1.2002	0.9926
420042	10/01/92	09/30/93	1.1998	0.9765
420043	10/01/92	09/30/93	1.2516	0.9743
420044	10/01/92	09/30/93	1.2132	0.9906
420048	10/01/92	09/30/93	1.1511	0.9661
420049	10/01/92	09/30/93	1.2267	0.9789
420051	10/01/92	09/30/93	1.5554	0.9967
420054	09/01/92	08/31/93	1.2026	0.9591
420055	10/01/92	09/30/93	1.0770	0.9824
420056	10/01/92	09/30/93	1.1005	0.9335
420057	10/01/92	09/30/93	1.1822	0.9744
420059	10/01/92	09/30/93	0.9977	0.9593
420061	10/01/92	09/30/93	1.2231	0.9483
420064	10/01/92	09/30/93	1.1418	0.9555
420065	09/01/92	08/31/93	1.3439	0.9991
420066	10/01/92	09/30/93	0.9710	0.9744
420067	10/01/92	09/30/93	1.2502	0.9669
420068	10/01/92	09/30/93	1.2132	0.9898
420069	10/01/92	09/30/93	1.1278	0.9613
420070	10/01/92	09/30/93	1.2808	0.9826
420071	10/01/92	09/30/93	1.3525	0.9860
420072	10/01/92	09/30/93	0.9324	0.9822

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
420073	10/01/92	09/30/93	1.3094	0.9932
420074	10/01/92	09/30/93	0.9667	0.9717
420075	10/01/92	09/30/93	0.9842	0.9699
420076	01/01/93	12/31/93	*1.1801	0.9947
420078	10/01/92	09/30/93	1.7184	0.9959
420081	10/01/92	09/30/93	0.8117	0.9924
420086	10/01/92	09/30/93	1.4254	0.9918
420087	10/01/92	09/30/93	1.6197	0.9993
420088	10/01/92	09/30/93	1.2311	0.9847
420089	09/01/92	08/31/93	1.3630	0.9893
420091	10/01/92	09/30/93	0.5742	1.0000
430008	01/01/93	12/31/93	1.1650	0.9709
430013	10/01/92	09/30/93	1.2240	0.9799
430014	10/01/92	09/30/93	1.3094	0.9876
430015	08/01/92	07/31/93	1.1905	0.9737
430016	10/01/92	09/30/93	1.7329	0.9971
430023	09/01/92	08/31/93	0.9304	0.9557
430024	01/01/93	12/31/93	0.9432	0.9222
430026	01/01/93	12/31/93	0.9208	0.9536
430031	01/01/93	12/31/93	0.9508	0.9713
430034	01/01/93	12/31/93	1.0333	0.9321
430036	01/01/93	12/31/93	1.0147	0.9891
430038	01/01/93	12/31/93	0.9989	0.9884
430040	10/01/92	09/30/93	0.9127	0.9710
430041	01/01/93	12/31/93	0.9569	0.9472
430043	01/01/93	12/31/93	1.1638	0.9854
430044	01/01/93	12/31/93	0.9474	0.9028
430047	01/01/93	12/31/93	1.0816	0.9812
430048	01/01/93	12/31/93	1.2262	0.9789
430049	01/01/93	12/31/93	0.9245	0.9397
430051	01/01/93	12/31/93	0.9633	0.9442
430056	01/01/93	12/31/93	0.8731	0.9506
430057	01/01/93	12/31/93	0.9348	0.9789
430060	01/01/93	12/31/93	1.0147	0.9511
430064	12/01/92	11/30/93	1.1226	0.9736
430065	10/01/92	09/30/93	1.0255	0.8930
430073	10/01/92	09/30/93	1.1134	0.9935
430076	01/01/93	12/31/93	1.0247	0.9436
430079	01/01/93	12/31/93	0.9761	0.9826
430080	10/01/92	09/30/93	1.2387	1.0000
430087	01/01/93	12/31/93	0.9221	0.9708
440008	01/01/93	12/31/93	0.9794	0.9778
440018	11/01/92	10/31/93	1.4130	0.9599
440020	10/01/92	09/30/93	1.1717	0.9782
440026	10/01/92	09/30/93	0.8359	1.0000
440034	01/01/93	12/31/93	1.4209	0.9982
440041	10/01/92	09/30/93	0.8462	0.9631
440046	01/01/93	12/31/93	1.3260	0.9976
440047	09/01/92	08/31/93	0.9144	0.9767
440048	10/01/92	09/30/93	1.7487	0.9989
440049	01/01/93	12/31/93	1.6519	0.9991
440050	01/01/93	12/31/93	1.1542	0.9816
440058	01/01/93	12/31/93	1.2336	0.9682
440061	10/01/92	09/30/93	1.2070	0.9798
440064	01/01/93	12/31/93	1.1053	0.9711
440068	10/01/92	09/30/93	1.1887	0.9811
440071	01/01/93	12/31/93	1.4120	0.9987
440072	01/01/93	12/31/93	1.3516	0.9604
440078	10/01/92	09/30/93	1.0157	0.9814
440081	01/01/93	12/31/93	1.1484	0.9825
440083	01/01/93	12/31/93	1.2326	0.9641
440091	09/01/92	08/31/93	1.5298	0.9987
440095	01/01/93	12/31/93	1.1343	0.9634
440100	01/01/93	12/31/93	1.0463	0.9658
440105	09/01/92	08/31/93	1.2872	0.9925
440110	01/01/93	12/31/93	0.9412	0.9463
440120	01/01/93	12/31/93	1.4507	0.9991
440125	01/01/93	12/31/93	1.4743	0.9986
440145	10/01/92	09/30/93	1.0532	0.9637
440146	01/01/93	12/31/93	1.2989	1.0000
440148	01/01/93	12/31/93	1.2023	0.9616
440149	11/01/92	10/31/93	1.2315	0.9669
440150	01/01/93	12/31/93	1.2427	0.9929
440157	01/01/93	12/31/93	1.0441	0.9560
440159	10/01/92	09/30/93	1.2072	0.9899
440161	01/01/93	12/31/93	1.5903	0.9990
440168	01/01/93	12/31/93	1.0412	0.9635
440173	09/01/92	08/31/93	1.4925	0.9968
440174	01/01/93	12/31/93	0.9408	0.9626
440181	01/01/93	12/31/93	0.9992	0.9641
440182	01/01/93	12/31/93	0.9613	0.9818
440184	01/01/93	12/31/93	1.4234	0.9888
440185	09/01/92	08/31/93	1.0731	0.9858
440186	11/01/92	10/31/93	1.1264	0.9457

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
440189	08/01/92	07/31/93	1.4808	0.9909
440194	09/01/92	08/31/93	1.3072	0.9781
440200	12/01/92	11/30/93	1.1187	0.9526
440203	01/01/93	12/31/93	0.9433	0.9724
440205	01/01/93	12/31/93	1.2744	0.9686
450002	01/01/93	12/31/93	1.4832	0.9994
450005	09/01/92	08/31/93	1.1391	0.9751
450010	10/01/92	09/30/93	1.3295	0.9983
450011	01/01/93	12/31/93	1.5169	0.9978
450014	01/01/93	12/31/93	1.1514	0.9516
450015	10/01/92	09/30/93	1.5321	0.9984
450016	01/01/93	12/31/93	1.6864	0.9979
450018	09/01/92	08/31/93	1.5604	0.9993
450020	01/01/93	12/31/93	1.0254	0.9592
450024	10/01/92	09/30/93	1.3651	0.9896
450025	01/01/93	12/31/93	1.4491	0.9979
450028	01/01/93	12/31/93	1.4760	0.9938
450032	10/01/92	09/30/93	1.2406	0.9752
450033	09/01/92	08/31/93	1.6381	0.9988
450037	10/01/92	09/30/93	1.5251	0.9966
450039	10/01/92	09/30/93	1.4428	0.9980
450046	10/01/92	09/30/93	1.3906	0.9966
450047	01/01/93	12/31/93	1.0976	0.9677
450050	01/01/93	12/31/93	1.1957	0.9643
450053	01/01/93	12/31/93	1.0808	0.9066
450054	09/01/92	08/31/93	1.6655	0.9980
450055	10/01/92	09/30/93	1.0953	0.9631
450058	09/01/92	08/31/93	1.5071	0.9986
450059	01/01/93	12/31/93	1.3557	0.9803
450063	10/01/92	09/30/93	1.0534	0.9139
450065	10/01/92	09/30/93	1.0161	0.9656
450068	10/01/92	09/30/93	1.7522	0.9985
450072	01/01/93	12/31/93	1.2769	0.9631
450073	01/01/93	12/31/93	1.1753	0.9575
450080	10/01/92	09/30/93	1.2486	0.9720
450081	01/01/93	12/31/93	1.1280	0.9641
450082	10/01/92	09/30/93	0.9873	0.9644
450083	11/01/92	10/31/93	1.6333	0.9954
450085	10/01/92	09/30/93	1.1216	0.9685
450087	09/01/92	08/31/93	1.5025	0.9952
450094	01/01/93	12/31/93	1.4235	0.9936
450097	01/01/93	12/31/93	1.4090	0.9941
450098	11/01/92	10/31/93	1.2299	0.9667
450101	09/01/92	08/31/93	1.3508	0.9967
450104	01/01/93	12/31/93	1.2856	0.9820
450107	01/01/93	12/31/93	1.5098	0.9993
450108	10/01/92	09/30/93	0.9920	0.9503
450110	10/01/92	09/30/93	1.2126	0.9813
450111	01/01/93	12/31/93	1.2314	0.9807
450112	01/01/93	12/31/93	1.2644	0.9851
450118	09/01/92	08/31/93	1.4703	0.9995
450119	10/01/92	09/30/93	1.3323	0.9792
450121	10/01/92	09/30/93	1.4392	0.9959
450123	01/01/93	12/31/93	1.0602	0.9765
450124	10/01/92	09/30/93	1.5024	0.9994
450127	10/01/92	09/30/93	0.9903	0.9672
450130	01/01/93	12/31/93	1.5092	0.9981
450131	08/01/92	07/31/93	1.2609	0.9834
450132	10/01/92	09/30/93	1.4911	0.9969
450133	10/01/92	09/30/93	1.5495	0.9977
450135	10/01/92	09/30/93	1.7013	0.9977
450137	10/01/92	09/30/93	1.4321	0.9984
450140	10/01/92	09/30/93	0.7344	1.0000
450142	09/01/92	08/31/93	1.3794	0.9909
450144	10/01/92	09/30/93	1.1596	0.9889
450145	01/01/93	12/31/93	0.8709	0.9877
450146	10/01/92	09/30/93	0.9840	0.9445
450148	10/01/92	09/30/93	1.2113	0.9678
450149	11/01/92	10/31/93	1.3300	0.9948
450150	10/01/92	09/30/93	0.9584	0.9347
450151	10/01/92	09/30/93	1.1366	0.9870
450152	10/01/92	09/30/93	1.2880	0.9802
450153	01/01/93	12/31/93	1.5695	0.9982
450154	10/01/92	09/30/93	1.1411	0.9705
450155	10/01/92	09/30/93	1.0793	0.9725
450160	10/01/92	09/30/93	0.8873	0.9636
450162	10/01/92	09/30/93	1.2792	0.9883
450163	01/01/93	12/31/93	1.1244	0.9613
450164	10/01/92	09/30/93	1.0264	0.9673
450165	01/01/93	12/31/93	1.0287	0.9837
450166	01/01/93	12/31/93	1.0260	0.9615
450169	01/01/93	12/31/93	0.8496	0.9265
450176	10/01/92	09/30/93	1.2799	0.9768
450178	01/01/93	12/31/93	1.1402	0.9688

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
450181	01/01/93	12/31/93	0.9665	0.9649
450185	10/01/92	09/30/93	1.0535	0.9620
450187	01/01/93	12/31/93	1.3229	0.9763
450191	01/01/93	12/31/93	1.1428	0.9738
450193	10/01/92	09/30/93	2.0729	0.9992
450194	01/01/93	12/31/93	1.2606	0.9919
450196	01/01/93	12/31/93	1.4483	0.9963
450197	09/01/92	08/31/93	1.1771	0.9905
450200	10/01/92	09/30/93	1.4946	0.9978
450201	01/01/93	12/31/93	0.9767	0.9204
450203	10/01/92	09/30/93	1.2856	0.9619
450209	10/01/92	09/30/93	1.4245	0.9967
450210	01/01/93	12/31/93	1.1430	0.9671
450211	01/01/93	12/31/93	1.3259	0.9921
450213	01/01/93	12/31/93	1.3590	0.9976
450214	09/01/92	08/31/93	1.4156	0.9859
450224	10/01/92	09/30/93	1.3844	0.9705
450229	09/01/92	08/31/93	1.4522	0.9938
450231	01/01/93	12/31/93	1.5217	0.9989
450234	10/01/92	09/30/93	0.9595	0.9540
450236	10/01/92	09/30/93	1.1361	0.9855
450237	01/01/93	12/31/93	1.4952	0.9965
450239	08/01/92	07/31/93	1.1632	0.9704
450243	09/01/92	08/31/93	0.8553	0.9541
450246	10/01/92	09/30/93	0.9664	0.9090
450249	01/01/93	12/31/93	0.9763	0.9776
450253	01/01/93	12/31/93	1.1186	0.9796
450259	01/01/93	12/31/93	1.1308	0.9880
450264	10/01/92	09/30/93	0.8332	0.9947
450271	01/01/93	12/31/93	1.1021	0.9527
450272	01/01/93	12/31/93	1.2218	0.9668
450276	10/01/92	09/30/93	0.9955	0.9731
450280	01/01/93	12/31/93	1.3367	0.9872
450283	11/01/92	10/31/93	1.0850	0.9363
450286	01/01/93	12/31/93	1.0435	0.9828
450292	10/01/92	09/30/93	1.3346	0.9721
450293	01/01/93	12/31/93	1.0136	0.8852
450296	01/01/93	12/31/93	1.2727	0.9654
450297	01/01/93	12/31/93	1.0763	0.9868
450303	01/01/93	12/31/93	0.9032	0.9655
450306	01/01/93	12/31/93	1.0461	0.9323
450315	09/01/92	08/31/93	1.1804	0.9905
450320	01/01/93	12/31/93	1.4131	0.9889
450321	01/01/93	12/31/93	0.8983	0.9347
450322	01/01/93	12/31/93	0.9826	0.9521
450327	10/01/92	09/30/93	1.0680	0.9805
450330	01/01/93	12/31/93	1.1839	0.9767
450334	10/01/92	09/30/93	0.9974	0.9890
450337	11/01/92	10/31/93	1.2181	0.9732
450340	01/01/93	12/31/93	1.3536	0.9902
450346	09/01/92	08/31/93	1.3487	0.9979
450347	01/01/93	12/31/93	1.1849	0.9745
450348	09/01/92	08/31/93	1.0046	0.9535
450351	10/01/92	09/30/93	1.2674	0.9821
450352	10/01/92	09/30/93	1.2141	0.9699
450353	09/01/92	08/31/93	1.2262	0.9717
450355	08/01/92	07/31/93	1.0721	0.9598
450358	01/01/93	12/31/93	2.0537	0.9987
450366	11/01/92	10/31/93	1.4859	0.9943
450369	10/01/92	09/30/93	1.1163	0.9684
450371	01/01/93	12/31/93	1.1441	0.9907
450373	11/01/92	10/31/93	1.1871	0.9591
450374	10/01/92	09/30/93	0.9045	0.9294
450378	09/01/92	08/31/93	1.1012	0.9822
450388	10/01/92	09/30/93	1.6238	0.9989
450389	11/01/92	10/31/93	1.1982	0.9778
450399	10/01/92	09/30/93	1.0512	0.9375
450410	10/01/92	10/28/93	1.0995	0.9794
450417	01/01/93	12/31/93	1.0336	0.9620
450418	01/01/93	12/31/93	1.3571	0.9795
450419	10/01/92	09/30/93	1.2376	0.9700
450422	10/01/92	09/30/93	0.6567	1.0000
450423	09/01/92	08/31/93	1.2947	0.9967
450424	01/01/93	12/31/93	1.2230	0.9831
450429	12/01/92	11/30/93	1.0429	0.9769
450431	01/01/93	12/31/93	1.5594	0.9981
450438	01/01/93	12/31/93	1.1015	0.9603
450446	01/01/93	12/31/93	0.9424	0.9991
450450	10/01/92	09/30/93	1.0317	1.0000
450462	10/01/92	09/30/93	1.8303	0.9993
450464	10/01/92	09/30/93	0.9909	0.9595
450465	10/01/92	09/30/93	1.2418	0.9733
450475	10/01/92	09/30/93	1.1162	0.9792
450488	10/01/92	09/30/93	1.2245	0.9716

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
450514	01/01/93	12/31/93	1.1370	0.9844
450518	01/01/93	12/31/93	1.4441	0.9961
450523	01/01/93	12/31/93	1.4932	0.9954
450530	12/01/92	11/30/93	1.3072	0.9871
450534	10/01/92	09/30/93	0.9752	0.9694
450535	01/01/93	12/31/93	1.1633	0.9785
450538	01/01/93	12/31/93	1.2042	0.9607
450544	08/01/92	07/31/93	1.2769	0.9836
450546	10/01/92	09/30/93	1.2723	0.9875
450547	10/01/92	09/30/93	1.0015	0.9683
450550	01/01/93	12/31/93	1.0494	0.9948
450559	10/01/92	09/30/93	0.8866	0.8683
450561	01/01/93	12/31/93	1.6626	0.9989
450565	10/01/92	09/30/93	1.3484	0.9787
450570	01/01/93	12/31/93	1.0703	0.9809
450571	10/01/92	09/30/93	1.4719	0.9985
450574	10/01/92	09/30/93	1.0200	0.9397
450575	10/01/92	09/30/93	0.9748	0.9712
450578	10/01/92	09/30/93	0.9341	0.9348
450580	10/01/92	09/30/93	1.1556	0.9891
450583	10/01/92	09/30/93	0.9511	0.9938
450584	10/01/92	09/30/93	1.1657	0.9814
450587	09/01/92	08/31/93	1.2707	0.9782
450591	10/01/92	09/30/93	1.1453	0.9770
450596	10/01/92	09/30/93	1.2575	0.9742
450597	10/01/92	09/30/93	1.0343	0.9849
450604	01/01/93	12/31/93	1.2793	0.9670
450605	01/01/93	12/31/93	1.3119	0.9880
450607	10/01/92	09/30/93	0.9595	0.9761
450609	10/01/92	09/30/93	0.9097	0.9701
450614	10/01/92	09/30/93	1.0651	0.9303
450615	01/01/93	12/31/93	0.9485	0.9606
450620	10/01/92	09/30/93	1.0977	0.9505
450623	10/01/92	09/30/93	1.1686	0.9580
450626	10/01/92	09/30/93	1.0407	0.9510
450628	10/01/92	09/30/93	0.9526	0.9494
450631	09/01/92	08/31/93	1.6508	0.9992
450632	10/01/92	09/30/93	1.0081	0.9743
450634	01/01/93	12/31/93	1.4317	0.9910
450637	09/01/92	08/31/93	1.4337	0.9785
450639	10/01/92	09/30/93	1.4535	0.9960
450644	09/01/92	08/31/93	1.6076	0.9966
450646	01/01/93	12/31/93	1.5501	0.9969
450648	10/01/92	09/30/93	1.0880	0.9681
450652	10/01/92	09/30/93	0.9808	0.9578
450654	10/01/92	09/30/93	0.9830	0.9911
450656	01/01/93	12/31/93	1.3583	0.9870
450659	01/01/93	12/31/93	1.4444	0.9973
450661	01/01/93	12/31/93	1.1990	0.9907
450662	09/01/92	08/31/93	1.3959	0.9793
450672	08/01/92	07/31/93	1.6183	0.9991
450673	10/01/92	09/30/93	1.1056	0.9488
450677	01/01/93	12/31/93	1.3598	0.9933
450686	01/01/93	12/31/93	1.5699	0.9956
450690	09/01/92	08/31/93	1.3647	0.9980
450696	11/01/92	10/31/93	1.7050	0.9872
450697	01/01/93	12/31/93	1.3499	0.9948
450698	10/01/92	09/30/93	0.9337	0.9197
450700	01/01/93	12/31/93	0.9273	0.9721
450702	09/01/92	08/31/93	1.4787	0.9958
450703	01/01/93	12/31/93	1.4690	0.9912
450705	10/01/92	09/30/93	0.7885	0.9353
450706	01/01/93	12/31/93	1.2043	0.9636
450711	10/01/92	09/30/93	1.6887	0.9986
450712	11/01/92	10/31/93	0.9574	0.9827
450713	01/01/93	12/31/93	1.4404	0.9981
450715	09/01/92	08/31/93	1.3023	0.9930
450716	01/01/93	12/31/93	1.2254	0.9727
450717	01/01/93	12/31/93	1.2321	0.9698
450718	01/01/93	12/31/93	1.2390	0.9834
450724	01/01/93	12/31/93	1.2022	0.9943
450726	10/01/92	09/30/93	0.8996	0.9687
450727	10/01/92	09/30/93	0.9013	0.9666
450728	10/01/92	09/30/93	0.9002	0.9897
450733	09/01/92	08/31/93	1.3816	0.9799
450734	09/01/92	08/31/93	1.5033	0.9916
450735	01/01/93	12/31/93	0.8222	0.9044
450745	01/01/93	12/31/93	0.8306	0.9924
450746	10/01/92	09/30/93	0.9600	0.9131
450747	01/01/93	12/31/93	1.3013	0.9898
450751	01/01/93	12/31/93	1.3089	0.9604
450754	10/01/92	09/30/93	1.0744	0.9731
450757	01/01/93	12/31/93	0.9753	0.9523
450760	01/01/93	12/31/93	1.2135	0.9820

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
450761	10/01/92	09/30/93	1.0987	0.9728
450763	10/01/92	09/30/93	1.0960	0.9665
450766	01/01/93	12/31/93	2.1686	0.9984
450769	10/01/92	09/30/93	0.9394	0.9809
450771	10/01/92	09/30/93	1.7787	0.9913
450775	01/01/93	12/31/93	1.2367	0.9928
450778	01/01/93	12/31/93	0.8795	0.9700
450779	10/01/92	09/30/93	1.2407	0.9753
450781	01/01/93	12/31/93	1.4260	1.0000
460001	01/01/93	12/31/93	1.6662	0.9986
460004	01/01/93	12/31/93	1.6966	0.9972
460006	01/01/93	12/31/93	1.2825	0.9864
460007	01/01/93	12/31/93	1.2450	0.9673
460010	01/01/93	12/31/93	2.0494	0.9990
460011	01/01/93	12/31/93	1.4116	0.9660
460013	09/01/92	08/31/93	1.5270	0.9819
460014	01/01/93	12/31/93	0.9603	0.9104
460015	01/01/93	12/31/93	1.2705	0.9730
460016	01/01/93	12/31/93	0.8869	0.9799
460017	09/01/92	08/31/93	1.3493	0.9576
460018	01/01/93	12/31/93	0.9364	0.9708
460019	01/01/93	12/31/93	0.9010	0.9478
460020	01/01/93	12/31/93	0.9660	0.9778
460021	01/01/93	12/31/93	1.3717	0.9870
460022	01/01/93	12/31/93	1.0070	0.9786
460023	01/01/93	12/31/93	1.1527	0.9704
460024	01/01/93	12/31/93	0.9599	0.8976
460025	01/01/93	12/31/93	0.8122	0.9970
460026	01/01/93	12/31/93	0.9555	0.9176
460027	01/01/93	12/31/93	0.9862	1.0000
460029	01/01/93	12/31/93	1.0516	0.9022
460033	01/01/93	12/31/93	0.9359	0.8857
460036	01/01/93	12/31/93	0.9067	0.9566
460039	01/01/93	12/31/93	0.9762	0.9536
460041	09/01/92	08/31/93	1.2303	0.9770
460042	10/01/92	09/30/93	1.5075	0.9907
460043	01/01/93	12/31/93	1.3975	0.9754
460044	01/01/93	12/31/93	1.1367	0.9654
460046	01/01/93	12/31/93	1.5177	1.0000
460047	11/01/92	10/31/93	1.6668	0.9995
460049	01/01/93	12/31/93	1.9188	0.9855
470001	10/01/92	09/30/93	1.1529	0.9788
470003	10/01/92	09/30/93	1.9353	0.9987
470004	10/01/92	09/30/93	1.0444	0.9721
470005	10/01/92	09/30/93	1.1868	0.9855
470006	10/01/92	09/30/93	1.1341	0.9682
470008	10/01/92	09/30/93	1.1675	0.9795
470010	10/01/92	09/30/93	1.0823	0.9560
470011	10/01/92	09/30/93	1.1180	0.9840
470012	10/01/92	09/30/93	1.2081	0.9827
470013	10/01/92	09/30/93	1.1462	0.9885
470015	10/01/92	09/30/93	1.1905	0.9828
470018	10/01/92	09/30/93	1.1276	0.9761
470020	10/01/92	09/30/93	1.0117	0.9955
470023	10/01/92	09/30/93	1.2259	0.9673
470024	10/01/92	09/30/93	1.1281	0.9521
490001	10/01/92	09/30/93	1.1212	0.9724
490002	10/01/92	09/30/93	1.0303	0.9805
490003	10/01/92	09/30/93	0.6533	1.0000
490004	01/01/93	12/31/93	1.1926	0.9916
490005	01/01/93	12/31/93	1.4747	0.9975
490006	10/01/92	09/30/93	1.1342	0.9784
490011	01/01/93	12/31/93	1.3154	0.9931
490012	08/01/92	07/31/93	1.1102	0.9597
490013	09/01/92	08/31/93	1.1656	0.9907
490014	01/01/93	12/31/93	1.5210	0.9746
490015	01/01/93	12/31/93	1.4380	0.9952
490017	09/01/92	08/31/93	1.3682	0.9906
490018	01/01/93	12/31/93	1.2061	0.9755
490019	10/01/92	09/30/93	1.1170	0.9708
490020	01/01/93	12/31/93	1.1625	0.9756
490021	01/01/93	12/31/93	1.4381	0.9975
490023	10/01/92	09/30/93	1.2276	0.9890
490024	10/01/92	09/30/93	1.6106	0.9987
490027	10/01/92	09/30/93	1.1662	0.9822
490030	10/01/92	09/30/93	1.2489	0.9933
490031	01/01/93	12/31/93	1.1272	0.9696
490033	01/01/93	12/31/93	1.1625	0.9743
490037	01/01/93	12/31/93	1.1563	0.9844
490038	10/01/92	09/30/93	1.2792	0.9815
490040	09/28/92	09/30/93	1.3654	0.9977
490041	01/01/93	12/31/93	1.2177	0.9836
490042	10/01/92	09/30/93	1.3528	0.9906
490044	10/01/92	09/30/93	1.3149	0.9891

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
490045	10/01/92	09/30/93	1.1794	0.9915
490047	10/01/92	09/30/93	1.0797	0.9693
490048	01/01/93	12/31/93	1.4825	0.9989
490050	01/01/93	12/31/93	1.3697	0.9969
490052	01/01/93	12/31/93	1.5252	0.9980
490054	10/01/92	09/30/93	1.0583	0.9626
490057	01/01/93	12/31/93	1.4443	0.9995
490059	09/01/92	08/31/93	1.5040	0.9983
490063	01/01/93	12/31/93	1.5830	0.9977
490066	01/01/93	12/31/93	1.2601	0.9679
490067	01/01/93	12/31/93	1.2726	0.9901
490069	10/01/92	09/30/93	1.3977	0.9991
490071	01/01/93	12/31/93	1.4564	0.9987
490073	09/01/92	08/31/93	1.3336	0.9901
490074	01/01/93	12/31/93	1.2696	0.9964
490075	01/01/93	12/31/93	1.2758	0.9881
490077	09/01/92	09/30/93	1.1976	0.9930
490079	01/01/93	12/31/93	1.3247	0.9864
490083	10/01/92	09/30/93	0.6598	0.9872
490084	01/01/93	12/31/93	1.2540	0.9275
490085	10/01/92	09/30/93	1.1265	0.9743
490088	10/01/92	09/30/93	1.2348	0.9678
490089	10/01/92	09/30/93	1.0421	0.9685
490091	10/01/92	09/30/93	1.1800	0.9950
490092	01/01/93	12/31/93	1.1719	0.9841
490095	01/01/93	12/31/93	1.2308	0.9927
490097	09/01/92	08/31/93	1.1397	0.9801
490099	09/01/92	08/31/93	0.9543	0.9747
490100	10/01/92	09/30/93	1.3135	0.9962
490101	01/01/93	12/31/93	1.1168	0.9865
490107	01/01/93	12/31/93	1.2403	0.9884
490110	10/01/92	09/30/93	1.1815	0.9958
490112	09/01/92	08/31/93	1.6120	0.9981
490113	11/01/92	10/31/93	1.3151	0.9737
490115	10/01/92	09/30/93	1.2135	0.9776
490116	09/01/92	08/31/93	1.1768	0.9831
490117	12/01/92	11/30/93	1.0905	0.9829
490122	01/01/93	12/31/93	1.2940	0.9931
490126	10/01/92	09/30/93	1.2624	0.9847
490130	01/01/93	12/31/93	1.2343	0.9794
500001	01/01/93	12/31/93	1.2956	0.9811
500002	01/01/93	12/31/93	1.4166	0.9925
500003	01/01/93	12/31/93	1.2748	0.9867
500005	01/01/93	12/31/93	1.7752	0.9988
500007	01/01/93	12/31/93	1.3853	0.9783
500009	01/01/93	12/31/93	1.2846	0.9910
500011	01/01/93	12/31/93	1.3627	0.9857
500012	01/01/93	12/31/93	1.4992	0.9983
500014	01/01/93	12/31/93	1.7478	0.9960
500015	01/01/93	12/31/93	1.3100	0.9839
500016	01/01/93	12/31/93	1.3521	0.9895
500019	01/01/93	12/31/93	1.2908	0.9735
500024	01/01/93	12/31/93	1.6333	0.9975
500025	01/01/93	12/31/93	1.8081	0.9993
500026	01/01/93	12/31/93	1.3471	0.9861
500027	01/01/93	12/31/93	1.5375	0.9985
500028	01/01/93	12/31/93	1.0691	0.9784
500029	01/01/93	12/31/93	0.9736	0.9645
500031	01/01/93	12/31/93	1.3115	0.9648
500033	01/01/93	12/31/93	1.2382	0.9664
500036	11/01/92	10/31/93	1.2606	0.9953
500037	01/01/93	12/31/93	1.1316	0.9741
500042	01/01/93	12/31/93	1.3298	0.9813
500043	01/01/93	12/31/93	1.2137	0.9517
500044	01/01/93	12/31/93	1.9182	0.9987
500045	01/01/93	12/31/93	1.0800	0.9877
500048	07/31/92	07/31/93	0.8958	0.9850
500049	01/01/93	12/31/93	1.3649	0.9884
500050	10/01/92	09/30/93	1.4158	0.9929
500051	10/01/92	09/30/93	1.6705	0.9974
500052	01/01/93	12/31/93	1.2445	0.9956
500053	01/01/93	12/31/93	1.1791	0.9835
500054	01/01/93	12/31/93	1.8311	0.9981
500055	07/31/92	07/31/93	1.0777	0.9624
500057	10/01/92	09/30/93	1.2986	0.9895
500058	01/01/93	12/31/93	1.4679	0.9829
500059	01/01/93	12/31/93	1.1381	0.9508
500060	01/01/93	12/31/93	1.3623	0.9776
500061	01/01/93	12/31/93	1.0214	0.9299
500062	01/01/93	12/31/93	1.0006	0.9582
500065	01/01/93	12/31/93	1.2467	0.9554
500068	01/01/93	12/31/93	1.0086	0.9877
500069	01/01/93	12/31/93	1.0708	0.9479
500071	01/01/93	12/31/93	1.3154	0.9610

TABLE 9.—1993 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider No.	Begin	End	Transfer adjusted case mix index	Transfer adjustment to discharges
500072	01/01/93	12/31/93	1.1679	0.9717
500073	01/01/93	12/31/93	1.0310	0.9704
500074	01/01/93	12/31/93	1.1535	0.9698
500075	01/01/93	12/31/93	1.2607	0.9876
500077	07/31/92	07/31/93	1.2964	0.9900
500079	10/01/92	09/30/93	1.2913	0.9806
500080	01/01/93	12/31/93	0.8502	0.9649
500084	01/01/93	12/31/93	1.1419	0.9770
500085	01/01/93	12/31/93	1.0406	0.9797
500088	01/01/93	12/31/93	1.2767	0.9932
500089	01/01/93	12/31/93	1.0438	0.9382
500090	01/01/93	12/31/93	0.9151	0.9491
500092	01/01/93	12/31/93	1.1053	0.9900
500094	01/01/93	12/31/93	0.8820	0.9436
500096	01/01/93	12/31/93	0.9566	0.9114
500097	01/01/93	12/31/93	1.1511	0.9917
500098	01/01/93	12/31/93	0.8613	0.9796
500101	01/01/93	12/31/93	0.9791	0.9257
500102	01/01/93	12/31/93	0.9557	0.9646
500106	01/01/93	12/31/93	0.9810	1.0000
500107	01/01/93	12/31/93	1.1299	0.9650
500110	01/01/93	12/31/93	1.1962	0.9660
500118	01/01/93	12/31/93	1.1366	0.9566
500119	01/01/93	12/31/93	1.3361	0.9850
500122	01/01/93	12/31/93	1.2758	0.9671
500123	01/01/93	12/31/93	0.9518	0.9693
500124	01/01/93	12/31/93	1.2620	0.9862
500125	01/01/93	12/31/93	0.9871	0.9753
500129	01/01/93	12/31/93	1.6213	0.9969
500132	01/01/93	12/31/93	0.9812	0.9778
500134	01/01/93	12/31/93	0.7564	0.9908
500140	10/01/92	09/30/93	0.9994	1.0000
500143	01/01/93	12/31/93	0.9606	1.0000
510001	01/01/93	12/31/93	1.6692	0.9967
510004	11/01/92	10/31/93	0.9852	0.9357
510005	01/01/93	12/31/93	0.9215	0.9664
510006	10/01/92	09/30/93	1.2082	0.9927
510007	10/01/92	09/30/93	1.4251	0.9996
510008	01/01/93	12/31/93	1.1030	0.9879
510009	01/01/93	12/31/93	0.9489	0.9634
510012	10/01/92	09/30/93	1.0837	0.9814
510013	10/01/92	09/30/93	1.1870	0.9961
510016	01/01/93	12/31/93	1.0547	0.9523
510018	10/01/92	09/30/93	1.0655	0.9715
510022	01/01/93	12/31/93	1.6800	0.9988
510028	01/01/93	12/31/93	1.1789	0.9959
510029	10/01/92	09/30/93	1.2601	0.9857
510030	10/01/92	09/30/93	1.1186	0.9742
510031	01/01/93	12/31/93	1.2811	0.9915
510033	01/01/93	12/31/93	1.2676	0.9909
510038	10/01/92	09/30/93	1.0372	0.9627
510039	01/01/93	12/31/93	1.3804	0.9927
510047	01/01/93	12/31/93	1.1575	0.9871
510048	01/01/93	12/31/93	1.0964	0.9891
510050	10/01/92	09/30/93	1.2948	0.9897
510053	10/01/92	09/30/93	1.0235	0.9571
510055	10/01/92	09/30/93	1.2079	0.9958
510059	01/01/93	12/31/93	1.1021	0.9868
510060	09/01/92	08/31/93	1.0778	0.9850
510063	01/01/93	12/31/93	1.0425	0.9849
510065	01/01/93	12/31/93	0.9752	0.9547
510066	01/01/93	12/31/93	1.1037	0.9925
510068	10/01/92	09/30/93	1.0689	0.9797
510076	01/01/93	12/31/93	1.0921	1.0000
510077	10/01/92	09/30/93	1.1403	0.9825
510081	10/01/92	09/30/93	0.9906	0.9820
510082	01/01/93	12/31/93	1.0537	0.9579
510084	01/01/93	12/31/93	0.9892	0.9632
510085	10/01/92	09/30/93	1.2735	0.9811
520002	10/01/92	09/30/93	1.2890	0.9818
520003	01/01/93	12/31/93	1.1050	0.9683
520008	10/01/92	09/30/93	1.4769	0.9960
520010	01/01/93	12/31/93	1.1270	0.9507
520014	10/01/92	09/30/93	1.2316	0.9837
520018	10/01/92	09/30/93	1.0667	0.9711
520019	10/01/92	09/30/93	1.2893	0.9819
520021	10/01/92	09/30/93	1.2964	0.9904
520024	10/01/92	09/30/93	1.0642	0.9702
520026	01/01/93	12/31/93	1.0323	0.9758
520029	10/01/92	09/30/93	0.9338	0.9580
520031	10/01/92	09/30/93	1.0938	0.9763
520032	10/01/92	09/30/93	1.1463	0.9725
520033	09/01/92	08/31/93	1.2266	0.9595
520034	10/01/92	09/30/93	1.1916	0.9779
520035	01/01/93	12/31/93	1.2612	0.9868
520037	10/01/92	09/30/93	1.6234	0.9986
520038	01/01/93	12/31/93	1.3704	0.9765
520039	01/01/93	12/31/93	0.9783	0.9535
520042	10/01/92	09/30/93	1.1130	0.9735
520045	01/01/93	12/31/93	1.6036	0.9969
520048	10/01/92	09/30/93	1.3810	0.9963
520049	10/01/92	09/30/93	1.9371	0.9962
520053	01/01/93	12/31/93	1.0585	0.9423
520054	01/01/93	12/31/93	1.0702	0.9753
520056	10/01/92	09/30/93	1.3230	0.9887
520057	01/01/93	12/31/93	1.0970	0.9732
520058	10/01/92	09/30/93	1.0794	0.9581
520059	10/01/92	09/30/93	1.2539	0.9852
520060	10/01/92	09/30/93	1.3107	0.9574
520062	10/01/92	09/30/93	1.2092	0.9629
520064	12/27/92	12/31/93	1.6474	0.9943
520069	01/01/93	12/31/93	1.2191	0.9893
520070	01/01/93	12/31/93	1.4103	0.9815
520071	10/01/92	09/30/93	1.1051	0.9747
520077	10/01/92	09/30/93	0.9968	0.9757
520078	01/01/93	12/31/93	1.4378	0.9934
520082	08/01/92	07/31/93	1.2970	0.9855
520083	01/01/93	12/31/93	1.5952	0.9992
520084	10/01/92	09/30/93	1.0802	0.9738
520089	01/01/93	12/31/93	1.5188	0.9972
520090	10/01/92	09/30/93	1.1714	0.9667
520095	01/01/93	12/31/93	1.3687	0.9769
520100	01/01/93	12/31/93	1.2380	0.9857
520101	10/01/92	09/30/93	1.1212	0.9571
520102	01/01/93	12/31/93	1.1948	0.9665
520103	10/01/92	09/30/93	1.2877	0.9748
520107	01/01/93	12/31/93	1.2787	0.9811
520109	10/01/92	09/30/93	1.0413	0.9618
520110	01/01/93	12/31/93	1.0906	0.9666
520113	10/01/92	09/30/93	1.1974	0.9771
520115	10/01/92	09/30/93	1.3121	0.9651
520116	10/01/92	09/30/93	1.2580	0.9670
520117	09/01/92	08/31/93	1.0937	0.9691
520118	01/01/93	12/31/93	0.9813	0.9424
520123	10/01/92	09/30/93	1.0403	0.9570
520130	10/01/92	09/30/93	1.0053	0.9478
520131	01/01/93	12/31/93	1.0173	0.9332
520132	01/01/93	12/31/93	1.1589	0.9583
520135	01/01/93	12/31/93	1.0036	0.9704
520138	12/26/92	12/31/93	1.8543	0.9984
520139	08/31/92	08/29/93	1.2257	0.9809
520140	01/01/93	12/31/93	1.4922	0.9974
520144	10/01/92	09/30/93	1.0560	0.9699
520145	01/01/93	12/31/93	1.0227	0.9840
520146	01/01/93	12/31/93	1.1404	0.9575
520148	01/01/93	12/31/93	1.1299	0.9744
520149	01/01/93	12/31/93	0.9074	0.9356
520152	10/01/92	09/30/93	1.1361	0.9660
520153	10/01/92	09/30/93	0.9318	0.9436
520154	10/01/92	09/30/93	1.1043	0.9690
520156	01/01/93	12/31/93	1.0618	0.9488
520157	01/01/93	12/31/93	0.9858	0.9626
520160	01/01/93	12/31/93	1.7738	0.9982
520171	01/01/93	12/31/93	1.0070	0.9663
520173	10/01/92	09/30/93	1.1165	0.9713
520174	01/01/93	12/31/93	1.4505	0.9901
520177	01/01/93	12/31/93	1.5704	0.9936
530008	01/01/93	12/31/93	1.1828	0.9768
530010	01/01/93	12/31/93	1.3037	0.9781
530023	01/01/93	12/31/93	0.9412	0.9082
530032	01/01/93	12/31/93	1.1791	0.9448

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS

Area	1982–1991 percentage difference	1984–1991 percentage difference	1988–1991 percentage difference	1990–1991 percentage difference
Rural Connecticut	17.895	20.236		
Rural Massachusetts	20.640	24.568	8.239	
Rural New Hampshire		9.986		
Rural Vermont		8.798		
Albany, GA	8.660	13.220	9.482	
Anchorage, AK				8.008
Anderson, SC				15.455
Ann Arbor, MI		12.237	14.069	
Athens, GA	9.131	14.730		
Atlanta, GA		11.062		9.275
Atlanta City, NJ		10.448		
Bergen-Passaic, NJ	8.272	10.120	12.033	
Boston-Lowell-Brockton-Lawrence-Salem, MA		10.987		
Bridgeport-Stamford-Norwalk-Danbury, CT		11.339		
Burlington, NC	8.991	12.261		
Caguas, PR		10.068		
Charlotte-Gastonia-Rock Hill, NC-SC		14.308		
Clarksville-Hopkinsville, TN-KY				9.997

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1991 percentage difference	1984–1991 percentage difference	1988–1991 percentage difference	1990–1991 percentage difference
Decatur, AL	.....	9.167		
Eugene-Springfield, OR	.....	.....	.....	11.538
Florence, SC	12.905	11.747		
Fort Walton Beach, FL	.....	8.739		
Hartford-Middletown-New Britain, CT	8.891	12.615		
Houma-Thibodaux, LA	.....	.....	8.143	
Kankakee, IL	.....	.....	10.417	10.808
Killeen-Temple, TX	17.565			
Las Cruse, NM	.....	.....	11.129	
Macon-Warner Robins, GA	.....	16.032		
Manchester-Nashua, NH	13.145	14.543		
Monmouth-Ocean, NJ	10.035	15.415	9.335	
Muncie, IN	.....	.....	17.659	11.058
Nassau-Suffolk, NY	.....	13.191		
New Bedford-Fall River-Attleboro, MA	8.973	11.721		
New Haven-West Haven-Waterbury, CT	10.226	14.515		
New London-Norwich, CT	8.071	11.576		
Newark, NJ	.....	11.177		
Omaha, NE-IA	.....	.....	8.881	
Orange County, NY	10.504	14.539		
Pine Bluff, AR	8.281	.....	9.202	
Pittsfield, MA	11.294	10.468		
Portsmouth-Dover-Rochester, RH	10.388	9.214		
Poughkeepsie, NY	.....	9.951		
Providence-Pawtucket-Woonsocket, RI	.....	14.391		
Redding, CA	.....	14.231		
Salinas-Seaside-Monterey, CA	10.247	9.283		
Santa Cruz, CA	9.664	9.744		
Santa Fe, NM	10.789	13.638	17.875	
Sarasota, FL	.....	8.860		
Savannah, GA	.....	12.264	13.341	8.786
Wilmington, NC	.....	13.339		
Worcester-Fitchburg-Leominster, MA	13.671	20.877	.....	8.214

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 final rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 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 implemented in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

II. Changes in the Final Rule

For the most part, the policies set forth in this final rule with comment period are the same as those in the proposed rule. For impact analysis purposes, the only significant alteration from the proposed rule is that we have decided not to change the definition and the payment methodology for transfer cases. In the proposed rule, the net effect on all payments of these changes were budget neutral compared to total payments under current transfer policy. The distributional effects of these changes were to increase payments to rural hospitals by 0.5 percent and decrease urban hospitals' payments by 0.1 percent.

Otherwise, the differences in this final rule impact analysis compared to that in the proposed rule are the result of using more recent or more complete hospital data. For example, a more complete FY 1993 MedPAR file (June 1994 update) is now available compared to the one available at the time of the proposed rule. In addition, more recent hospital-specific data, including cost reports, are used in this analysis.

Our most recent hospital market basket forecasts are unchanged from the forecasts reported in the proposed rule: 3.6 percent for prospective payment system hospitals and 3.7 percent for hospitals excluded from the prospective payment system. Therefore, the applicable update factors for inpatient hospital operating payments are unchanged from the proposed rule.

We note that one other change implemented in this final rule is the revision of the criteria used by the MGCRB to decide on applications by hospitals for geographic reclassification for prospective payment purposes. As discussed in section III.F of this final rule with comment period, we are eliminating the requirement that an individual hospital be located in an area adjacent to the area to which it seeks reclassification. This change is effective for hospitals seeking reclassification for FY 1996 and thus has no economic effect in FY 1995.

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 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.

We received no comments on the methodology used for the impact analysis in the proposed rule.

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 48 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 August 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. These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impact on these hospitals of the changes implemented in this final rule is discussed below.

V. Impact on Excluded Hospitals and Units

As of August 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 is 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 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 since their base period at a level below the percentage increases in the rate-of-increase limits, 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 will 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 final rule, we are establishing new exclusion criteria for long-term care hospitals that define a minimum level of independence a new hospital must meet to qualify for exclusion from the prospective payment system (see section VI.A. of the preamble). We anticipate that this change will slow the proliferation of entities qualifying for exclusion as long-term care hospitals. Thus, these entities will be paid under the prospective payment system rather than on a reasonable cost basis subject to the rate-of-increase ceiling. Although we cannot quantify the impact of this change on Medicare payments to hospitals, we anticipate that it will result in a small decrease in aggregate payment levels.

In addition, we are removing from the regulations the "1986 malpractice rule" as explained in section VI.B of the preamble. This technical change is necessary to conform the codified Medicare regulations to the various authorities that have previously established that the malpractice rule is invalid. This conforming change would not, standing alone, have significant economic effects.

VI. Quantitative Impact Analysis of the Policy Changes In the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are implementing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate analyses of the 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 (as of June 1994) 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 cost data, we did use the most recently available hospital cost report data to create some of the variables by which hospitals are categorized. Our analysis is subject to several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these policy changes. Second, due to the interdependent

nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with a given 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 the FY 1995 changes to the capital prospective payment system are discussed later in this impact analysis. The 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 geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) 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 changes, our FY 1995 baseline simulation model uses: the FY 1994 GROUPER (version 11.0); wage indexes based on FY 1990 wage data; 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 two statutory changes effective beginning in FY 1995: higher disproportionate share hospital (DSH) payments for some DSH hospitals, and the elimination of the special protection for Medicare-dependent, small rural hospitals (MDHs). Outlier payments are estimated to be 5.1 percent of total FY 1995 DRG payments.

Each policy change is then added incrementally to this baseline, finally arriving at an FY 1995 model incorporating all of the changes. This allows us to isolate the effects of each change, as shown in the columns of Table I.

Finally, we also compare the changes in payments per case from FY 1994 to FY 1995. In this comparison, our FY 1994 baseline reflects payment policies during the current Federal fiscal year, compared to the FY 1995 simulation, which reflects the combination of the statutory and regulatory changes to go into effect during FY 1995. As described above, several policy changes that occur in FY 1995 are not modeled separately but are shown as combined changes from FY 1994 to FY 1995. These changes (which are included in the FY 1995 baseline, as described above) are:

- The update factor applied to the standardized amounts (other than the differential update to the rural amount that is modeled separately, as described above).
- 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 Public Law 103–66).

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 3.9 percent of total DRG payments. When the FY 1994 final rule was 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, another significant impact on payments in FY 1994 compared to FY 1995 is the effect of changes in hospitals' geographic classification from one year to the next. In particular, as hospitals are reclassified by the MGCRB, or as they lose their reclassification, significant payment impacts occur.

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 5,254 hospitals included in the analysis. This is 48 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 32 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 2,956 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,629 hospitals located in large urban areas (populations over 1 million), and 1,327 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,298 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)(8) and (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 3,248, 1,835, 1,413, and 2,006, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have graduate medical education residency

programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive DSH payments, or some combination of these two adjustments. There are 4,198 nonteaching hospitals in our analysis, 831 with fewer than 100 residents, and 225 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 five rows examine the impacts of the 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.

The rural referral centers (137), sole community hospitals (591), and rural referral center/sole community hospitals (56) shown here were not reclassified for purposes of the standardized amount. There are 17 rural referral centers and 29 sole community hospitals that are reclassified for the standardized amount in FY 1995 and are therefore not included in these rows. In addition, three hospitals that are both rural referral centers and sole community hospitals 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 latest available Medicare cost report files. Data needed to calculate Medicare utilization percentages were unavailable for 29 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 reflect the geographic reclassication 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. The next rows illustrate the overall number of reclassifications, as well as the numbers and types of reclassified hospitals grouped by urban and rural location. We have combined Table II from the proposed rule into Table I for this final rule. The added rows can be found here. 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 CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments per Case]

	No. of hosps.[1] (0)	Eliminate rural standard amount[2] (1)	DRG recalibration[3] (2)	New wage data[4] (3)	MGCRB reclassification[5] (4)	Day outlier policy changes[6] (5)	Cost outlier policy changes[7] (6)	All FY 95 changes[8] (7)
(By Geographic Location)								
All Hospitals	5,254	0.7	0.0	0.0	0.0	0.0	0.0	3.3
Urban Hospitals	2,956	0.3	0.1	0.0	−0.3	0.0	0.0	3.3
Large Urban	1,629	0.4	0.1	0.1	−0.5	−0.1	0.0	3.3
Other Urban	1,327	0.3	0.1	−0.1	0.0	0.1	0.0	3.2
Rural Hospitals	2,298	3.0	−0.1	−0.1	2.2	0.1	−0.1	3.6
Bed Size (Urban)								
0–99 Beds	741	0.3	−0.1	−0.3	−0.3	0.1	−0.2	2.5
100–199 Beds	923	0.3	0.0	−0.2	−0.4	0.1	−0.2	3.0
200–299 Beds	610	0.3	0.0	−0.1	−0.3	0.0	0.0	3.1
300–499 Beds	493	0.3	0.1	0.1	−0.4	0.0	0.1	3.4
500 or more Beds	189	0.4	0.2	0.2	−0.3	−0.2	0.2	3.7
Bed Size (Rural)								
0–49 Beds	1,188	4.7	−0.2	−0.2	−0.1	0.1	−0.1	3.7
50–99 Beds	685	4.2	−0.2	−0.2	0.7	0.1	−0.2	4.0
Pacific	145	2.1	−0.1	0.3	1.7	0.2	−0.2	3.7
Puerto Rico	5	18.1	−0.1	−11.1	−0.6	0.2	−0.2	−0.9
(By Payment Categories)								
Urban Hospitals	3,248	0.4	0.1	0.0	−0.2	0.0	0.0	3.3
Large Urban	1,835	0.4	0.1	0.1	−0.2	−0.1	0.0	3.4
Other Urban	1,413	0.4	0.1	−0.2	−0.2	0.1	0.0	3.1
Rural Hospitals	2,006	2.8	−0.1	−0.1	1.5	0.0	−0.1	3.5
Teaching Status								
Non-Teaching	4,198	1.0	0.0	−0.2	0.3	0.1	−0.1	3.3
Less than 100 Res.	831	0.3	0.1	0.0	−0.3	0.0	0.1	3.2
100+ Residents	225	0.4	0.2	0.4	−0.3	−0.3	0.2	3.6
Disproportionate Share Hospitals (DSH)								
Non-DSH	3,311	0.8	0.0	0.0	0.0	0.1	0.0	3.3

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments per Case]

	No. of hosps.[1]	Eliminate rural standard amount[2]	DRG recalibration[3]	New wage data[4]	MGCRB reclassification[5]	Day outlier policy changes[6]	Cost outlier policy changes[7]	All FY 95 changes[8]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Urban DSH:								
100 Beds or More	1,381	0.4	0.1	0.1	−0.1	−0.1	0.0	3.3
Fewer than 100 Beds	142	1.2	−0.3	−0.5	−0.3	0.1	−0.1	2.7
Rural DSH:								
Sole Community (SCH)	145	3.3	−0.2	−0.3	0.0	0.0	−0.1	4.0
Referral Centers (RRC)	46	0.1	0.0	−0.1	3.1	0.0	−0.1	2.7
Other Rural DSH Hosp.:								
100 Beds or More	67	6.1	−0.1	−0.3	0.8	0.1	−0.2	4.6
Fewer than 100 Beds	162	6.1	−0.3	−0.3	0.1	0.1	−0.1	5.7
100–149 Beds	229	3.0	−0.1	−0.1	3.2	0.1	−0.2	3.2
150–199 Beds	103	1.7	0.0	−0.1	3.0	0.1	−0.2	3.5
200 or more Beds	93	1.0	0.0	0.1	4.4	0.0	−0.1	3.2
Urban by Region								
New England	170	0.4	0.1	1.5	−0.3	−0.2	−0.1	4.0
Middle Atlantic	442	0.4	0.1	0.3	−0.4	−0.5	0.0	3.0
South Atlantic	436	0.3	0.1	0.2	−0.3	0.1	0.0	3.7
East North Central	491	0.3	0.1	0.0	−0.2	0.1	0.0	3.4
East South Central	170	0.2	0.1	−0.1	−0.3	0.1	0.2	3.6
West North Central	199	0.3	0.1	−0.3	−0.5	0.2	0.0	2.9
West South Central	385	0.3	0.0	−0.6	−0.4	0.2	0.2	3.4
Mountain	121	0.3	0.1	−1.3	−0.4	0.2	0.0	2.0
Pacific	493	0.4	0.0	−0.1	−0.2	0.1	0.0	3.4
Puerto Rico	49	0.8	0.1	−7.4	−0.5	0.1	0.1	−4.3
Rural by Region								
New England	53	1.8	0.0	0.0	1.7	0.1	−0.3	3.0
Middle Atlantic	84	1.6	0.0	0.0	0.7	−0.2	−0.1	1.3
South Atlantic	298	3.2	−0.1	0.1	3.1	0.0	−0.1	5.3
East North Central	310	3.1	0.0	0.2	1.8	0.1	−0.2	3.0
East South Central	283	3.7	−0.2	−0.5	3.1	0.0	−0.1	4.6
West North Central	536	3.2	−0.1	−0.1	2.2	0.1	−0.1	3.0
West South Central	360	3.6	−0.2	−0.2	2.5	0.1	−0.2	2.8
Mountain	224	1.7	−0.1	−0.2	0.1	0.1	−0.1	2.8
Urban Teaching and DSH								
Both Teaching and DSH	647	0.3	0.1	0.2	−0.4	−0.2	0.1	3.2
Teaching and No DSH	361	0.4	0.1	0.2	−0.3	0.0	0.2	3.7
No Teaching and DSH	876	0.5	0.0	−0.1	0.3	0.1	−0.1	3.5
No Teaching and No DSH	1,364	0.5	0.0	−0.2	−0.2	0.1	−0.1	3.0
Rural Hospital Types								
Nonspecial Status Hospitals	843	5.8	−0.1	−0.2	0.8	0.1	−0.2	5.2
RRC	137	0.2	0.0	0.0	4.3	0.1	−0.1	2.7
SCH	591	1.8	−0.2	−0.3	0.2	0.0	−0.1	3.5
Medicare-Dependent Hospital	393	6.0	−0.2	−0.2	0.0	0.1	−0.2	−0.7
SCH and RRC	56	0.0	−0.1	0.0	1.0	0.0	−0.1	3.5
Type of Ownership								
Voluntary	3,291	0.6	0.1	0.1	−0.1	0.0	0.0	3.3
Proprietary	747	0.7	−0.1	−0.4	0.2	0.2	−0.1	3.5
Government	1,216	1.2	0.0	0.0	0.1	−0.1	0.0	3.5
Medicare Utilization as a Percent of Inpatient Days								
0–25	319	0.4	0.0	−0.3	−0.2	−0.2	0.0	3.0
25–50	1,428	0.5	0.1	0.0	−0.1	−0.1	0.1	3.4
50–65	2,276	0.7	0.0	0.1	0.1	0.0	0.0	3.4
Over 65	1,202	1.1	0.0	−0.1	−0.1	0.0	−0.2	2.9
Unknown	29	0.6	0.0	−1.0	−0.3	−0.9	0.0	1.4
Hospitals Reclassified by the Medicare Geographic Review Board								
Reclassification Status during FY 94 and FY 95								
Reclassified during both FY 94 and FY 95	479	1.3	0.0	−0.1	4.1	0.0	0.0	3.3
Urban	191	0.4	0.0	−0.1	2.2	0.0	0.0	3.5
Rural	288	3.2	0.0	0.1	8.2	0.1	−0.1	2.8

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments per Case]

	No. of hosps.[1]	Eliminate rural standard amount[2]	DRG recalibration[3]	New wage data[4]	MGCRB reclassification[5]	Day outlier policy changes[6]	Cost outlier policy changes[7]	All FY 95 changes[8]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Reclassified during FY 95 Only	207	1.2	0.0	0.3	4.3	0.1	−0.1	10.1
Urban	43	0.4	0.1	0.5	2.9	0.3	0.0	10.4
Rural	164	2.1	−0.1	0.0	5.8	0.0	−0.1	9.8
Reclassified during FY 94 Only	220	1.3	0.0	0.1	−0.8	−0.1	−0.1	−1.9
Urban	65	0.4	0.1	0.4	−1.1	−0.2	−0.1	−0.9
Rural	155	2.5	−0.1	−0.2	−0.4	0.1	−0.1	−3.2
FY 95 Reclassifications								
All Reclassified Hosp.	686	1.2	0.0	0.0	4.2	0.1	0.0	4.9
Stand. Amount Only	287	2.0	0.0	0.4	1.6	0.1	−0.1	2.9
Wage Index Only	207	1.1	0.0	0.0	7.6	0.0	0.0	6.6
Both	192	0.8	0.0	−0.3	3.6	0.1	0.0	5.0
Nonreclassified	4,541	0.6	0.1	0.0	−0.6	0.0	0.0	3.1
All Urban Reclass.	234	0.4	0.1	0.0	2.4	0.1	0.0	4.9
Stand. Amount Only	62	0.4	0.1	0.6	0.6	0.1	0.0	3.1
Wage Index Only	26	0.4	0.1	0.2	5.9	−0.2	0.2	8.6
Both	146	0.4	0.0	−0.3	2.3	0.2	0.0	4.6
Nonreclassified	2,722	0.3	0.1	0.0	−0.6	−0.1	0.0	3.2
All Rural Reclass.	452	2.8	0.0	0.1	7.4	0.1	−0.1	4.9
Stand. Amount Only	225	4.4	0.0	0.2	3.0	0.1	−0.2	2.6
Wage Index Only	181	1.5	0.0	−0.1	8.5	0.0	−0.1	5.6
Both	46	4.6	−0.1	0.3	16.2	0.1	−0.1	8.3
Nonreclassified	1,819	3.1	−0.1	−0.1	−0.4	0.1	−0.1	2.9
Other Reclassified Hospitals (Section 1886(d)(8)(B))	27	0.4	0.0	−1.0	0.2	0.1	−0.3	1.8

[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 discharge data are from FY 1993, and hospital cost report data are from reporting periods beginning in FY 1992 and FY 1993.

[2] This column illustrates the changes in FY 1995 payments per case 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 the 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] 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.

[6] This column illustrates the payment impacts of our changes affecting payments for day outliers, in accordance with section 13501(c) of Pub. L. 103–66.

[7] This column displays the impacts of implementing the fixed loss threshold and other changes to our policy for cost outliers, 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 (although the percent changes from Column 4 do not factor into the percent changes here. It also displays the impacts of the update 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 (less Column 4) 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 to be 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 update to the large and other urban standardized amounts is 1.1 percent. The update to the rural standardized amount is 8.4 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 standardized payment amounts, is described in the Addendum to this final 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 FY 1995 standardized amount for rural hospitals and their FY 1994 amount is 4.7 percent. This smaller net increase can primarily 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 3.1 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 3.1 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 rather than the 5.1 percent offset for FY 1995. For FY 1995, the increase in the size of the outlier offset for rural hospitals mitigates the effect of the higher standardized amount.

Our FY 1995 baseline simulation 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 4.5 percent. Because the urban standardized amounts increase by 0.3 percent when the 5.1 national outlier offset is applied rather than the larger urban outlier offset, the increase in the rural standardized amount to bring it up to the other urban amount (prior to applying any budget neutrality adjustments) is 4.8 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 determining 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 3.0 percent increase in payments from this change, compared to a 0.3 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 3.0 percent increase for hospitals in rural areas is below the increase in the standardized amount as discussed above for several reasons. First, this row includes all hospitals that are located in rural areas, but some rural hospitals already receive the higher urban payment rate. This is reflected in the "Rural Hospital Types" rows. Rural referral centers (RRCs) have only a 0.2 percent payment increase 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 591 SCHs in this row, 414 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 65 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, MDHs, and rural hospitals receiving DSH all experience above average payment gains (between 5.8 percent and 6.1 percent). This effect appears to be primarily attributable to the decrease in the labor share of the standardized amount. In fact, our analysis indicates that substituting the current higher rural labor share on both models in this comparison reduces the simulated payment gains for these hospital groups by roughly 1.5 percentage points.

The row demonstrating the largest benefit from this change is rural Puerto Rico, with an 18.1 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. However, it is far below the rural Puerto Rico increase (0.8 percent vs. 18.1 percent).

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 adjustment 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 3.2 percent after eliminating the separate rural amount, and the average urban outlier payment per case rises by 0.8 percent. This occurs because relatively fewer rural cases qualify for outlier payments under the 8.4 percent update required to set the rural standardized amount equal to the other urban standardized amount. This leads to additional outlier payments going to outlier cases in urban hospitals.

The fact that many of these cases are 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, outlier payment policies are set 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 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 final 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 changes is budget neutral. That is, the percentage change when adding the 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 implementing 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 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 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 FY 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 FY 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 amounts, this adjustment factor is 0.998050. 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 final rule, 91 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 1.5 percent, while payments per case for urban hospitals in the West South Central and Mountain census divisions fall by 0.6 and 1.3 percent, respectively. The most dramatic shifts occur in Puerto Rico, where payments decline by 11.1 percent in rural hospitals and 7.4 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 0.4 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 significant decline in payments per case of 1.0 percent 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. Impacts of MGCRB Reclassifications (Column 4)

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. For FY 1995, the MGCRB may reclassify a hospital to an adjacent urban area or to a rural area with which the hospital has a close proximity, for the purposes of assigning to the reclassified hospital 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.)

Column 4 reflects changes in payments after accounting for the MGCRB's reclassification decisions that will be effective for FY 1995, including all decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions and any reclassification withdrawal requests that were received by the MGCRB. These Administrator's decisions and withdrawals may affect the number of reclassified hospitals relative to those shown in the May 27, 1994 proposed rule. They may also determine whether a redesignated hospital receives the wage index of the area to which it is redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals.

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 4 reflect the per case payment impact of incorporating the MGCRB decisions for FY 1995 into our simulation model. As noted above, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified to an urban area for the standardized amount also qualify to be treated as urban for purposes of the DSH adjustment.

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 0.994055 to ensure that the effects of reclassification are budget neutral.

Rural hospitals benefit disproportionately from geographic reclassification. Their payments rise 2.2 percent, while payments to urban hospitals decline 0.3 percent. Rural referral centers experience a 4.3 percent increase overall as a result of reclassification. Of the 137 hospitals in this category, 51 are reclassified for purposes of the wage index. This positive impact on RRCs also appears in the category of rural hospitals with 200 or more beds, which have a 4.4 percent increase in payments.

Hospitals in large urban areas lose 0.5 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 so that the net impact on payments per case for this group is zero. Among urban hospital groups generally, payments fall between 0.3 and 0.5 percent.

Among hospitals grouped by reclassification status, the changes are largely predictable. Hospitals reclassified for FY 1995 have increases in their payments per case, ranging from 0.6 for urban hospitals reclassified for the standardized amount, to 16.2 percent for rural hospitals reclassified for both the standardized amount and the wage index. In addition, rural hospitals reclassified for the wage index only receive an 8.5 percent payment increase, and urban hospitals reclassified for the wage index have 5.9 percent higher payments. The overall impact on reclassified hospitals is 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, essentially the geographic reclassification budget neutrality factor.

The number of reclassifications for purposes of the standardized amount have not declined from FY 1994. The payment impact upon hospitals reclassified for the standardized amount only is significantly lower than it is for hospitals reclassifying either for only wage indexes, or for purposes of both the wage index and the standardized amount.

F. Outlier Changes (Columns 5 and 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, a case will receive cost outlier payment if costs exceed the DRG amount plus $20,500. We are also increasing the marginal cost factor for cost outliers from 75 to 80 percent.

Columns 5 and 6 of Table I display the changes to day and cost outlier policy separately. In column 5, the day outlier policy changes are modeled. The cost outlier thresholds in this simulation are based on current policy (threshold based on the lesser of a fixed multiple of the DRG payment amount or a fixed dollar loss). 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 0.2 percent decline. In New England, urban hospitals experience a payment decrease of 0.2 percent. Since the changes to the day outlier policy result in a shift in payments from cases paid as day outliers to cases paid as cost outliers, these areas evidently have higher percentages of day outliers than other areas. 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). Also experiencing a negative impact are major teaching hospitals (100 or more residents), with a 0.3 percent decline in payments. The largest negative impact occurs among hospitals for which we could not determine Medicare utilization rates. This group experiences a 0.9 percent fall in payments per case. A number of these hospitals are urban hospitals in the Middle Atlantic census division. In fact, because these are generally large hospitals with many outlier cases, they have a significant effect in the overall decline in the Middle Atlantic division.

Column 6 models the changes in cost outlier policy. The net effects of the combined outlier changes can be determined by the sum of the percentage changes in these two columns. Once again, the relative payment impacts here are minimal. Major teaching hospitals recoup 0.2 percent of the 0.3 percent their payments fell due to the day outlier changes. Urban Middle Atlantic hospitals' payments are unchanged here, consequently the net effect of the outlier policy changes on them is a 0.5 percent decline in payments. This is the same percentage change for this hospital group that we estimated in the proposed rule.

G. All Changes (column 7)

Column 7 compares our estimate of payments per case for FY 1995 to our estimate of payments per case for FY 1994. It includes the changes discussed in the previous columns, although the changes due to MGCRB reclassifications in column 4 do not factor into the changes shown here. This is because column 4 shows the effects of reclassifications relative to an FY 1995 baseline without reclassifications, rather than in comparison with FY 1994 reclassifications. Changes in hospitals' reclassification status from FY 1994 to FY 1995 are shown here, and have a significant effect on payments.

This column includes the impacts of statutory differences from FY 1994 to FY 1995 that are not shown in the previous columns. 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 1.2 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 FY 1995 standardized amounts of 0.994055. 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 0.998050. Although the net effect of these changes are small, they do impact 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 standardized 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 (less Column 4) plus the other impacts that we are able to identify.

The impact on all hospitals is a 3.3 percent increase in payments from FY 1994. The net change in total payments due to the 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 standardized amounts is 1.6 percent. As described in the discussion of the impacts of eliminating the rural standardized 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, apart from elimination of the rural standardized amount, is about 1.3 percent.

Other significant changes that have not been isolated in the previous columns include the following:

- A 1.2 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 3.5 percent decline in payments for this group of hospitals, and a 0.1 percent decline for rural hospitals. The impact on total payments is less than 0.1 percent.

As a group, hospitals in rural areas experience the largest payment increase, a 3.6 percent rise in payments per case over FY 1994. The increase in estimated outlier payments over FY 1994 for rural hospitals is 0.6 percent, below the 1.2 percent difference for all hospitals. As we noted in the discussion of column 4, eliminating the rural standardized 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 standardized amount. This effect is shown in Column 7 when examining the rows containing rural hospitals reclassified during both FY 1994 and FY 1995 and rural hospitals reclassified during FY 1994 only. The 288 hospitals in the former category experience an overall increase in payments per case of 2.8 percent, closer to that of urban hospitals, and the 155 hospitals in the latter category experience a 3.2 percent decline.

Hospitals in both large and other urban areas experience 3.3 percent increases. Urban hospitals are affected the most by the change in outlier payments from FY 1994 to FY 1995, a 1.3 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 experience as great a decline as rural hospitals.

Among urban bed size groups, column 7 shows changes in payments ranging from 2.5 percent for the smallest hospitals to 3.7 percent for the largest hospitals. The relatively smaller increases for the smaller urban hospitals appear 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 II.—IMPACT ANALYSIS OF CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per Case]

	Number of hospitals	Average FY 1994 payment per case	Average FY 1995 payment per case	All changes
	(1)	(2)[1]	(3)[1]	(4)
(BY GEOGRAPHIC LOCATION)				
ALL HOSPITALS	5,254	6,077	6,279	3.3
URBAN HOSPITALS	2,956	6,565	6,782	3.3
LARGE URBAN AREAS	1,629	7,073	7,309	3.3
OTHER URBAN AREAS	1,327	5,887	6,077	3.3
RURAL AREAS	2,298	4,041	4,185	3.6
BED SIZE (URBAN)				
0–99 BEDS	741	4,498	4,611	2.5
100–199 BEDS	923	5,589	5,755	3.0
200–299 BEDS	610	6,056	6,245	3.1
300–499 BEDS	493	6,935	7,174	3.4
500 OR MORE BEDS	189	8,475	8,787	3.7

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hospitals (1)	Average FY 1994 payment per case (2)[1]	Average FY 1995 payment per case (3)[1]	All changes (4)
BED SIZE (RURAL)				
0–49 BEDS	1,188	3,356	3,481	3.7
50–99 BEDS	685	3,745	3,893	4.0
100–149 BEDS	229	4,202	4,337	3.2
150–199 BEDS	103	4,261	4,411	3.5
200 OR MORE BEDS	93	4,949	5,109	3.2
URBAN BY REGION				
NEW ENGLAND	170	6,886	7,162	4.0
MIDDLE ATLANTIC	442	7,319	7,541	3.0
SOUTH ATLANTIC	436	6,228	6,458	3.7
EAST NORTH CENTRAL	491	6,311	6,523	3.4
EAST SOUTH CENTRAL	170	5,748	5,958	3.6
WEST NORTH CENTRAL	199	6,216	6,399	2.9
WEST SOUTH CENTRAL	385	6,017	6,223	3.4
MOUNTAIN	121	6,390	6,519	2.0
PACIFIC	493	7,476	7,731	3.4
PUERTO RICO	49	2,594	2,482	−4.3
RURAL BY REGION				
NEW ENGLAND	53	4,792	4,938	3.0
MIDDLE ATLANTIC	84	4,565	4,622	1.3
SOUTH ATLANTIC	298	4,122	4,341	5.3
EAST NORTH CENTRAL	310	4,063	4,187	3.0
EAST SOUTH CENTRAL	283	3,656	3,824	4.6
WEST NORTH CENTRAL	536	3,792	3,907	3.0
WEST SOUTH CENTRAL	360	3,727	3,831	2.8
MOUNTAIN	224	4,375	4,500	2.8
PACIFIC	145	4,916	5,096	3.7
PUERTO RICO	5	1,902	1,885	−0.9
(BY PAYMENT CATEGORIES)				
URBAN HOSPITALS	3,248	6,470	6,685	3.3
LARGE URBAN AREAS	1,835	6,935	7,172	3.4
OTHER URBAN AREAS	1,413	5,736	5,917	3.1
RURAL AREAS	2,006	4,020	4,159	3.5
TEACHING STATUS				
NON-TEACHING	4,198	5,018	5,184	3.3
FEWER THAN 100 RESIDENTS	831	6,498	6,704	3.2
100 OR MORE RESIDENTS	225	10,065	10,430	3.6
DISPROPORTIONATE SHARE HOSPITALS (DSH)				
NON-DSH	3,311	5,347	5,523	3.3
URBAN DSH:				
100 BEDS OR MORE	1,381	7,141	7,379	3.3
FEWER THAN 100 BEDS	142	4,263	4,378	2.7
RURAL DSH: SOLE COMMUNITY (SCH)	145	3,879	4,036	4.0
REFERRAL CENTERS (RRC)	46	5,020	5,156	2.7
OTHER RURAL DSH HOSP.:				
100 BEDS OR MORE	67	3,695	3,863	4.6
FEWER THAN 100 BEDS	162	3,211	3,396	5.7
URBAN TEACHING AND DSH				
BOTH TEACHING AND DSH	647	8,170	8,435	3.2
TEACHING AND NO DSH	361	6,625	6,867	3.7
NO TEACHING AND OSH	876	5,681	5,880	3.5
NO TEACHING AND NO DSH	1,364	5,182	5,338	3.0
RURAL HOSPITAL TYPES				
NONSPECIAL STATUS HOSPITALS	843	3,507	3,688	5.2
RRC	137	4,711	4,839	2.7
SCH	591	4,080	4,221	3.5
MEDICARE-DEPENDENT HOSPITALS (MDH)	393	3,377	3,352	−0.7
SCH AND RRC	56	4,943	5,118	3.5
TYPE OF OWNERSHIP				
VOLUNTARY	3,291	6,203	6,407	3.3

TABLE II —IMPACT ANALYSIS OF CHANGES FOR FY 1995 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hospitals (1)	Average FY 1994 payment per case (2)[1]	Average FY 1995 payment per case (3)[1]	All changes (4)
PROPRIETARY	747	5,542	5,734	3.5
GOVERNMENT	1,216	5,796	5,998	3.5
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS				
0–25	319	8,312	8,559	3.0
25–50	1,428	7,226	7,474	3.4
50–65	2,276	5,538	5,728	3.4
OVER 65	1,202	4,877	5,017	2.9
UNKNOWN	29	7,724	7,833	1.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD				
RECLASSIFICATION STATUS DURING FY 94 AND FY 95				
RECLASSIFIED DURING BOTH FY 94 AND FY 95:	479	5,741	5,929	3.3
URBAN	191	6,631	6,864	3.5
RURAL	288	4,519	4,645	2.8
RECLASSIFIED DURING FY 95 ONLY	207	5,011	5,517	10.1
URBAN	43	6,124	6,758	10.4
RURAL	164	4,154	4,561	9.8
RECLASSIFIED DURING FY 94 ONLY	220	5,644	5,536	−1.9
URBAN	65	7,263	7,199	−0.9
RURAL	155	4,405	4,263	−3.2
FY 95 RECLASSIFICATIONS				
ALL RECLASSIFIED HOSP	686	5,552	5,822	4.9
STAND. AMT. ONLY	287	5,028	5,185	2.9
WAGE INDEX ONLY	207	5,403	5,761	6.6
BOTH	192	6,148	6,456	5.0
NONRECLASS	4,541	6,165	6,357	3.1
ALL URBAN RECLASS	234	6,525	6,842	4.9
STAND. AMT. ONLY	62	6,166	6,357	3.1
WAGE INDEX ONLY	26	7,686	8,350	8.6
BOTH	146	6,429	6,726	4.6
NONRECLASS	2,722	6,569	6,776	3.2
ALL RURAL RECLASS	452	4,402	4,618	4.9
STAND. AMT. ONLY	225	4,006	4,112	2.6
WAGE INDEX ONLY	181	4,676	4,937	5.6
BOTH	46	4,482	4,853	8.3
NONRECLASS	1,819	3,862	3,973	2.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	4,350	4,427	1.8

[1] These payment amounts per case do not reflect any estimates of annual case mix increase.

Table II 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. 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 June 1994 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 is 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 III 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 random 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 hospitals' 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 IV. In Table V 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. We proposed omitting the cross-sectional analysis of changes in the Federal rate (referred to as Table VII in the proposed rule 59 FR 27867). We requested comments on the utility of this table and its continued use in future impact statements. Since we received no comments on this issue, we are omitting this table and corresponding descriptive text from the impact statement.

B. Projected Impact Based on the 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 final 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 June 1994 update of 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 July 1, 1994 in the Provider-Specific file. We used this data to determine the 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 0.85 percent in FY 1994.
- 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 FY 1995 update factor for inflation is 3.44 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 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 III 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	47	49
High cost hospital	36	41	53	51

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 III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1994 to FY 1995 using the above described actuarial model.

TABLE III.—IMPACT OF CHANGES FOR FY 1995 ON 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	3,332	6,137,315	$201.48	33.77	$240.85	$25.76	$7.72	$475.80
Fully Prospective	1,879	3,553,295	180.86	30.00	272.81	.....	3.27	456.94
Rebase—Fully Prospective	1,141	1,956,526	174.89	30.00	260.04	.....	17.90	452.84
Rebase—100% Federal Rate	144	342,220	621.36	100.00	.....	.....	.....	621.46
Rebase—Hold Harmless	168	285,273	136.86	23.53	.....	554.10	2.52	693.49
High Cost Hospitals	1,897	4,209,462	320.53	52.59	.....	409.88	5.11	735.52
100% Federal Rate	654	1,556,520	637.05	100.00	.....	.....	0.10	637.15
Hold Harmless	1,243	2,652,942	134.82	22.72	.....	650.36	8.05	793.23
Total hospitals	5,229	10,346,777	249.91	41.52	142.86	182.03	6.66	581.46

	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	3,332	6,137,315	$259.44	42.89	$208.32	$27.00	$14.26	$509.02	6.98
Fully Prospective	1,879	3,553,295	244.06	40.00	235.97	.....	5.97	486.00	6.36
Rebase—Fully Prospective	1,141	1,956,526	236.55	40.00	224.94	.....	33.25	494.74	9.25
Rebase—100% Federal Rate	147	346,144	634.80	100.00	.....	.....	.....	634.80	2.15
Rebase—Hold Harmless	165	281,350	151.08	25.36	.....	588.89	4.30	744.27	7.32
High Cost Hospitals	1,897	4,209,462	360.43	57.05	.....	394.93	7.74	763.09	3.75
100% Federal Rate	721	1,725,736	652.13	100.00	.....	.....	0.30	652.43	2.40
Hold Harmless	1,176	2,483,726	157.75	25.54	.....	669.33	12.91	839.98	5.89
Total hospitals	5,229	10,346,777	300.52	48.80	123.57	176.68	11.60	612.38	5.32

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 90.32 percent of reasonable costs, or 0.32 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 5.32 percent increase in FY 1995 Medicare capital payments over the FY 1994 payments.

We project that low capital cost hospitals will experience an average case-weighted increase in payments of 6.98 percent, and high capital cost hospitals will experience an average increase of 3.75 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 22.72 percent to 25.54 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 34.5 percent to 38.0 percent.

The average hospital-specific rate payment per discharge falls from $142.86 in FY 1994 to $123.57 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 from FY 1994 to FY 1995.

We are implementing no changes in our exceptions policies that affect exceptions payments 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 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 1.1 percent of payments in FY 1994 to 1.9 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	361	73
High capital cost ...	176	27
Total	537	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 IV.—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	5,229	25.6	16.6	57.8
Large urban areas (populations over 1 million)	1,613	29.8	21.3	48.9
Other urban areas (populations or 1 million of fewer)	1,320	31.4	20.0	48.6
Rural areas	2,296	19.4	11.3	69.3
Urban hospitals	2,933	30.5	20.7	48.8
0–99 beds	719	28.7	20.3	51.0
100–199 beds	922	37.0	19.4	43.6
200–299 beds	610	31.3	20.0	48.7
300–499 beds	493	22.9	24.5	52.5
500 or more beds	189	23.3	21.2	55.6
Rural hospitals	2,296	19.4	11.3	69.3
0–49 beds	1,186	14.2	8.9	77.0
50–99 beds	685	23.4	12.3	64.4
100–149 beds	229	26.6	20.1	53.3
150–199 beds	103	23.3	12.6	64.1
200 or more beds	93	35.5	12.9	51.6
By Region:				
Uban by Region	2,933	30.5	20.7	48.8
New England	170	11.8	20.6	67.6
Middle Atlantic	442	20.4	24.0	55.7
South Atlantic	436	41.1	21.1	37.8
East North Central	490	24.7	15.3	60.0
East South Central	170	43.5	14.7	41.8
West North Central	197	32.0	15.2	52.8
West South Central	372	49.2	26.3	24.5
Mountain	120	30.0	30.8	39.2
Pacific	488	24.4	21.5	54.1
Puerto Rico	48	20.8	10.4	68.8
Rural by Region	2,296	19.4	11.3	69.3
New England	53	13.2	13.2	73.6
Middle Atlantic	84	16.7	19.0	64.3
South Atlantic	298	25.5	11.1	63.4
East North Central	310	16.5	7.4	76.1
East South Central	282	25.2	16.7	58.2
West North Central	536	13.6	9.0	77.4
West South Central	359	19.2	16.2	64.6
Mountain	224	21.4	8.9	69.6
Pacific	145	24.8	4.8	70.3
By Payment Classification:				
All hospitals	5,229	25.6	16.6	57.8
Large urban areas (populations over 1 million)	1,819	29.4	21.1	49.5
Other urban areas (populations of 1 million or fewer)	1,406	31.4	17.9	50.7
Rural areas	2,004	18.2	11.6	70.2

TABLE IV.—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)	
Teaching Status:				
Non-teaching	4,174	26.1	16.2	57.6
Fewer than 100 residents	830	25.9	17.5	56.6
100 or more Residents	225	15.6	20.4	64.0
Disproportionate share hospitals (DSH):				
Non-DSH	3,291	23.9	15.2	60.9
Urban DSH:				
100 or more beds	1,381	30.6	21.5	47.9
Less than 100 beds	137	33.6	16.8	49.6
Rural DSH:				
Sole Community (SCH)	145	19.3	6.2	74.5
Referral Center (RRC)	46	28.3	17.4	54.3
Other Rural:				
100 or more beds	67	26.9	20.9	52.2
Less than 100 beds	162	17.3	10.5	72.2
Urban teaching and DSH:				
Both teaching and DSH	647	23.3	19.6	57.0
Teaching and no DSH	360	23.3	16.9	59.7
No teaching and DSH	871	36.4	22.2	41.4
No teaching and no DSH	1,347	31.6	18.9	49.6
Rural Hospital Types:				
Non special status hospitals	838	16.7	13.4	69.9
RRC	137	27.0	14.6	58.4
SCH	56	28.6	14.3	57.1
Medicare-dependent hospitals (MDH)	412	9.5	11.2	79.4
SCH or MDH	56	28.6	14.3	57.1
Type of Ownership:				
Voluntary	3,268	24.4	16.8	58.7
Proprietary	745	46.0	24.6	29.4
Government	1,216	16.4	11.1	72.5
Medicare Utilization as a Percent of Inpatient Days:				
0–25	296	30.7	19.9	49.3
25–50	1,422	28.3	18.6	53.0
50–65	2,274	25.9	15.5	58.5
Over 65	1,198	21.0	15.4	63.7

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 25 of the 5,254 hospitals in our data base. Consequently, the payment methodology distribution is based on 5,229 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 IV indicates that 57.8 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 into account 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 (69.3 percent and 72.5 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 29.4 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 changes for FY 1995 on total capital payments per case, using a universe of 5,229 hospitals. The individual hospital payment parameters are taken from the best available data, including: the July 1, 1994 update to the Provider-Specific file, cost report data, and audit information supplied by intermediaries. Table V 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 0.04 percent decrease in the Federal rate, a 0.85 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), changes in capital outlier payments and

reclassifications by the Medicare Geographic Classification Review Board. The residual increase in the total percentage change in payments 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 5.3 percent in FY 1995. The results show that the effect of the Federal rate changes alone is to increase payments by 1.0 percent. The remainder of the increase (4.3 percent) is 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 (5.3 percent and 5.4 percent, respectively). Urban hospitals will gain more than rural hospitals (1.1 percent compared to 0.5 percent) from the Federal rate changes. However, urban hospitals will gain slightly less than rural hospitals (4.2 percent compared to 4.9 percent) from the effects of transition changes.

By region, rural hospitals of the New England region have the highest rate of increase (15.7 percent, all of which is due to the effects of transition changes, with Federal rate changes having no impact). Puerto Rico hospitals fare worst: these hospitals will experience a 1.1 percent decline attributable to Federal rate changes, which is offset by a 2.7 percent increase attributable to the effects of transition changes, resulting in only a 1.6 percent increase in payments.

By type of ownership, government hospitals are projected to have the highest rate of increase (6.1 percent, of which 0.8 percent is due to Federal rate changes and 5.3 percent to the effects of transition changes). Payments to proprietary hospitals will increase 3.0 percent (1.0 percent due to the Federal rate changes and 2.0 percent attributable to the effects of transition changes) and payments to voluntary hospitals will increase 5.6 percent (1.0 percent due to Federal rate changes and 4.6 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 for FY 1995 as a whole are projected to experience a 5.2 percent increase in payments (1.3 percent attributable to Federal rate changes and 3.9 percent attributable to the effects of transition changes). Nonreclassified hospitals will gain slightly more (5.3 percent) than reclassified hospitals (5.2 percent) overall. While nonreclassified hospitals will gain less (0.9 percent compared to 1.3 percent) than reclassified hospitals from the Federal rate changes, they will gain more (4.4 percent to 3.9 percent) from the effects of transition changes.

TABLE V.—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 attibutable to Federal rate change
By Geographic Location					
All hospitals	5,229	581	612	5.3	1.0
Large urban areas (populations over 1 million)	1,613	662	700	5.7	1.0
Other urban areas (populations of 1 million of fewer)	1,320	584	612	4.8	1.1
Rural areas	2,296	384	404	5.4	0.5
Urban hospitals	2,933	629	662	5.3	1.1
0–99 beds	719	480	502	4.5	0.7
100–199 beds	922	579	603	4.1	0.9
200–299 beds	610	605	631	4.3	0.9
300–499 beds	493	633	664	4.9	1.1
500 or more beds	189	762	825	8.2	1.4
Rural hospitals	2,296	384	404	5.4	0.5
0–49 beds	1,186	281	302	7.4	0.3
50–99 beds	685	357	373	4.5	0.5
100–149 beds	229	421	438	4.0	0.5
150–199 beds	103	391	410	4.9	0.5
200 or more beds	93	492	525	6.8	0.6
By Region					
Urban By Region	2,933	629	662	5.3	1.1
New England	170	567	613	8.2	1.4
Middle Atlantic	442	647	692	7.0	0.8
South Atlantic	436	657	685	4.4	1.2
East North Central	490	580	609	5.0	1.1
East South Central	170	594	621	4.5	1.1

TABLE V.—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
West North Central	197	626	657	5.0	0.8
West South Central	372	683	704	3.1	1.6
Mountain	120	647	663	2.4	0.6
Pacific	488	674	716	6.3	1.0
Puerto Rico	48	236	240	1.6	−1.1
Rural by Region	2,296	384	404	5.4	0.5
New England	53	473	547	15.7	0.0
Middle Atlantic	84	390	418	7.0	0.9
South Atlantic	298	405	421	4.1	0.7
East North Central	310	367	383	4.5	0.7
East South Central	282	364	380	4.4	0.4
West North Central	536	350	371	6.0	0.1
West South Central	359	370	390	5.5	0.2
Mountain	224	451	466	3.4	0.6
Pacific	145	425	456	7.4	0.6
Payment Classification					
All hospitals	5,229	581	612	5.3	1.0
Large urban areas (populations over 1 million)	1,819	652	688	5.6	1.0
Other urban areas (populations of 1 million or fewer)	1,406	571	599	4.7	1.0
Rural areas	2,004	376	397	5.7	0.5
Teaching Status:					
Non-teaching	4,174	518	540	4.1	0.8
Fewer than 100 Residents	830	604	636	5.3	1.2
100 or more Residents	225	825	900	9.0	1.1
Disproportionate share hospitals (DSH):					
Non-DSH	3,291	535	562	5.1	1.0
Urban DSH:					
100 or more beds	1,381	657	694	5.6	1.0
Less than 100 beds	137	433	446	2.9	0.5
Rural DSH:					
Sole Community (SCH)	145	360	370	3.0	0.2
Referral Center (RRC)	46	454	476	4.8	0.6
Other Rural:					
100 or more beds	67	363	383	5.6	0.2
Less than 100 beds	162	297	310	4.5	0.6
Urban teaching and DSH:					
Both teaching and DSH	647	707	754	6.7	1.0
Teaching and no DSH	360	615	654	6.2	1.5
No teaching and DSH	871	584	606	3.8	1.0
No teaching and no DSH	1,347	562	584	3.9	0.8
Rural Hospital Types:					
Non special status hospitals	838	330	347	5.1	0.3
RRC	137	458	485	6.0	0.7
SCH	591	378	399	5.4	0.3
Medicare-dependent hospital (MDH)	412	282	297	5.3	0.4
SCH and MDH	56	464	497	7.2	0.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY94 and FY95:					
Reclassification During Both FY94 and FY95	479	583	608	4.2	0.8
Reclassification During FY95 Only	207	497	540	8.6	3.2
Reclassification During FY94 Only	197	489	505	3.1	−1.4
FY95 Reclassifications:					
All Reclassified Hospitals	686	561	590	5.2	1.3
All Nonreclassified Hospitals	4,516	585	616	5.3	0.9
All Urban Reclassified Hospitals	234	663	696	4.9	1.4
Urban Nonreclassified Hospitals	2,699	626	659	5.3	1.0
All Reclassified Rural Hospitals	452	440	465	5.7	1.2
Rural Nonreclassified Hospitals	1,817	356	374	5.2	0.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	27	433	450	4.1	0.3
Type of Ownership:					
Voluntary	3,268	591	624	5.6	1.0
Proprietary	745	628	647	3.0	1.0
Government	1,216	479	509	6.1	0.8
Medicare Utilization as a Percent of Inpatient Days:					
0–25	296	633	680	7.6	0.8
25–50	1,422	670	714	6.5	1.0

TABLE V.—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 attributable to Federal rate change
50–65	2,274	544	568	4.3	1.0
Over 65	1,198	505	529	4.6	0.7

E. Impact of Changes to the MGCRB Criteria for FY 1996 Hospital Reclassifications

As discussed in detail in section III.F of the preamble, this final rule with comment period revises the criteria for individual hospitals seeking geographic reclassification by eliminating the requirement that a hospital be located in an area adjacent to the area to which it seeks reclassification effective for FY 1996 reclassifications. Hospitals that are able to qualify for reclassification as a result of this final rule will receive increased Medicare payments. However, in accordance with the budget neutrality requirement of section 1886(d)(8)(D) of the Act, proportional adjustments will be made to the large urban and other area standardized amounts, thereby eliminating any effect of the increased hospital payments on aggregate Medicare payments.

Because we cannot predict which hospitals will apply for geographic reclassification or how the MGCRB will rule on applications, we are unable to estimate the economic impact that the revised reclassification criteria will have on prospective payment system hospitals.

However, in the past, the number of hospitals who have been denied reclassification for failure to meet the adjacency requirement has not been significant. For example, the MGCRB received 1343 applications for reclassification for FY 1994. Of that number, only two applications were denied on the basis of the adjacency provision alone. Thus, we do not anticipate that the elimination of the adjacency requirement will result in a significant increase in the number of hospitals that qualify for reclassification. However, we note that we are unable to estimate how many additional hospitals might have applied for reclassification had the adjacency requirement not been in effect.

In some instances, geographic reclassification may result in a substantial increase in revenues for a hospital and may also represent a boost to the local economy through an increase in employment and additional purchases of goods and services. Therefore, there may be significant effects on a small number of hospitals that are reclassified as a result of our elimination of the adjacency requirement. If these hospitals are able to spend additional funds for patient care services, then access to care may also increase. Finally, while we are unable to reach any specific, quantifiable conclusions regarding potential effects of this rule, we note that some redistributive effects on hospital payments will result from MGCRB decisions to approve requests for reclassification based on the elimination of the adjacency requirement.

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 adjusted 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 rates at which old capital will be depreciated and written off and 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 June 1994 update of the PPS–9 cost reports, the July 1994 update of the provider-specific file, and the March 1994 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	Number of hospitals
Provider Specific File Only	66
Provider Specific and Audit File	5188
Total	5254

Forty-six 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	Number of hospitals
PPS–5 Cost Reports	2
PPS–6 Cost Reports	1
PPS–7 Cost Reports	2
PPS–8 Cost Reports	3
PPS–9 Cost Reports	13
Total	21

We did not have data for 25 hospitals, and had to eliminate them from the capital analysis. Most of these hospitals are new hospitals or hospitals with very few Medicare admissions. This leaves us with 5229 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 4,873 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 final 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 0.85 percent in FY 1993. Even though FY 1994 is not complete, it appears from examination of the data through July 1994 that the case-mix increase for FY 1994 will be about 0.85 percent. Since case-mix increases appear to have decelerated, we have reduced our projected long-term increase of 2 percent to 0.85 percent for 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 0.9998 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 0.9980 and the FY 1994 incremental adjustment of 1.0053), yielding a cumulative adjustment of 1.0031 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 FYs 1992 through FY 1995, and the estimated factors that would be applicable through FY 1999. We caution that the projections for FY 1996 and thereafter 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 1.0031 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	3.83	N/A	0.9813	0.9602	415.59
1993	0.84	6.07	.9756	.9162	[2] 417.29
1994	3.78	3.04	.9485	.8947	[3] 378.34
1995	4.81	3.44	.9734	.8432	[4] 376.83
1996	5.04	2.33	.9784	N/A	459.67
1997	5.29	2.30	.9662	N/A	464.38
1998	5.47	4.29	.9541	N/A	478.24
1999	5.55	4.92	.9378	N/A	493.19

[1] Note: Adjusted for estimated 1.55 percent annual increase in case mix for FY 1992, 0.85 percent for FY 1993 and later.
[2] Note: Includes the DRG/GAF adjustment factor of 0.9980 and the change in the outlier adjustment for 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 1.0031 and the change in the outlier adjustment from 0.9454 in FY 1994 to 0.9414 in FY 1995. Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Appendix C: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of 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)(IX) of the Act sets the applicable percentage increases for prospective payment hospitals for FY 1995 as the market basket percentage increase 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 make the rural national average standardized amounts equal to the other urban national average standardized amount. Section 1886(b)(3)(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) sets the FY 1995 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system equal to the rate of increase in the hospital market basket minus a reduction factor (not to exceed −1.0 percent) depending on the hospital's operating costs and target amounts.

In accordance with section 1886(d)(3)(A) of the Act, we are updating the average standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided for 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 updates in the standardized amounts are 1.1 percent for hospitals in urban areas and 8.4 percent for hospitals in rural areas. The 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 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 an appropriate 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 for FY 1995 that takes into account changes in the market basket index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for FY 1995 that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. As required by section 1886(e)(5) of the Act, we published the recommended FY 1995 update factors under section 1886(e)(4) of the Act as Appendix D of the May 27, 1994 proposed rule (59 FR 27873).

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

We received several public comments concerning our proposed recommendation. After consideration of the arguments presented, we have decided that our final recommendation will be the same as our proposed recommendation. That is, we are recommending that the standardized amounts be increased by an average amount equal to the market basket percentage increase minus 2.5 percentage points for hospitals located in urban areas and the market basket percentage 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 equal to the market basket rate of increase minus 2.2 percentage points for the hospital-specific rate for sole community hospitals. We believe that the hospital-specific rate should be updated by the update factor that approximates the percentage increase in the urban standardized amounts. These figures are consistent with the President's budget recommendation, given the current market basket forecast of 3.6 percent.

In recommending these increases, we have followed section 1886(e)(4) of the Act, which requires that we take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC. We believe our analyses, which measure changes in hospital productivity, scientific and technological advances, practice patterns changes, and changes in case mix, support our recommendations.

Comment: A few commenters agree with ProPAC's recommendation that the share of hospital wages in the market basket should be increased.

Response: We responded to this same comment in detail in the September 4, 1990 final rule (55 FR 36047), when the current hospital market basket was implemented. In addition, as we stated in the FY 1994 proposed and final rules (58 FR 30445 and 58 FR 46488), respectively, we believe that it would be equally inappropriate to use 100 percent internal (that is, hospital industry-specific) price proxies or 100 percent external price proxies. We prefer to use economy-wide proxies for those occupations that are generally employed both inside and outside hospitals, such as managers, administrators, clerical and maintenance workers. We believe that the economy-wide rate of increase is the more appropriate measure for these types of employees, since that is the relevant labor market for these employees. In contrast, we use hospital-industry proxies for those categories of workers, such as registered nurses, that are not hired in large numbers in other sectors of the economy.

Comment: One commenter stated that current law should be changed to include an allowance for scientific and technological advances. The commenter believes that this change would provide additional funds for hospitals to adopt quality-enhancing health care advances.

Response: The update framework accounts for the role of new technologies in two ways. First, we account for cost-increasing, quality-enhancing new technologies in the intensity component of our update recommendation (which is an add-on to the market basket rate of increase). Second, we account for cost-decreasing new technologies through a productivity adjustment. This adjustment allows for those technologies that allow hospitals to treat their patients at lower cost.

Comment: One commenter states that urban hospitals should continue to receive a higher standardized amount than rural hospitals because of the higher operating costs of urban facilities.

Response: Section 1886(d)(3)(A)(iii) of the Act requires that the rural standardized amount be set equal to the other urban standardized amount effective for discharges occurring on or after October 1, 1994. We note that even though rural hospitals and other urban hospitals will now receive the same standardized amount payment, hospitals in other urban areas will receive a higher standardized amount than they would have otherwise received because they benefit from the effects of applying a single outlier offset rather than separate rural and urban offsets. The reduction applied to the other standardized amount for FY 1995 is 5.1 percent compared to the separate urban offset of 5.4 percent that was applied to the other urban rate in FY 1994.

Comment: One commenter stated that reductions from the market basket are no longer necessary and that Congress should begin granting hospitals the full market basket payments once more. Another commenter asks that sole community hospitals be granted the full market basket increase because of their importance to the Medicare population.

Response: Section 1886(b)(3)(i)(X) of the Act sets the FY 1995 percentage increases in the operating cost standardized amounts and hospital-specific rates applicable to sole community hospitals. Therefore, we have no discretion in this regard. However, we believe that payments under the prospective payment system are sufficient to ensure the continued availability of efficient high quality care for Medicare beneficiaries and that the updates established by Congress are appropriate.

Comment: ProPAC has several concerns about the single intensity adjustment included in HCFA's update framework and believes that each element should be quantified separately. In addition, ProPAC believes that it is inappropriate to adjust for changes in the use of services due to reductions in cost-ineffective practices or practice patterns.

Response: We continue to disagree with ProPAC that accounting separately for changes in within-DRG complexity, science and technology changes, and practice patterns would be more accurate. In view of the interactive nature of the three elements, we believe it is difficult to measure accurately the effects of each element separately. Instead, we believe that it is more appropriate and accurate to account for all three elements in a single measure. Thus, our intensity measure is designed to encompass the net effect of all three changes. With regard to practice pattern changes, which are also reflected in our intensity adjustment, we do not adjust for changes that have not taken place.

Comment: ProPAC states that since its framework already accounts for case-mix index changes, it is inappropriate for HCFA to make prospective payments for case-mix index changes that HCFA attributes to reclassification or recalibration either through changing the weights or the standardized amounts. The Commission states that its framework already accounts for this.

Response: We believe that it is appropriate to account for case-mix index changes attributed to reclassification or recalibration within the update framework, since these changes reflect changes in relative resource requirements, not absolute resource requirements. We note that section 1886(d)(4)(C)(iv) of the Act requires that the Secretary include recommendations with respect to adjustments to weighting factors in our update recommendation.

Comment: Several commenters questioned why HCFA changed from using actual case-mix change to using projected case mix change in the update formula.

Response: Our update analysis takes into account changes in case mix adjusted for changes attributable to improved coding practices and DRG reclassification and recalibration. In the past, we used the observed increase in case mix for the most recent year available. For example we based our FY 1994 update on the observed increase in case mix from FY 1992. Recent data on case-mix change demonstrates that the growth in case mix has slowed.

The use of projected case mix allows us to take into account emerging trends in case mix more quickly. We note that ProPAC uses an estimate of the total case-mix index in the year prior to the update as part of its update framework. In our framework, we have decided to use our estimate of what case-mix change will be in the year of the update, which is consistent with the other components of the update framework.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

We received no public comments concerning our proposed recommendation on the update factor for excluded hospitals and hospital units. Therefore, our final recommendation will be that hospitals and hospital units 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. Thus, given the current estimate of the change in the market basket for excluded hospitals of 3.7 percent, our final recommendation is an update of 2.7 percent. We note that the updates for hospitals and units excluded from the prospective payment system as set in Public Law 103–66 is the market basket rate of increase minus 1.0 percentage point, adjusted to account for the relationship between the

provider's allowable operating cost per case and its target amount.

Appendix D: Development of Update Framework for Prospective Payment System for Inpatient Hospital Capital-Related Costs

I. Introduction

For FY 1992 through FY 1995, § 412.308(c)(1) provides that the update for the capital prospective payment rates (Federal rate and hospital-specific rate) will be based on a 2-year moving average of actual increases in Medicare inpatient capital costs per discharge. 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, FY 1994, and FY 1995 rulemaking documents. We received one comment, from the Prospective Payment Assessment Commission, on elements of the most recent model framework, which appeared in the May 27, 1994 proposed rule (59 FR 27876). 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. We also respond to the comment from ProPAC.

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 × "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 to maximize 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 factors, 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 any further developments. We will formally propose an analytical update framework for implementation in FY 1996 during the rulemaking process for that year. To assure consideration in the development of our formal proposal, comments should be sent by December 31, 1994 to: Update Framework, Division of Hospital Payment Policy, Health Care Financing Administration, 1–H–1 East Low Rise, Baltimore, Maryland 21207.

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. 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. 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.

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 important substantive difference between the ProPAC and HCFA frameworks. ProPAC's framework is based on the premise that capital prospective payments are only for future capital purchases and do not reflect the vintage nature of capital. Thus, ProPAC's proposed capital market basket reflects the projected increase in the purchase price of capital goods from one year to the next. HCFA's framework is based on the premise that capital prospective payments are for hospitals' future capital-related expenses, which include the expenses related to future capital-related purchases. That is, HCFA's framework addresses the input price component of 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 changes in input prices associated with 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 the disagreement with ProPAC over whether the CIPI should reflect the vintage nature of capital, we also disagree with ProPAC 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 typically 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 little or no 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 will continue to study the ProPAC recommendations in preparation for developing our formal proposal for an analytical update framework in the proposed rule for FY 1996. We provide further comments on particular ProPAC recommendations in section III of this appendix.

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), September 1, 1993 (58 FR 46490), and May 27, 1994 (59 FR 27876) 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 typically 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 that, 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 appropriately 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.

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

TABLE 1.—RELATIVE WEIGHTS FOR CAPITAL PRICE PROXIES DEPRECIATION—Continued

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
Total	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 movable 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
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.—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
Weights	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.—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.

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. We graphically demonstrated the stability of the HCFA vintage-weighted CIPI compared to annual changes in capital purchase prices in Figures 1 and 2 in our discussion of May 27, 1994 (59 FR 27882).

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 of our May 27, 1994 proposed rule (59 FR 27882) would introduce an unacceptable degree of volatility in prospective capital payments.

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 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.

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.

D. Projection of the CIPI for Fiscal Year 1995

We project a 0.9 percent increase in the CIPI for FY 1995 (Table 3). This is the outcome of a 3.1 percent increase in projected weighted depreciation prices in FY 1995, partially offset by a 3.6 percent decline in vintage- weighted interest rates in FY 1995.

E. 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.

2. 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. (See Table 3 above, and Figure 7 in the May 27, 1994 proposed rule (59 FR 27890).) 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.

• 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. (See Table 3 above, and Figure 8 in the May 27, 1994 proposed rule (59 FR 27890).)

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 above and Figure 8 (Inset) of our May 27, 1994 discussion (59 FR 27891). 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 annual 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. (See Figure 9 in our proposed rule of May 27, 1994 (59 FR 27893).) 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.

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.

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.

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 payment 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 capital 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, 1985–1992

Year	CIPI [1]	Real CMI [2]	Allowable intensity [3]	Resulting increase [4]	Percent change cost/case [5]	Residual [6]
1985	5.8	1.0	3.7	10.8	12.6	1.6
1986	4.5	1.0	2.1	7.7	20.2	11.5
1987	3.8	1.0	2.5	7.5	15.0	7.0
1988	3.7	1.0	1.5	6.3	7.2	0.9
1989	3.1	1.0	0.5	4.7	7.7	2.9
1990	2.8	1.0	0.2	4.0	6.8	2.7
1991	2.3	1.0	0.1	3.4	5.6	2.2
1992	1.8	1.0	−0.7	2.1	5.4	3.2
Cumulative (compounded)	.....	.....	.....	56.7	113.6	36.4

[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 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, 1.038×1.01×1.025=1.075 for 1987).
[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, 1.150/1.075=1.070, a 7.0 percent residual for 1987).

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 26.6 percent (1.567/2.136=0.7336, or −26.6 percent) would be necessary.

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Thursday
September 1, 1994

Part III

Environmental Protection Agency

40 CFR Part 700, et al.
Microbial Products of Biotechnology; Proposed Regulation Under the Toxic Substances Control Act; Proposed Rule

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 700, 720, 721, 723, and 725

[OPPTS–00049c; FRL–4778–4]

RIN 2070–AB61

Microbial Products of Biotechnology; Proposed Regulation Under the Toxic Substances Control Act

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing this regulation under section 5 of the Toxic Substances Control Act (TSCA), 15 U.S.C 2604, to screen microorganisms before they are introduced into commerce. Under an interpretation EPA issued in 1986 (51 FR 23302, June 26, 1986), "new" microorganisms are those formed by deliberate combinations of genetic material from organisms in different genera. This proposed rule is designed to prevent unreasonable risk to human health and the environment without imposing unnecessary regulatory burdens on the biotechnology industry. This proposed regulation describes notification procedures and microorganisms that would be exempt from notification.

DATES: Written comments on this proposed rule should be received by October 31, 1994.

EPA may hold an informal hearing in Washington, DC, if EPA receives written requests to hold a public hearing. For further information on the hearing, see Unit IV.I. of this preamble. Written requests to make an oral presentation should be submitted to the Environmental Assistance Division by October 3, 1994 at the address below. Persons are advised to call the Environmental Assistance Division after October 11, 1994 to ascertain if a hearing is to be held, and the date, time, and location.

ADDRESSES: Comments on issues concerning this proposed rule should bear the docket control number OPPTS–00049C, and should be submitted to the following address: Document Processing Center (7407), Office of Pollution Prevention and Toxics, Environmental Protection Agency, Rm. L–100, 401 M St., SW., Washington, DC 20460.

FOR FURTHER INFORMATION CONTACT: For general information including copies of this document and related materials: Susan Hazen, Director, Environmental Assistance Division (7408), Office of Pollution Prevention and Toxics, Environmental Protection Agency, Rm. EB–44, 401 M St., SW., Washington, DC 20460, In the USA: (202–554–1404), TDD: (202–554–0551). For technical information regarding this document: Paul Campanella, Office of Pollution Prevention Toxics (7405), Environmental Protection Agency, Rm. E-611, 401 M St., SW., Washington, DC 20460, In the USA: (202–260–3725).

SUPPLEMENTARY INFORMATION: The preamble accompanying this proposed rule is divided into the following Units:

I. Introduction
A. Purpose of This Proposed Rule
B. Role of This Propose Rule in the Federal Coordinated Framework for Regulation of Biotechnology
C. Statutory Framework
II. Structure of This Proposed Rule
A. Determining Whether Reporting is Required
B. General Administrative Procedures
C. Reporting General Commercial Use of TSCA Microorganisms
D. Reporting R&D Activities for TSCA Microorganisms
III. Rationale for Proposed Reporting Mechanisms
A. Research for Commercial Purposes
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C. Section 5(h)(4) Exemptions
IV. Other Issues
A. Microorganisms Covered By This Rulemaking
B. Listing Microorganisms on the Inventory
C. SNUR Process
D. Confidential Business Information
E. User Fees
F. Section 8(e) Reporting Requirements
G. Export Notification and State Preemption
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I. Introduction

A. Purpose of This Proposed Rule

This document proposes procedures for EPA to screen new microorganisms. EPA's goals in proposing these rules are to take into account scientific uncertainties surrounding the behavior of these microorganisms and avoid unreasonable risks to health and the environment which may be associated with their use, to avoid imposing unwarranted costs and restrictions on a promising industry, and to establish a flexible review program that can adjust as the technology evolves and matures.

EPA will screen new microorganisms before they are manufactured for general commercial use, or in some circumstances used for commercial research and development (R&D) purposes, until sufficient familiarity is gained with their behavior. As EPA acquires familiarity with new microorganisms through reviews or other avenues, EPA expects certain of these organisms to become eligible for reduced reporting or to be eliminated from screening altogether.

EPA recognizes the enormous potential of biotechnology to fight disease, pollution, and hunger, and to replace some chemicals that are harmful to the environment. The realization of these benefits depends upon public confidence in the safety of biotechnology. Public perception will strongly affect the conduct of field tests and the acceptance of commercial applications of biotechnology (Ref. 1). At the same time, EPA recognizes the importance of retaining the competitive advantage the United States presently maintains in the development and application of biotechnology. Recognizing that regulations can affect competitiveness and public acceptance either negatively or positively (Ref. 2), EPA is proposing rules that it believes balance the needs of the public without adversely affecting the capacity for innovation.

B. Role of This Proposed Rule in the Federal Coordinated Framework For Regulation of Biotechnology

This proposed rule implements EPA's program for oversight of microorganisms in accordance with the Federal "Coordinated Framework for Regulation of Biotechnology; Announcement of Policy and Notice for Public Comment" which was published by the Office of Science and Technology Policy (OSTP) on June 26, 1986 (51 FR 23302, 23313). EPA's policies regarding use of its statutes to regulate biotechnology products are published in the "Statement of Policy: Microbial Products Subject to the Federal Insecticide, Fungicide, and Rodenticide Act and Toxic Substances Control Act" ("1986 Policy Statement") which was published as part of the Coordinated Framework. EPA is currently operating its biotechnology program under the 1986 Policy Statement.

Prior to the 1986 Policy Statement, EPA issued a "Proposed Policy Regarding Certain Microbial Products" on December 31, 1984 (49 FR 50880) ("1984 Proposed Policy Statement"). Subsequent to the 1986 Policy

Statement, EPA issued a notice, entitled "Biotechnology; Request for Comment on Regulatory Approach" on February 15, 1989 (54 FR 7027), in order to solicit comments on the direction of EPA's program under TSCA. Comments on the 1984 and 1986 documents and the February 15, 1989 Federal Register notice are addressed, as appropriate, in this preamble.

On September 7, 1990, EPA convened a subcommittee of its Biotechnology Science Advisory Committee (Subcommittee on Implementation of Scope) to comment on topics associated with this proposed rule. EPA again convened a subcommittee, the Subcommittee on the Proposed Biotechnology Rule under TSCA, which met on July 22, 1991. Advice from both of these subcommittees has been incorporated as appropriate in this preamble, and summaries of subcommittee deliberations have been placed in the docket for this rulemaking. This proposed rule announced today is intended to describe implementation of EPA's program for regulation of microorganisms under TSCA.

C. Statutory Framework

This Unit describes the TSCA provisions used for this rulemaking.

1. *Jurisdiction.* TSCA authorizes EPA to regulate any chemical substance, except for certain substances covered by other Federal agencies. The Act defines chemical substance broadly enough to cover microorganisms. Specifically, section 3(2) of TSCA defines chemical substance, in part, as any organic substance of a particular molecular identity including any combination of such substances resulting in whole or in part from a chemical reaction or occurring in nature.

a. *Organisms are chemical substances.* The TSCA definition of chemical substance describes any deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) molecule, however created, that is a component of an organism's genetic material. Similarly, a microorganism is a chemical substance, because it is a combination of substances of particular identities that occur in nature or occur, in whole or in part, as a result of a chemical reaction (Ref. 3). EPA has consistently applied this definition to life forms and in the 1984 Proposed Policy Statement (49 FR 50886-87) clarified that this interpretation applies to microorganisms. While the statutory term "chemical substance" has been interpreted to include microorganisms, EPA acknowledges that microorganisms are not generally referred to as chemicals. Therefore, throughout this preamble, the term "traditional chemicals" will be used to refer to chemical substances other than microorganisms.

The fact that microorganisms can be considered chemical substances under TSCA only establishes EPA authority over them. Implementation of that authority requires further action, either to interpret specific terms or to issue rules. Discussion of the types of microorganisms covered in this proposal can be found in Unit IV.A. of this preamble.

b. *Plants and animals are not subject to this proposed rule.* Plants and animals could also be chemical substances under TSCA. Nevertheless, as a matter of policy, EPA has limited this rulemaking to microorganisms, e.g., microalgae of the plant kingdom. Transgenic plants and animals are not subject to requirements under this proposed rule, either as whole organisms or when their cells or parts of cells are cultured in vitro. However, microorganisms into which plant or animal gene segments are intentionally incorporated would be considered microorganisms potentially subject to TSCA. Traditional chemicals extracted from a plant or animal also may be subject to TSCA, as are other chemical substances. EPA is reserving authority under TSCA to screen transgenic plants and animals in the future as needed.

c. *Microorganisms excluded by statute.* The definition of "chemical substance" in TSCA excludes pesticides, tobacco and tobacco products, food, food additives, drugs (including human drugs, animal drugs, and animal biologics), cosmetics, and substances that are used as medical devices. These substances are regulated under other statutes by the EPA Office of Pesticide Programs, the United States Department of Agriculture (USDA), or the Food and Drug Administration (FDA).

Certain microorganisms that are subject to TSCA but are also known plant pests are regulated jointly by EPA under TSCA and the USDA under the Federal Plant Pest Act. In cases where microorganisms are not known to be plant pests, the microorganisms used for TSCA purposes would be regulated solely by EPA. However, USDA would become involved if an EPA review determined that the microorganism had plant pest qualities.

d. *Microorganisms used as intermediates.* Microorganisms may be used as intermediates to produce substances that are in turn used as products subject to TSCA or other statutes. Under the Federal Food, Drug, and Cosmetics Act (FFDCA), intermediates used to make products subject to FFDCA are considered to be components of foods, food additives, drugs, cosmetics and medical devices, as the case may be. Therefore, those microorganism intermediates are excluded from regulation under TSCA. All other intermediates, including pesticide intermediates, are subject to TSCA jurisdiction. Traditional chemicals not excluded from TSCA and produced by microorganism intermediates are subject to TSCA section 5. These chemicals produced by microorganisms are subject to the same requirements and procedures as chemicals produced by other means. EPA discussed its approach to microorganism intermediates and their products in its 1984 Proposed Policy Statement (49 FR 50887, 50890; December 31, 1984).

2. *Application of TSCA section 5.* TSCA gives EPA comprehensive authority to regulate chemical substances and mixtures of chemical substances under four major provisions. Section 4 authorizes the issuance of rules requiring testing of chemicals. Section 6 authorizes the Agency to issue substantive regulations to protect against chemicals that present an unreasonable risk. Section 7 authorizes protection against imminent hazards. EPA has based its biotechnology rulemaking efforts on section 5, the other major TSCA provision. Section 5 establishes a 90-day process for EPA to screen certain chemical substances before they are produced. Within the 90 days following receipt of notification, EPA has to decide whether to drop the substance from further consideration or to impose controls.

Section 5(a) allows EPA to require submission of a notification for two types of microorganisms, those that are considered "new" chemical substances and those that will be made for a "significant new use." In both cases, notification is not triggered by a determination that a risk is present. Risk is fully considered during or after the screening process. Those substances defined as "new chemical substances" are automatically subject to notice requirements. Chemical substances which are made for a significant new use are subject to notification when EPA issues a rule for the particular substance.

While the statute TSCA does not distinguish between the form or content of the notifications for new substances or new uses, EPA's current regulatory program, which is largely applicable to traditional chemicals, does. The notification for a new chemical substance is called a premanufacture

notice (PMN). The notification for a significant new use is called a significant new use notice (SNUN). For the biotechnology program, however, EPA is proposing to refer to either type of notification as a Microbial Commercial Activity Notice or MCAN.

Notices under section 5(a) are submitted by manufacturers of new chemical substances, and by persons who manufacture or process chemical substances for a significant new use. TSCA section 3(7) defines "manufacture" to mean import into the United States, production or manufacture. Thus, the word manufacture as used in this preamble refers to importation and any type of production, as well as to those activities that may commonly be considered manufacture. TSCA section 3(10) defines "process" as preparation of a substance, after its manufacture, for distribution in commerce.

a. *Distinction between "commercial purposes" and "general commercial use."* TSCA section 5(i) limits section 5 screening to activities "for commercial purposes." The term "commercial purposes" applies to all activities that derive actual or potential commercial benefit for persons associated with those activities. This includes R&D designed to result in a commercial product, whether or not a product is actually developed. A discussion of various options for EPA to decide what constitutes commercial purposes under this rule appears at Unit III.A.

These rules propose different review procedures for microorganisms used for commercial R&D and for microorganisms that are no longer in R&D and are intended for commercial distribution. In order to distinguish between commercial R&D and other types of commercial activity, EPA is describing use for commercial purposes beyond R&D as "general commercial use."

b. *Definition of "new."* The term, "new chemical substance," is defined at TSCA section 3(9) as a substance not on the TSCA Inventory of Chemical Substances ("Inventory") manufactured in the United States. Compilation and publication of the Inventory is a requirement imposed on EPA by TSCA section 8(b). When EPA completes review of a new substance, the substance is placed on the Inventory upon EPA's receipt of a Notice of Commencement which indicates that production has begun. At this point, the substance is no longer new, and subsequent producers do not have to submit PMNs.

EPA has a longstanding policy of not explicitly listing on the Inventory unprocessed naturally occurring substances. Instead, these substances are considered to be implicitly included on the Inventory (see 40 CFR 710.4(b)). Thus, they are not "new" and do not require PMNs.

In defining what constitutes an unprocessed naturally occurring substance, EPA has distinguished between substances isolated from nature using more or less mechanical means and those isolated from nature using more sophisticated forms of human intervention, such as chemical reactions. The latter substances remove from a natural product something that, by itself, does not exist in nature. One example is that natural latex extracted from trees is a naturally occurring substance, but the rubber formed after chemical coagulants are added is not (42 FR 64589, December 23, 1977).

EPA is retaining for this rulemaking its interpretation of "new" microorganisms as discussed in the 1986 Policy Statement. Under that interpretation, microorganisms resulting from deliberate, intergeneric combinations of genetic material constitute "new" microorganisms subject to PMN requirements. For the purposes of the Policy Statement, the Agency defined intergeneric microorganisms as those formed by deliberate combinations of genetic material from source organisms in different genera. EPA may decide to reconsider its interpretation of "new" microorganism at a later time and in aseparate rulemaking. EPA requests comment on whether it should explore alternative interpretations of "new" microorganism.

In the 1986 Policy Statement, EPA excluded from the definition of a "new" microorganism, those microorganisms that have resulted from the addition of intergeneric material that is well-characterized and contains only non-coding regulatory regions such as operators, promoters, origins of replication, terminators, and ribosome-binding regions. EPA is also proposing to retain this exclusion as part of its interpretation of "new" microorganism.

In the course of implementing the 1986 Policy Statement, the Agency recognized that it had to develop additional guidance concerning the definition of a new microorganism. It became apparent that a policy was needed to address certain genetic elements which can be transferred between microorganisms of different genera. These are termed mobile genetic elements (MGEs) and include plasmids and transposons. EPA developed additional guidance concerning whether microorganisms modified using vectors that contained MGEs or parts of MGEs were considered new. The Agency indicated that the major consideration is the source of the original isolation of the MGE. EPA stated that microorganisms would be considered "new" and thus subject to PMN requirements, if the MGE was originally isolated from a microorganism in a genus different from the recipient genus. Microorganisms would be considered intrageneric, and hence not subject to PMN requirements, if the MGE was originally isolated from a microorganism in the same genus as the recipient.

The Agency has adopted this interpretation for reasons of regulatory clarity and uncertainty about the possibility of the resulting microorganism exhibiting new traits. For example, some MGEs may contain genetic material that normally is not expressed in one microorganism but, when inserted into another microorganism, may be expressed and result in a new trait. Since the Agency plans to continue to use the 1986 Policy Statement interpretation of "new" to be intergeneric microorganisms, the Agency will continue to use this MGE guidance to clarify what microorganisms would be subject to TSCA section 5 reporting. EPA specifically requests comments on whether the MGE interpretation provides appropriate assistance for determining whether a microorganism is intergeneric or whether additional modifications which would be useful in clarifying which intergeneric microorganisms should be reported under TSCA section 5.

c. *Significant new use.* EPA determines a use is a significant new use by issuing a rule. The rule is called a significant new use rule or SNUR. Section 5(a)(2) sets forth some of the relevant considerations for issuing a SNUR. The considerations generally include changes in the type or form of exposure to a substance. Although EPA is not proposing any specific SNURs in this rulemaking, EPA is proposing to set up processes for issuing SNURs for microorganisms if needed in the future. See Unit IV.C. of this preamble for a discussion of the proposed SNUR processes.

d. *Section 5 regulatory mechanisms.* If the 90–day period provided for review of a PMN or SNUN expires and EPA has taken no action, production of the substance may begin. However, within the review period, EPA may prevent or limit production of the substance under section 5(e) or 5(f). Under section 5(e) EPA may issue an order prohibiting or limiting production of a substance, if the Agency determines that information

is insufficient and the substance may present unreasonable risk or its use may result in substantial exposure. If the notification submitter objects, the section 5(e) order does not take effect and EPA may go to court to obtain an injunction to accomplish the same goals as the section 5(e) order.

Alternatively, if EPA finds that a substance presents or will present an unreasonable risk, the Agency may, under section 5(f), go to court for an order restricting or prohibiting production or issue an administrative order or immediately effective rule to accomplish that result.

If EPA decides subsequent to Inventory listing that further oversight is needed, the Agency may use other provisions of TSCA. These could include SNURs or other rules that would require testing (TSCA section 4), information submission (TSCA section 8) or substantive restrictions (TSCA section 6).

e. *Exemptions from the section 5 notification process.* Section 5(h) provides for certain exemptions from screening. Three are relevant to biotechnology. Section 5(h)(1) allows manufacturers or processors of substances only for test marketing to apply to EPA for an exemption from full notification. Unit II.C.3. of this preamble discusses the test marketing exemption (TME) for microorganisms.

Section 5(h)(3) provides that the screening mechanisms do not apply to substances manufactured or processed only in "small quantities" for R&D, provided that persons engaged in R&D activities for a manufacturer are notified of any risks to health associated with the substance. Section 5(h)(3) authorizes EPA to define by rule what constitutes small quantities and to prescribe the form and manner of risk notification. EPA is proposing a small quantities definition that is limited to contained structure R&D uses of microorganisms. There would be no small quantities exemption for microorganisms introduced into the environment during commercial R&D, thus use of such microorganisms must be reviewed. This modification is described at Unit II.D. of this preamble. The rationale for this modification is discussed at Unit III.B. of this preamble.

Section 5(h)(4) allows EPA to exempt new substances from all or part of section 5 screening requirements, if the Agency determines, by rule, that such substances will not present an unreasonable risk. EPA is proposing to use section 5(h)(4) to exempt certain categories of microorganisms from screening as new microorganisms. Additionally, EPA is proposing under section 5(h)(4) to allow R&D introductions of microorganisms into the environment on the condition that EPA has approved them through expedited review of information submitted in a TSCA Experimental Release Application, or TERA. The TERA process is described in Unit II.D. of this preamble. EPA is also proposing other section 5(h)(4) exemptions for specific microorganisms and classes of microorganisms as described in Unit II.C. of this preamble. The rationale for all exemptions proposed under section 5(h)(4) appears in Unit III.C. of this preamble.

3. *Substantial risk notification.* Section 8(e) requires reporting by manufacturers, processors and distributors who come across information that their chemical substance could cause a "substantial risk." Section 8(e) is a self-implementing provision of TSCA. Thus, if a manufacturer, processor or distributor of a microorganism finds applicable information, that information must be submitted to EPA. Unit IV.F. of this preamble discusses section 8(e) in further detail.

4. *Applicability of TSCA section 26.* Section 26(c) authorizes EPA to take any action under TSCA for a category of chemical substances. EPA proposes to use this authority extensively in this rule. The reasons for grouping microorganisms into categories, which include new microorganisms used for R&D and certain new microorganisms manufactured for general commercial use, are explained in applicable sections.

II. Structure of the Proposed Rule

This portion of the preamble discusses the major provisions of these rules. The rationale supporting these provisions follows in Unit III. Unit II.A. describes how to determine whether reporting is required. Unit II.B. describes general administrative procedures that would be applicable to all notices submitted. To facilitate understanding of this proposed rule, requirements for microorganisms manufactured for general commercial use are discussed separately from those for microorganisms used for commercial R&D. Unit II.C. describes procedures applicable to microorganisms which are manufactured for general commercial use. Unit II.D. contains a similar description of procedures applicable to microorganisms used for R&D.

While these regulations are modelled after and incorporate many of the procedures in the existing TSCA section 5 screening program for traditional chemical substances which EPA has operated for the past decade, modifications have been made, as appropriate, to address the specific characteristics of microorganisms. In this respect, this proposed rule incorporates well-established procedures which EPA has adopted in previous rulemakings. The procedures are currently contained in the Code of Federal Regulations ("CFR") at parts 720 (premanufacture notification) and 721 (significant new use notification requirements). EPA has decided, however, to establish a new part in the CFR which applies specifically to microorganisms. EPA believes that placing regulations affecting microorganisms screened under TSCA section 5 in one place, part 725, will be more convenient and efficient.

EPA has only made changes to the procedures in parts 720 and 721 to the extent required by unique characteristics of microorganisms. EPA is therefore not soliciting comment on the procedures in proposed part 725 that are incorporated from parts 720 and 721.

EPA will only consider comments to the extent they address the new procedures and requirements in proposed part 725.

In addition to a preferred approach for certain issues, this preamble often contains a discussion of alternatives. EPA solicits public comment on the preferred approaches and the alternatives discussed in this document. Depending on public comment received on the various proposals, any of these alternatives may be adopted in the final rules.

A. Determining Whether Reporting Is Required

Manufacturers or processors would follow the process laid out below to determine whether their microorganism is subject to reporting and, if it is, how it would be treated under this proposed rulemaking. They must first determine whether their microbial products are subject to TSCA. Subpart A of part 725 contains the regulations applicable to this determination. Many microorganisms are not subject to the requirements of this proposed rule, because they are statutorily outside the jurisdiction of TSCA. Statutory jurisdiction is discussed in Unit I.C. of this preamble.

1. *Determining whether a microorganism is new or subject to a SNUR.* After manufacturers of microorganisms determine that their products are subject to TSCA, they must determine whether the microorganisms are new. Section 725.3 defines a new microorganism as one that is not

included on the Inventory. Microorganisms may be either implicitly or explicitly included on the Inventory.

a. *Implicit inclusion.* In its 1986 Policy Statement, EPA stated that intergeneric microorganisms were the only microorganisms that would not be implicitly included on the Inventory. As discussed in Unit I.C. of this preamble, EPA will continue to use the 1986 Policy Statement interpretation for this rulemaking.

b. *Explicit listing.* A microorganism is not new, if it is explicitly listed or implicitly included on the Inventory. Microorganisms are placed on the Inventory if they have been previously manufactured in the United States for general commercial use. EPA explicitly lists microorganisms that it has previously reviewed, after it is informed that production has begun through receipt of a Notice of Commencement of Manufacture (NOC) (see § 725:190). If a microorganism is not considered to be implicitly included on the Inventory, the public Inventory needs to be consulted to determine whether the microorganism is explicitly listed. Microorganisms may also be explicitly listed but treated as confidential and not placed on the public Inventory.

c. *SNUR listing.* After persons determine that their microorganisms are included on the Inventory, they must then check to see if the microorganisms are subject to a SNUR. Where appropriate, microorganisms subject to SNURs will be identified, both on the Inventory and in Subpart M of part 725. The SNUR process is discussed in Unit IV.C. of this preamble.

2. *Consulting EPA when microorganism identity or use is confidential or uncertain.* Specific situations arise under these rules when persons would need to consult listings of microorganisms to determine whether a particular microorganism, or use of a microorganism, is subject to reporting. These listings include the Inventory; Subpart M of part 725, which lists significant new use rules; and § 725.239, which lists certain microorganisms exempt from R&D reporting under part 725. The listings are explained in the text of the regulation.

There would be two specific circumstances under which it may not be possible to determine whether a particular microorganism is listed. First, the actual identity or use may be claimed confidential by a person who originally manufactured or processed the microorganism. In this case, a so-called generic name or use would appear on the public Inventory, and the actual identity or use would be on a confidential listing not available to the public. Unit IV.D. on Confidential Business Information (CBI) explains the generic name and use. The second circumstance would be that a non-confidential identity of a microorganism may not be precise enough for a person to determine whether it describes a particular microorganism that could be subject to reporting. This circumstance may arise because of the imprecision of scientific nomenclature in biology, particularly in microbiology, or because similarities in modified genetic material may raise questions of equivalency (see Unit IV.B.).

To assist persons in determining their reporting obligations, EPA has established a procedure whereby a person may file a submission establishing a *bona fide* intent to manufacture or process a microorganism and request that the Agency determine whether that microorganism is on the applicable listing. EPA's goal is to respond in 30 days to the request, informing the requestor whether there is an obligation to report under these regulations (see § 725.15). This procedure allows EPA to ensure appropriate reporting while maintaining the confidentiality of legitimate trade secrets. This is a well-established procedure in the Agency's current regulations on TSCA section 5 reporting (see §§ 720.25 and 721.11). This preamble will note when this process, known as a "*bona fide*," applies.

B. General Administrative Procedures

After submitters determine that they have a microorganism subject to TSCA section 5, they must determine what type of submission will satisfy their reporting obligations. The first decision is whether the microorganism will be used for R&D or general commercial use. The specifics of the submission and review processes for general commercial use and for R&D are covered in Units II.C. and II.D. of this preamble, respectively. However, some administrative procedures apply generally to all microorganism submissions. Therefore, general administrative procedures are discussed in this Unit.

Subpart B of part 725 contains administrative procedures generally applicable to all submissions. Most of these are rather mechanical, such as general recordkeeping requirements, procedures for determining whether submissions are complete and properly filed, how to determine when the Agency will begin the review period designated for a particular submission, and under what circumstances the Agency or the submitter may suspend, extend, or terminate a review. The more important administrative procedures are discussed in this Unit.

1. *Prenotice consultation.* EPA recommends that potential submitters begin discussions with EPA staff early in the submission planning process to identify any special data requests and preliminary concerns that may be associated with the microorganism. This may save significant time later in the review process. Any meetings and relevant written communications may be claimed confidential. Persons who are unsure as to whether their microorganisms are subject to any of the requirements of part 725 should consult with EPA before preparing any submission.

With reference to R&D, EPA recognizes that research proceeds through various stages. Potential submitters may find it advantageous to begin discussions with EPA as early as the grant proposal stage, even though they would not be required to file a submission under part 725 until the latter stages of their research program. Early consultation with the Agency could assist submitters in the planning stages of their research program in addition to providing a smoother submission and review process.

2. *Submission process.* The general requirements pertaining to the submission process are found at §§ 725.25 through 725.36.

a. *Preparing submissions.* The data to be included in submissions for microorganisms would be different from those for traditional chemicals, because microorganisms may pose different risks than those posed by traditional chemicals. To assist persons preparing submissions under this proposed rule, EPA has developed a special guidance document entitled "Points to Consider in the Preparation and Submission of TSCA Notifications for Microorganisms." At this time, a special form has not been developed for microorganism submissions. Therefore, persons preparing microorganism submissions should follow the format outlined in the guidance document. This document is available from the Environmental Assistance Division (see the address listed under the FOR FURTHER INFORMATION CONTACT Unit).

The regulatory text describes the type of information that is relevant for each specific type of submission. Submitters should submit all reasonably ascertainable information which they believe will assist EPA in evaluating the microorganisms, including information not specifically listed that submitters believe will be useful for EPA's risk

assessment. When information listed in the regulatory text is not submitted, a brief explanation of why such information is not available or not applicable should be included. Prenotice consultation may assist in identifying specific information appropriate for a submission.

b. *Incomplete submissions.* After an initial evaluation, EPA may determine that a submission is incomplete and that the review period cannot begin (see § 725.33 of the regulatory text). If EPA finds the submission incomplete, EPA will notify the submitter within 30 days of receipt of the submission and will provide the submitter with an opportunity to provide additional information. If the submitter promptly provides additional information sufficient to evaluate the effects of the microorganism, the evaluation will not be delayed beyond time for a reasonable consideration of the new information. Otherwise, EPA may declare the submission incomplete and the review period will not begin until EPA receives the necessary information.

3. *Review process.* The requirements pertaining generally to the review process are found at proposed §§ 725.40 through 725.60.

a. *Public involvement.* EPA is aware that there is considerable public interest in the review of submissions involving new microorganisms and is committed to keeping the process as open as possible. Following receipt of a submission, EPA is required by TSCA to issue a notice in the **Federal Register** describing the submission (see § 725.40 of the regulatory text). The **Federal Register** notice would include nonconfidential information on such items as the identity of the microorganism, the type of use, occupational exposure, production volume, a summary of test data included in the submission, and the submitter's identity. If microorganism identity and use are claimed confidential, EPA includes generic descriptions of this information in the Federal Register notice. Unit IV.D. of this preamble discusses confidentiality and generic descriptions. EPA would maintain a nonconfidential copy of the submission in the TSCA Nonconfidential Information Center for public inspection. The public will have an opportunity to comment on submissions received by EPA. The length of the comment period may be affected by the need to hold a meeting of experts to address a particular submission, or to consider novel scientific issues raised by the submission.

b. *State coordination.* EPA has developed comprehensive procedures to coordinate reviews of submissions and to share scientific information to the fullest extent with appropriate State and local authorities. For example, under EPA's current procedures for review of field tests under the 1986 Policy Statement, within the first week of receipt of a submission, an EPA review coordinator contacts by telephone the appropriate regulatory agencies in the State(s) where the test will be conducted to inform them of the submission. If requested, a nonconfidential copy of the submission is mailed to the State. If a site visit is to be conducted, EPA staff contacts State and EPA regional personnel early in the review period to begin coordination of the site visit. Nonconfidential reports, assessments, and public comments added to the Public Docket are routinely made available to State personnel upon request. In addition, State personnel receive a copy of EPA's draft risk assessment, and comments and concerns raised by the State(s) are given careful attention in the risk assessment. At the conclusion of the review period, State personnel receive a copy of any document which addresses the conditions under which the field test can be performed.

EPA is also requiring that persons who are preparing submissions for R&D activities provide evidence of having notified appropriate State authorities (see § 725.255 of the regulatory text). Submission of copies of any correspondence with State authorities concerning the proposed field trial, for example, would satisfy this requirement. EPA also strongly encourages such submitters to inform communities located near potential test sites of their plans to introduce microorganisms into the environment.

c. *Use of experts.* In performing assessments, EPA intends to supplement its staff expertise as necessary by using experts from other government agencies, academia, and other independent sources. EPA assessments may be reviewed by a subcommittee, composed of scientists with relevant expertise, of EPA's Biotechnology Science Advisory Committee (BSAC) at a public meeting. Certain portions of the meetings may be closed to discuss confidential business information (CBI). EPA will consider all BSAC Subcommittee recommendations in its final decisions. Procedures have been developed to ensure that experts contributing to EPA's biotechnology reviews will not have conflicts of interest.

d. *Changes to the review process.* The review period starts on the date EPA determines the submission is complete and runs for a period of time specified for each submission type. A submitter may voluntarily withdraw a submission at any time, or suspend the review period for a specified period of time. Suspension of the review period may be beneficial when questions that arise during the notice review period require additional time to address. For good cause, EPA may extend the review period up to a total of the length of time specified for each type of submission.

4. *Recordkeeping and compliance.* The requirements for recordkeeping, compliance, and inspections are found at §§ 725.65, 725.70, and 725.75, respectively. In addition to recordkeeping requirements generally applicable to all submissions, EPA is proposing recordkeeping requirements specific to each submission type. For certain exemptions from full reporting under section 5, the recordkeeping requirements are a key part of compliance with the exemption. Compliance and inspection requirements are the same as those for traditional chemicals.

5. *Petitions to exempt new microorganisms.* Provisions for applications to request exemptions for new microorganisms from the requirements of all or part of part 725 are found at § 725.67.

C. Reporting General Commercial Use of TSCA Microorganisms

This Unit discusses who is subject to microbial commercial activity notice (MCAN) reporting, the MCAN submission and review process, and exemptions from MCAN reporting for general commercial use.

1. *Determining whether MCAN reporting is required.* Subpart D of part 725 would require, with some exceptions, submission of a MCAN by persons who intend to manufacture or import new microorganisms, and by persons who intend to manufacture, import, or process microorganisms for a significant new use. A MCAN must be submitted 90 days before manufacture, import, or processing of the microorganism for commercial purposes. Because EPA has a separate, less burdensome, screening process for R&D involving microorganisms (see Unit II.D. of this preamble), the Agency expects that, in general, the MCAN will be submitted only for microorganisms for general commercial use.

2. *MCAN submission and review process*—a. *MCAN submission process.* The purpose of EPA's review of MCANs would be similar to EPA's purpose in

reviewing PMNs and SNUNs submitted for traditional chemical substances. The purpose of a MCAN would be to provide EPA with information necessary to identify and list a microorganism on the TSCA Inventory (if the microorganism is new) and to determine whether the microorganism would pose an unreasonable risk to human health or the environment. EPA must conduct a review that considers all the reasonably ascertainable information on potential human health and environmental effects of a microorganism. The information to be included in the MCAN is listed in §§ 725.155 and 725.160 of subpart D. Submitters must develop a MCAN that describes the characteristics and construction of the new microorganism as well as describing conditions of manufacture and use. In addition, submitters must reference any published literature on the microorganism and its parental strains and submit available data from laboratory, greenhouse studies, and/or R&D field tests using the microorganism.

b. *MCAN review process.* All reviews of microorganisms will follow established administrative steps that are the same for all chemical substances subject to 90-day review. For good cause, EPA may extend the initial review period by an additional 90 days, for a total of 180 days. During this time the microorganism cannot be manufactured or processed for commercial purposes.

c. *Regulatory decision.* EPA may reach one of three decisions during the review period based on a balancing of the risks and benefits presented by the microorganism: There is sufficient information to determine that the risks will not be unreasonable; there is sufficient information to determine that the risks are unreasonable; or there is insufficient information to make a reasoned evaluation of risk, and the substance may present an unreasonable risk or there may be significant or substantial human or environmental exposure to it.

Unless EPA notifies the submitter to the contrary, the submitter may begin to manufacture and use the microorganism at the end of the 90–day period. However, if the information available is insufficient to reasonably evaluate the risk and the substance may present an unreasonable risk, EPA may issue an order under TSCA section 5(e) to limit or prohibit the manufacture, processing, distribution in commerce, use, or disposal of the microorganism. In the past, EPA has found it useful to negotiate with submitters to develop consent orders, sparing both the submitter and EPA the legal proceedings that may be involved in a unilaterally issued order. Under a consent order, the submitter generally agrees to develop additional information or to accept certain restrictions in return for permission to proceed with its plans to manufacture or import the substance.

In the situation where EPA decides that risks will be unreasonable, it may use TSCA section 5(f) to require measures to reduce risks to an acceptable level as a condition of manufacture and use. Alternatively, EPA may prohibit manufacture or use, if there are no measures available or practicable to sufficiently reduce the risk.

3. *Exemptions from MCAN reporting.* Persons intending to manufacture new microorganisms for general commercial use may not have to submit a MCAN prior to commencing manufacture, if the microorganisms they intend to use qualify for exemptions from MCAN reporting. This unit discusses one exemption developed for traditional chemicals that will not be applied to microorganisms and two exemptions that are applicable to microorganisms.

a. *Low volume exemption.* EPA has previously promulgated rules providing for an exemption from the notification requirements of section 5 of TSCA for new chemical substances produced for general commercial use in volumes less than 1,000 kilograms per year (see 40 CFR 723.50). This exemption requires applicants to submit a notice to EPA 21 days before manufacture begins to provide the Agency an opportunity to review the chemical. EPA believes that this exemption is inappropriate for microorganisms, which have the ability to reproduce, disseminate, and transfer genetic material. EPA is therefore proposing to amend § 723.50 to state that the exemption provisions of that section do not apply to microorganisms.

b. *Test marketing exemption.* Test marketing activities usually involve limited sale or distribution of a substance within a predetermined period of time to determine its competitive value when its market is uncertain. EPA is required by TSCA section 5(h)(6) to grant or deny the test marketing exemption (TME) no later than 45 days after receipt of an application. Subpart F of part 725 proposes the requirements for obtaining a TME. These requirements are adopted verbatim from § 720.38, the Agency regulations that currently apply to all chemicals substances.

In general, EPA suggests that manufacturers who intend to test market new microorganisms file a MCAN rather than a request for a TME. However, there may be situations in which this exemption may be appropriate, such as for microorganisms which were previously reviewed by EPA at the R&D stage. EPA encourages anyone who is considering requesting a TME for a new microorganism to begin prenotice consultation as early as possible, so that EPA can determine if it would have sufficient information to determine that the test marketing activities would not present an unreasonable risk.

c. *Tiered exemption for general commercial use.* Under TSCA section 5(h)(4), EPA is proposing to exempt from MCAN requirements certain new microorganisms manufactured for general commercial use which it has determined will not present an unreasonable risk. Subpart G of part 725 contains the conditions for this exemption, which consists of two tiers, each based on certain criteria discussed below. The rationale for this exemption appears in Unit III.C.7. of this preamble. Microorganisms produced under this exemption would not be listed on the Inventory.

(i) *Tier I.* Manufacturers meeting Tier I requirements will be completely exempt from review by EPA. They would submit a one-time certification statement to EPA 30 days prior to the first use of a microorganism eligible for a Tier I exemption. The conditions for this exemption are listed at § 725.424. The statement must include information identifying the manufacturer or importer, the location of the facility involved, and a statement certifying that the manufacturer complies with all the criteria required for the Tier I exemption. Information in the statement may be claimed confidential. A certification would be required for the first use of an eligible recipient microorganism at a specific facility. Subsequent uses of the same recipient microorganism at the same facility would not require additional certification, so long as the manufacturer complied with the other Tier I exemption conditions.

(ii) *Tier II.* Manufacturers meeting the requirements at proposed § 725.428 may submit an exemption request to EPA 45 days prior to use of the microorganisms, if they believe that containment conditions other than those listed at proposed § 725.422 would still allow the requirements of the exemption to be met (see § 725.455 of the regulatory text). Information included in such a submission may be claimed confidential. Submitters must certify in the request that they have complied with the requirements. EPA would approve or deny an exemption request within 45 days and could impose

restrictions to ensure that the microorganisms would not present an unreasonable risk (see § 725.470 of the regulatory text).

(iii) *Criteria for the exemption.* Three conditions are placed on the Tier I and Tier II exemptions. The recipient microorganisms must be listed at proposed § 725.420, the introduced genetic material must meet certain requirements, and performance-based criteria for containment and inactivation of the new microorganisms are to be used.

(A) *Recipient microorganisms.* EPA is proposing that new microorganisms certified to be developed using a recipient species or strain listed at proposed § 725.420 would qualify for the tiered exemption.

(B) *Introduced genetic material.* The introduced genetic material used to modify the recipient microorganisms must be well characterized, limited in size to the genetic material required to perform the intended function, and poorly mobilizable (see § 725.421 of the regulatory text). Further explanation of these terms appears in Unit III.C.7. of this preamble. In addition, genetic material which encodes for all or part of the toxins listed in proposed § 725.421(d) may not be used to modify any recipient microorganism.

(C) *Containment and inactivation.* EPA is also proposing performance-based criteria for limiting exposures. These criteria would have to be used for the Tier I exemption, because EPA would not review these activities prior to production. For the Tier II exemption, because the containment and inactivation controls would be reviewed in the exemption request, the criteria would serve as guidance for submitters. Proposed § 725.422 lists the criteria for containment and inactivation at a facility.

(iv) *Exemption applications.* Using the provisions in proposed § 725.67, individuals may submit an application under section 5(h)(4) requesting that a recipient microorganism be added to the exempt list. Submitters may request an exemption with different conditions. EPA would evaluate the request using appropriate procedures under section 5(h)(4).

D. Reporting R&D Activities for TSCA Microorganisms

This Unit discusses EPA's proposal for which microorganisms are subject to R&D reporting and recordkeeping, exemptions from R&D reporting, and the TSCA experimental release application (TERA) submission and review process.

1. *Overview of considerations for determining whether a researcher has TSCA section 5 obligations for R&D activities.* Persons planning to conduct R&D activities involving new microorganisms subject to TSCA may be subject to these rules. While any researcher may submit a complete MCAN as required for general commercial use, EPA is proposing a number of exemptions from MCAN reporting that reduce researchers' reporting obligations under TSCA section 5. All R&D activities are eligible for reporting using the TERA process which is discussed below. However, EPA expects that the TERA will be used primarily for environmental experiments. Laboratory and other research in contained structures would more likely comply with certain recordkeeping requirements provided under TSCA section 5(h)(3) in the rule. Finally, certain research may be exempt from TSCA section 5, because EPA has determined review is unnecessary altogether or it is appropriate to defer in whole, or in part, to another Federal agency.

The series of considerations to be used to determine TSCA section 5 obligations for R&D activities is displayed in chart form in Figure 1 below. The following paragraphs summarize the steps on Figure 1.

The first three steps list the issues that must be addressed for determining if any substance is subject to TSCA section 5 reporting, whether for general commercial use or for R&D activities. The subsequent steps are employed to determine R&D obligations. Determining whether an R&D activity is subject to TSCA jurisdiction and whether the microorganism is intended for commercial purposes are discussed below in Units II.D.2.a. and 2.b., respectively. Determining whether a microorganism is "new" for the purposes of TSCA section 5 is discussed in Unit I.C. of this preamble.

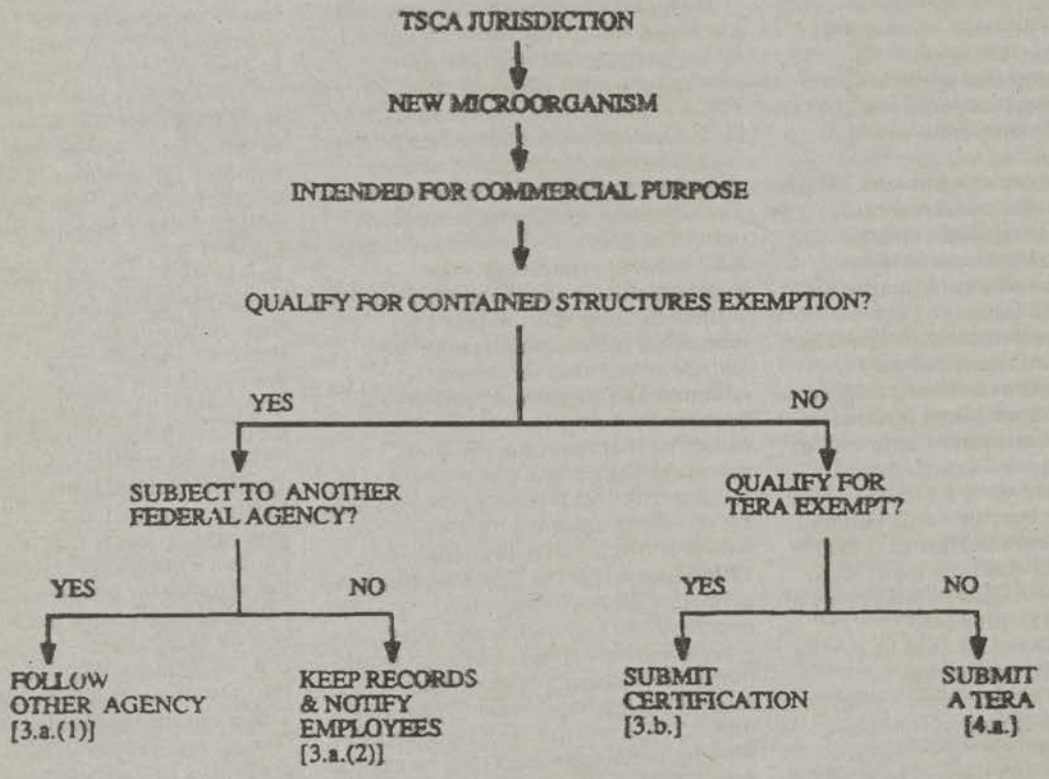
If researchers have determined that their R&D activities are subject to TSCA jurisdiction, are intended for commercial purposes, and involve new microorganisms, their R&D activities will be subject to some obligations under TSCA section 5. Researchers would then proceed through the remainder of the questions to determine their reporting status. They would first determine whether their R&D activities are eligible for the contained structures exemption. This determination is discussed below in Unit II.D.2.c.

The next question deals with other agencies. An R&D activity that is eligible for the contained structures exemption may also be subject to the authority of another Federal agency. Overlapping jurisdiction for R&D conducted in contained structures is discussed below in Unit II.D.2.d.

If the R&D activity does not qualify for the contained structures exemption, TERA reporting would next need to be considered. However, EPA is also proposing in this rulemaking a category of specific microorganisms that are exempt from TERA reporting. Thus, researchers who are not eligible for the contained structures exemption and/or for deferral to another agency may qualify for a specific TERA exemption. The determination of whether the research qualifies for a TERA exemption is discussed below in Unit II.D.2.e.

Figure 1 shows the four distinct types of TSCA section 5 obligations existing for R&D activities. The reporting requirements for each of these obligations are discussed below in Units II.D.3. and 4. The corresponding paragraphs are noted on the following Figure 1.

DETERMINING TSCA SECTION 5 OBLIGATIONS FOR R&D ACTIVITIES



2. *Specifics for determining eligibility for R&D exemptions.* The five points which researchers must consider in order to determine their TSCA section 5 obligations for R&D are discussed in this paragraph.

a. *Determination that the R&D activity is subject to TSCA jurisdiction.* Statutory jurisdiction is discussed in Unit I.C. of this preamble. As noted in that Unit, uses of some microorganisms are specifically excluded from TSCA section 5, because they are subject to other statutes. Uses that are not specifically excluded are subject to TSCA. When developing the initial TSCA Inventory, EPA indicated that undifferentiated uses of chemical substances would be subject to TSCA (42 FR 64585, December 23, 1977). In the 1986 Policy Statement, EPA stated that unless the uses were explicitly excluded by TSCA, "all microorganisms produced for environmental, industrial, or consumer uses are potentially regulable under TSCA" (51 FR 23324, June 26, 1986). Thus, EPA would consider that R&D activities involving new microorganisms where researchers are unsure of the final use would be subject to TSCA section 5. This would include microorganisms in early stages of research, where the researchers have not determined a specific commercial application of the microorganism. As noted in Unit II.B. of this preamble, researchers who are uncertain of the status of their microorganism, for any reason, should consult EPA regarding their TSCA section 5 obligations.

b. *Determination that the R&D activity is intended for commercial purposes.* TSCA section 5 covers only uses of new microorganisms for commercial purposes. EPA discusses its interpretation of commercial R&D in Unit III.A. of this preamble. The Agency is proposing three alternative interpretations of commercial purposes. Depending on public reaction to the alternative interpretations discussed in this proposal, the interpretation of commercial R&D could differ from one R&D activity to another in a final rule, if public comment supports different interpretations for different types of R&D activities.

c. *Determination that the R&D activity is eligible for the contained structures exemption.* This exemption would most likely apply to research performed in contained structures such as pilot fermentation plants, greenhouses, laboratories, and certain bioreactors used for waste treatment. The term "structure" is defined in proposed § 725.3. Research involving intentional testing of microorganisms in the environment would not be eligible for this exemption. Requirements for the exemption are in section 3 of this Unit. The rationale for this exemption is discussed in Unit III.B. of this preamble.

d. *Determination that oversight of the R&D activity is also subject to the authority of another Federal agency.* Some R&D activities may be subject to the authority of another Federal agency in addition to EPA. Where there is overlapping jurisdiction for R&D activities that are eligible for the contained structures exemption, EPA proposes to defer to the other Federal agency which has authority for oversight over such activities. This would apply to researchers who are

receiving funding from the other Federal agency, which requires that researchers comply with the "NIH Guidelines for Research Involving Recombinant DNA Molecules" ("NIH Guidelines") in order to receive funding. Researchers who are voluntarily complying with the NIH Guidelines but are not actually receiving funding from a Federal agency would not be eligible for the deferral.

e. *Determination that specific microorganisms are exempt from TERA reporting.* EPA is proposing exemptions from TERA reporting for certain new microorganisms derived from the microorganisms *Bradyrhizobium japonicum* and *Rhizobium meliloti*. R&D involving these microorganisms performed in accordance with specified conditions would be exempt from review. Additional microorganisms may be exempted by rule under section 5(h)(4), as EPA gains familiarity with them. Unit III.C.5. of this preamble discusses the rationale for this exemption.

3. *Requirements necessary for eligibility for exemptions from TERA reporting.* Once researchers have determined which exemptions their R&D activities are eligible for, they must determine their specific TSCA section 5 obligations. Proposed §§ 725.232 through 725.239 specify the requirements for each of the exemptions from TERA reporting.

a. *The contained structures exemption—(i) R&D subject to another Federal agency.* R&D activities which are eligible for the contained structures exemption (see § 725.234(a) and (c) of the regulatory text) but are also subject to the oversight of another Federal agency will be exempt from the requirements of TSCA section 5. If researchers comply with the other agency's requirements, there will be no EPA-specific requirements (see § 725.232 of the regulatory text).

(ii) *R&D not subject to another Federal agency.* This document proposes that R&D eligible for the contained structures exemption but not subject to another Federal agency must be conducted in accordance with proposed §§ 725.234 (containment and recordkeeping) and 725.235 (employee notification). Although researchers that comply with these provisions are not required to report to EPA under TSCA section 5, the recordkeeping and employee notification requirements would apply and would be enforceable by EPA.

There are two types of standards in §§ 725.234 and 725.235. The employee notification standards of § 725.235 are taken directly from current regulations in §§ 720.36 and 721.47, and are the same as those for traditional chemical substances. Section 725.234 contains general research standards but adds some provisions that apply specifically to microorganisms. However, these additional provisions are minor changes to EPA's current requirements for the research exemption, and these provisions should be standard practices for research activities involving microorganisms.

Specifically, the small quantities exemption for traditional chemical substances requires research to be conducted by, or directly under the supervision of, a technically qualified individual (TQI). This is a requirement under EPA's current regulations at §§ 720.36 and 721.47. Section 725.234 applies the same requirement to microorganisms eligible for the contained structures exemption.

Section 725.234 states that the TQI must select appropriate measures to control release of the research microorganism, write a brief description of the reasons for choosing the measures and ensure maintenance of records to document routine use of the selected controls. In addition, the choice of control measures must be certified by an authorized official of the institution at which the research is conducted. Finally, EPA may request that the records be sent to EPA for review. Subsequent to such review, EPA may in some circumstances offer recommendations to modify control or documentation measures. In what EPA anticipates would be rare occurrences, EPA might order the researcher to modify controls or documentation measures. Failure to comply with such an order would result in loss of eligibility for the exemption for the specific R&D activity.

For those researchers who are voluntarily complying with, but are not subject to, the NIH Guidelines, the requirements of the contained structures exemption could be met by having the principal investigators serve as the TQIs (see § 725.234(b) of the regulatory text) and keep records indicating that they abide by the NIH Guidelines.

b. *Exemption from TERA reporting for specific microorganisms.* In order to be exempt from both TERA reporting and MCAN reporting, persons using the exemptions for microorganisms listed in § 725.239 must comply with the general requirements for the exemption listed in § 725.238 as well as any specific requirements listed in § 725.239. Similar to its proposal for the tiered exemption for general commercial use discussed in Unit II.C., EPA is proposing to place restrictions on the recipient microorganisms, the introduced genetic material, and the conditions of use (see § 725.239 of the regulatory text).

4. *TERA submission and review process.* EPA is proposing to establish the TERA, which is an abbreviated notification process for environmental testing of new microorganisms.

a. *TERA submission process.* Sections 725.255 and 725.260 detail specific information that should be submitted with a TERA. The basic microorganism identity information is the same as that for the MCAN. Other information requested specifically addresses the proposed R&D activity and therefore is not as extensive as the MCAN information.

b. *TERA review process.* EPA's goal is to review TERAs in 60 days (see § 725.270 of the regulatory text). For good cause, EPA could extend the initial TERA review period by an additional 60 days, for a total of 120 days (see § 725.56 of the regulatory text). Due to the small number of experiments that have been conducted and the uncertainty concerning field tests that involve new microorganisms, EPA expects that initial TERA reviews may take closer to 120 days. During the prenotice consultation, EPA would estimate for the submitter whether the review is likely to require closer to 120 days or 60 days.

Generally, EPA believes that approval of TERAs in 60 days or less would be possible for field tests that are similar to previously reviewed field tests (for example, use of the same or similar microorganisms, modifications to a previous test, or change in geographic conditions). When novel circumstances are presented in a TERA, however, EPA may need to extend the review period in order to complete its review. Specific examples of extension for good cause would include the need for a subcommittee meeting of the Biotechnology Science Advisory Committee to supplement Agency expertise or the need to coordinate review with other Federal agencies. When EPA coordinates the review of a microorganism with another Federal agency, the review period would automatically be extended to the length of the other agency's review, to allow the two agencies to coordinate reviews and decisionmaking. TERA submitters may not proceed with their field trials until EPA has provided written approval of the TERA submission. As soon as EPA completes its review, however, researchers will be able to start their test immediately upon notification from EPA.

c. *Regulatory decision.* EPA will approve a TERA if it determines that the experiment(s) will not present an

unreasonable risk to human health or the environment. If the submission is approved, EPA may negotiate with the submitter a TERA Agreement, which would be legally binding on all parties and would set out any conditions governing the conduct of the specific field trial (see § 725.270 of the regulatory text). The TERA Agreement could include provisions for maintaining restrictions on the use of the test site after the completion of the test. This may require the submitter to make appropriate arrangements with the owner of the test site, in cases where the submitter does not own the test site. If EPA concludes that the proposed R&D activity may present an unreasonable risk of injury to human health or the environment, EPA will deny the TERA and will provide reasons for the denial in writing. Section 725.288 provides for revocation or modification of TERA approvals following the receipt of additional information.

5. *Options for oversight of R&D activities*—a. *Range of options possible.* EPA's intent in offering a variety of alternatives for oversight of R&D activities was to provide a flexible process which tailored oversight to the level of risk. In developing TSCA section 5 obligations for R&D activities using new microorganisms, EPA looked at a range of options. These fall on a continuum ranging from an option which would exempt all R&D activities under a small quantities exemption similar to the exemption for traditional chemicals to an option which would require TERA reporting for all R&D activities, including those conducted in laboratories and other contained structures.

As discussed in Unit III.B. of this preamble, because microorganisms can multiply and spread beyond the site of introduction, EPA must redefine the small quantities definition applied to traditional chemicals. EPA developed the TERA process, because it believes that review of environmental uses of microorganisms should begin during the R&D stage. At the same time, EPA does not believe that all microorganisms used in all R&D activities should be subject to TERA reporting. Neither of the extreme options seemed appropriate to EPA for coverage of R&D, because they would not be tailored to potential risk. Thus, EPA chose an intermediate approach.

In keeping with the goals of the Coordinated Framework, EPA has included in its proposed option opportunities to address overlapping jurisdiction with other Federal agencies. EPA has attempted to balance the Coordinated Framework's goal to reduce duplicative oversight with TSCA section 5's goal to screen for potential unreasonable risks. As discussed in Unit III.B. of this preamble, in developing its requirements for the contained structures exemption, EPA selected an approach which recognized the diversity of microorganisms which would be used in research and therefore left to the researcher the choice of appropriate containment and inactivation controls. Additionally, in order to keep the TERA process flexible, EPA has developed a provision allowing microorganisms tested in the environment to be exempted from TERA reporting as the Agency gains more familiarity with them.

EPA requests comments on its proposed option for R&D activities for TSCA microorganisms. In particular, EPA would like to know whether commenters feel that the flexibility provided by the various exemptions available under the proposed option counterbalances the complexity of the approach. The public may suggest other options along the continuum, providing those options also meet the intent of TSCA and adequately protect public health and the environment from unreasonable risks. In addition to the proposed option, when EPA prepares its final rule, it will consider the variety of options along the continuum discussed above, as well as options suggested by the public.

b. *Specific alternative for low risk field tests.* EPA realizes that there are a variety of possible options along the continuum discussed above. Although EPA has decided that case-by-case review is important for many microorganisms intentionally tested in the environment, EPA recognizes that there will be low risk field tests that would not require TERA review. For this reason, some have suggested an alternative exemption for certain R&D releases. This alternative, which is similar to the R&D contained structures exemption in that it would be dependent on determinations made by a TQI, would apply to certain low risk field tests and would be included with the exemptions which are part of the proposal for coverage of R&D activities under TSCA section 5. Like the proposed exemption for R&D in contained structures, this alternative would contain requirements for documentation and recordkeeping by a TQI and certification by an authorized company official. It would also provide for EPA to inspect records and order changes, if necessary.

Under this alternative, a company planning a small-scale field test which meets the eligibility requirements for the exemption would have the option of submitting a TERA for review by EPA or submitting a notice with the determination that the field test qualified for the exemption. The alternative includes a number of requirements which are intended to minimize the likelihood of inconsistent determinations.

The TQI would be expected to make the determination that the new microorganism was eligible for the exemption, based on the following: (1) The test site must be 10 acres or less of land, (2) the parent microorganism(s) must have a history of safe use, and (3) the introduced genetic material must be limited in size, well-characterized, free of certain nucleotide sequences, and poorly mobilizable. Further explanation of the terms in (3) appears in Unit III.C.7. of this preamble.

In determining that the parent microorganism has a history of safe use, EPA would expect researchers to be able to classify taxonomically the microorganism and to evaluate its relationship with closely related microorganisms which may have a potential for adverse effects on human health or the environment. Information on the potential for the microorganism to cause adverse effects on human health and the environment should be evaluated.

EPA recognizes that a determination that a microorganism has a history of safe use involves a balancing of various factors. This determination should be premised on the researcher's prediction of the behavior of the microorganism based on experience with its use. The more information the researcher has on the behavior of the microorganism (for example, the ability to establish, compete, and survive in the environment), the better the researcher can estimate the safety of the field test. In conducting their risk assessment, researchers should consider the scale, since the tests must be conducted on 10 acres or less of land.

An additional requirement for this alternative exemption would be that an official having authority to represent the organization (e.g., the Chief Executive Officer, the General Counsel) certifies that the determination has been made by a TQI and is considered to be the official position of the organization. The official would also be required to state that the organization accepts full liability for all potentially harmful consequences of the field test. To show that relevant considerations had been evaluated, a TQI would be required to prepare a written analysis to be kept in the company's records. These records would be kept for 5 years from the date

of the field test, with EPA retaining the right to review the records upon request. In lieu of a TQI, the analysis could be performed by a third party review group with relevant scientific expertise (i.e., ecological expertise) as exemplified by the Institutional Biosafety Committees (IBCs) described in the NIH Guidelines.

Following the TQI's determination, the researcher would be required to submit a short notice to EPA, providing the organization name and address, a summary of the new microorganism and the proposed field test, the name of the TQI, and the official certification, including the liability statement. EPA would have 45 days to determine whether to require submission of a TERA before the researcher could conduct the planned field test.

EPA requests comments on this alternative approach for low risk field tests. In particular, EPA would like to know whether there are other criteria which would be appropriate for defining a category of low risk small-scale field tests and what additional guidance would be needed for researchers to utilize such an approach. The rationale for this alternative exemption is discussed in Unit III.C. of this preamble.

III. Rationale for Proposed Reporting Mechanisms

A. Research for Commercial Purposes

1. *Introduction.* TSCA section 5(i), while it limits all section 5 screening to activities for commercial purposes, has had little practical effect on research using traditional chemicals, because of the research exemption. However, because this proposed rule would place more requirements on research with microorganisms than on research with traditional chemicals, EPA believes it should provide its current view on the applicability of the commercial purposes limitation to this proposed rule.

As a preliminary matter, there is no difficulty in determining when any chemical substance, including a microorganism, is being manufactured or processed for a commercial purpose after the R&D stage. It is clear when a PMN is required or when a MCAN would be required at general commercial use.

Research on traditional chemicals is not generally affected by the commercial purposes limitation, because EPA's current regulatory definition of small quantities for R&D using traditional chemicals (any amounts reasonably necessary for research) at § 720.3 effectively exempts research with these chemicals from section 5 screening. However, as noted in Unit III.B. of this preamble, these rules propose a small quantities definition for microorganisms; and this definition, because it would recognize the ability of microorganisms to reproduce, would differ from the definition for traditional chemicals. A researcher utilizing microorganisms, therefore, may need to consider what constitutes a commercial purpose.

Research involving microorganisms used in contained structures would be considered "small quantities solely for research and development" as defined at § 725.3 of the regulatory text. Although EPA expects the requirements for this contained structures exemption simply to reflect common practices, a researcher may have to evaluate whether research conducted in contained structures is commercial. The contained structures exemption would not apply to field testing of microorganisms because of the ability of living microorganisms to reproduce and spread in the environment (see Unit III.B. of this preamble). As a result researchers will, in all cases, need to decide which environmental testing is commercial.

EPA wishes to emphasize that any coverage of research under this proposed rule should not duplicate appropriate oversight by other Federal authorities. As explained in Unit III.C.3. of this preamble, contained research appropriately overseen by other Federal agencies would be exempt from EPA oversight, because EPA believes such research does not present an unreasonable risk. As a practical matter, therefore, while testing conducted at institutions that do not normally consider themselves commercial (academic and non-profit institutions) could theoretically be commercial under interpretations discussed in this Unit, EPA anticipates that other parts of these rules will exempt much of the research from EPA oversight.

2. *Public comments.* During development of regulations on biotechnology, EPA has received numerous public comments that differ substantially on oversight of research. Of particular concern has been the appropriateness of EPA review based on the status of an activity as commercial rather than on its potential risk.

Comments argue that there is no reason to suspect any difference in risk between commercial or noncommercial research. Thus, if a university and a business release the same microorganism in similar settings, both should be subject to oversight.

On the other hand, comments suggest there may be risk differences. Some argue that a commercial enterprise is more likely to be careful than a noncommercial institution due to concern for liability. Others argue that academic researchers are more likely to be concerned with, and aware of, the need to consider health and environmental safety issues and that commercial entities may be willing to take shortcuts in the interest of reducing costs.

Other comments complain that increased government regulations may have a deleterious effect on academic research, because it may be more difficult for pure research institutions to comply. Burdens that are relatively minor for a business could be major for a university or an individual researcher.

Comments have also indicated that a number of practical difficulties increase the burden on research institutions. For example, increasingly complex and intermingled financial arrangements in the biotechnology field have emerged as universities seek funding from businesses. These arrangements may result in universities conducting product development for money or equipment donations from business. Undue burdens to academic researchers can result from requirements that research which is funded by a commercial entity be distinguished from that funded by a noncommercial entity, particularly when a university may pool its funds from various sources.

Finally, even though an academic research institution may engage in product development for a business, the institution may not be engaging in a commercial activity for its own benefit. For example, a university may use income from a commercial entity to improve its teaching and its ability to increase knowledge. Industry could be an important source of income for upgrading equipment used for teaching.

The remainder of this Unit discusses EPA's view of the law and policy and responds to these public comments.

3. *EPA's view of the law as it applies to commercial activities at noncommercial institutions.* EPA wishes to make it clear that the interpretations discussed in this Unit are consistent with interpretations in current regulations. That is, a commercial activity is one undertaken with the purpose of obtaining an immediate or eventual commercial advantage. This is the common thread in § 720.3(r) which defines "manufacture or import for commercial purposes" and § 721.3 which defines "process for commercial purposes." Similarly, § 720.30(i) provides that "non-commercial research and development" consists of activities

conducted by academic, government, or independent not-for-profit organizations "unless the activity is for eventual commercial purposes."

All research conducted directly by a commercial entity is clearly for commercial purposes, as was decided in *The Dow Chemical Company v. EPA*, 605 F.2d 673 (3d Cir. 1979). Consequently, if a business directly funds a research activity for product development, the activity is for commercial purposes, regardless of the location. A business may not avoid review by simply funding research at an academic institution.

In section 5, Congress distinguished between commercial and noncommercial activities and, thus, expected them to be treated differently. Although the statute has no definitive explanation as to what this distinction means, it does not appear to have been risk-based. EPA believes that Congress did not provide a definitive explanation and therefore left to the Agency's discretion the balancing of competing interests. TSCA section 2(b) states that it is the policy of the United States that TSCA authority should be exercised so as not to "impede unduly or create unnecessary economic barriers to technological innovation," while fulfilling the primary purpose of assuring that innovation does not present unreasonable risks.

If EPA considers that section 5 provides a screening mechanism, as opposed to a direct regulatory mechanism, EPA has an indication why the commercial purposes limitation applies. Under other TSCA provisions, EPA may regulate without regard to a commercial purposes limitation. For example, the commercial purposes limitation does not apply to EPA's authority under TSCA section 6 to prohibit or limit manufacture, processing, or distribution in commerce of chemical substances if the Agency finds that the particular activities present an unreasonable risk.

By providing a commercial purposes limitation for EPA to cover early phases of product development, Congress recognized the need for EPA to balance the competing interests of fostering innovation and protecting human health and the environment from unreasonable risk. In balancing these interests, EPA could construe the commercial purposes limitation to exclude relatively few activities during screening to cover a broad range of risk possibilities. Therefore, the broadest meaning of commercial purposes would miss hardly any research.

4. *Alternative interpretations affecting which activities at noncommercial institutions will be considered commercial.* Any of the three alternative interpretations of commercial purposes set forth below, as well as any other interpretation that is suggested by public comment and meets the intent of TSCA and adequately protects public health and the environment from unreasonable risks, may be adopted by the Agency in its final rule. Regardless of the alternative chosen, EPA would encourage researchers to voluntarily consult with EPA to find out if EPA considers their research to be commercial.

a. *Indicia of commercial purposes.* The usual way to interpret a statutory term of art like "commercial purposes" would be to look for indicia of commercial intent. This is what EPA does in its TSCA section 5 program for traditional chemicals. The Agency has not provided any detailed public discussion of what these indicia may be for traditional chemicals, but because the Agency will be reviewing R&D activities in its biotechnology program, a discussion of these indicia for the biotechnology program is appropriate.

While EPA may develop a general discussion, no exhaustive list of commercial indicia can be developed *a priori*. If EPA adopts this approach, the commercial indicia would apply to R&D in laboratories and other contained structures, as well as to intentional testing in the environment. Some environmental testing of new microorganisms would not be screened, because it would not be for commercial purposes.

EPA acknowledges that noncommercial institutions may find it difficult to trace funding for particular activities or to decide whether an activity is commercial or not. However, EPA supports this alternative, under the theory that the burdens of reporting to EPA are costs of doing business for any organization that wants the benefits of commercial financing. In addition, EPA believes that reporting at the research stage under this proposed rule does not impose an unnecessary burden on innovation and that the indicia described below would be consistent with the intent of TSCA. There are two general categories of commercial indicia for activities at nonprofit institutions; one involves industry involvement, either directly or indirectly; the other does not.

(i) *Direct industry involvement.* As noted above, any direct industry involvement in an activity at a noncommercial institution is for commercial purposes. Examples of direct commercial funding include situations in which a commercial entity contracts directly with a university, or gives a conditional grant where the commercial entity holds patent rights, or establishes a joint venture where the commercial entity holds patent or licensing rights.

(ii) *Indirect industry involvement.* Indirect benefits to the commercial entity are not as clear. For example, a commercial entity may give a gift to a research institution with no limits on the use of the funds or research results. However, since the funds originated from a commercial source, a commercial purpose may nonetheless exist. Other indirect relationships between commercial and noncommercial entities need to be considered. For example, a commercial entity may guarantee a university bank loan for research, a faculty member associated with biotechnology research may have a financial interest in a biotechnology company, research may be conducted at a science park jointly owned by a university and commercial enterprises.

(iii) *No industry involvement.* If there is no industry involvement, EPA needs to look at the intent of the individual researcher or institution. Entrepreneurial faculty members may obtain financial rewards from their own inventions. Some may take out personal patents or derive personal income. The university may benefit from the patents or may sell products or services commercially, for example, to farmers. Because products may be sold to consumers, EPA is inclined to consider these activities commercial. However, if profits are used to support research or improve teaching facilities, EPA may recognize a case for considering the activity not to be commercial.

EPA could also consider activities supported by Federal or State government to be commercial. Many of these government activities are designed to foster economic benefits for particular groups, such as farmers. Also, the government may support university centers for technology transfer to industry. The issue may be philosophical, regarding whether government economic activities benefit individuals or the general welfare. EPA believes there are legitimate arguments for either view.

Finally, EPA may consider all activities at a nonprofit institution to be commercial if any activity is. Thus, if a company finances one activity at the university, all of the university's research may be considered commercial. If a university has an equity interest in a biotechnology company or a faculty member is associated with a firm, all the university's research activities may be considered commercial. This

interpretation is supported by the fact that commercial activities free resources for noncommercial activities.

If EPA interprets all these situations strictly, for practical purposes, almost all research could be commercial. EPA notes for comment, however, not-for-profit institutions that obtain self-generated funds through charitable or religious donations and government grants for pure research to identify health or environmental hazards. These situations may not be commercial under any circumstances.

Regardless of the alternative chosen for environmental research, EPA would base its interpretation of commercial purposes for research qualifying for the contained structures exemption on the broad set of indicia discussed under this first alternative, in light of its belief that EPA requirements for contained commercial R&D are similar to requirements placed on academic researchers by the NIH Guidelines. See Unit III.B. of this preamble. Therefore, the second and third alternatives would apply only to research which does not qualify for the contained structures exemption.

b. *All environmental research is commercial.* Because of the ability of microorganisms to reproduce, disseminate and spread and the features of intentional testing in the environment, EPA believes it should propose another interpretation to address such testing. Under this interpretation, all intentional testing outside of contained structures would be commercial. This interpretation would avoid the most significant problem identified by comments, which is that there is no real difference in risk between research conducted by industry and by noncommercial entities.

As discussed more fully in Unit III.B. of this preamble, microorganisms function differently than other chemical substances. Because R&D involving the introduction of new microorganisms into the environment involves greater uncertainty than R&D involving use of microorganisms under contained conditions, EPA believes that a different position is warranted for intentional testing of microorganisms in the environment.

Because the TERA burden is structured to be minimal, EPA believes reporting will not seriously restrict academic R&D. In fact, this interpretation of commercial purposes in some respects could lessen the burden on universities, because they will not have to separate their industry funding from other funding that they may not consider commercial.

While considering all environmental releases to be commercial may seem contrary to the usual view, the actual status of funding for the biotechnology industry supports this interpretation. Research relationships in biotechnology are pervasive and take many forms. According to an Office of Technology Assessment (OTA) report,

> in recent years, the rapid proliferation of collaborations in biological research, involving partnerships between universities, industry and government, has greatly extended the frequency, scope and visibility of such activities. Attempts to commercialize biological techniques have occurred at an accelerated rate when compared to other fields, involving a greater range of commercial application than discoveries in most other disciplines. (Ref. 4, page 13).

Even the United States government is involved, under the Technology Transfer Act, in the commercialization of biotechnology, having developed a technology transfer policy between universities and industry with the goal of developing commercially useful products. Nonprofit foundations also participate in activities for commercial purposes, often to finance other nonprofit activities.

c. *Rebuttable presumption of commercial activity.* The same arguments for the option that all environmental releases are commercial support the rebuttable presumption option. The rebuttable presumption is also supported by the need to distinguish commercial and noncommercial activities under TSCA. The above discussion of commercial indicia indicates the types of evidence that a researcher may present to rebut the presumption. However, EPA believes that this option would be burdensome to researchers, because it would require them to maintain evidence concerning sources of funding for each environmental experiment. EPA also believes that this approach would be less protective of public health and the environment, because it does not adequately address uncertainty about the behavior of new microorganisms in the environment.

d. *Voluntary consultation.* EPA recognizes that regardless of the interpretation of commercial purposes adopted for the final rule, it will be difficult to apply any one interpretation in all cases. For this reason, EPA would encourage persons who believe that they are engaging in non-commercial R&D to voluntarily consult the Agency before initiating testing of microorganisms that would be considered new if used for commercial purposes.

B. Exemption for Research in Contained Structures

This Unit explains EPA's reasons for exempting from section 5 screening R&D activities performed under conditions that would minimize the number of microorganisms emitted, or where appropriate prevent emission of microorganisms from structures such as pilot fermentation facilities, greenhouses, and laboratories. The R&D reporting process is discussed in Unit II.D. of this preamble.

1. *Background.* The statutory authority for this exemption is TSCA section 5(h)(3). Section 5(h)(3) exempts from section 5 screening chemical substances manufactured or processed in small quantities solely for R&D, and directs EPA to define small quantities by rule. Accordingly, proposed § 725.3 provides that R&D activities involving microorganisms would qualify for the section 5(h)(3) exemption when these activities are conducted under conditions designed to meet appropriate standards of containment and when employees are notified of risks. Some R&D activities which are eligible for the contained structures exemption may also be subject to the jurisdiction of another Federal agency. In these cases, EPA proposes to defer to the authority of the other Agency. The rationale for this proposed deferral is discussed in Unit III.C.3. of this preamble.

2. *Difficulties in ensuring that microorganisms used for R&D will not increase beyond small quantities.* EPA's current regulations for traditional chemicals at § 720.3(cc) define "small quantities solely for R&D" as those quantities that are "not greater than reasonably necessary for ... [R&D] purposes." This definition of small quantities for R&D has been appropriate for traditional chemical substances, because these chemicals do not have the ability to increase their own volume or amount. To the extent a finite amount of a traditional chemical released during an experiment may leave a test site, it will only be diluted in the environment.

Living microorganisms are not, however, subject to these same limitations. Microorganisms may reproduce and increase beyond the number initially introduced, may establish in the environment (i.e., develop a self-sustaining population), and may spread beyond the test site. Thus, what begins as a small, localized population of microorganisms may become a large, widespread population. Even if certain microorganisms do not exhibit the ability to reproduce, increase in number, establish, and spread beyond the test site, they may be capable of

passing some of their traits to other microorganisms in the environment. These other microorganisms may, in turn, multiply, establish, spread and subsequently pass the acquired trait to other microorganisms. This could result in widespread propagation of the trait, and exposure of a number of different environments to novel traits.

These abilities of living microorganisms render the general definition of small quantities that applies well to traditional chemicals invalid for microorganisms. If the definition developed for traditional chemicals was applied to living microorganisms, EPA would not review microorganisms until they were produced for general commercial use. New microorganisms could be released, with no EPA review, during R&D testing in the environment, perhaps numerous times, and could become established and spread. This would defeat the purpose of TSCA, which is designed to permit EPA to review chemical substances before they become widely disseminated.

Consequently, a determination of what constitutes small quantities for microorganisms requires that more factors be taken into consideration than are considered for traditional chemicals. These factors revolve around the probability that a microorganism will establish itself in the environment. Establishment is a key consideration, because unless a microorganism establishes, any effects it might have would probably be spatially and temporally limited. Several factors influence whether a microorganism will be able to establish itself. These include the numbers of microorganisms involved, the frequency with which they are applied to the area, the method of application, the characteristics of the microorganism, the physiological condition of the microorganism at the time of application, and the characteristics and condition of the receiving environment.

Case histories of both disease epidemics and invasions of higher organisms suggest that the number of organisms present in the inoculum directly influences whether the introduction yields a self-sustaining population (Ref. 5). Experience with microorganisms used in biocontrol (i.e., purposeful use of microorganisms as antagonists to reduce the disease-producing ability of plant pathogens) has shown that success in some instances can be enhanced if a large number of the biocontrol microorganism is introduced (Ref. 6).

It can be inferred from this information that the number of organisms, both with regard to the density of the inoculum and the geographic range over which it is introduced (Refs. 7 and 8), is related to probability of establishment. Several hypotheses on why this may be so can be offered. In some cases, mortality in the introduced population can be overcome if the inoculum contains a large number of individuals. In other situations, a large inoculum population may provide sufficient genetic variation that individuals that can tolerate or prosper in the environment of introduction will be within the inoculum (Refs. 9 and 10). A biocontrol strategy that relies on the inoculum containing large numbers of microorganisms is thought to be successful because the introduced microorganisms may by sheer numbers have an advantage in reaching and filling available suitable microhabitats, availability of suitable habitat being a limiting factor for any population of organisms.

The frequency with which organisms are released to an environment also affects whether an organism can establish. Frequent releases increase the likelihood that the microorganism will find sites favorable for establishment by increasing the total number of microorganisms placed in the environment and by increasing the probability that a microorganism will be introduced during a time favorable for establishment. This latter probability is related to factors such as the variations in temperature, moisture, light, and biota observed with seasonality. In other words, conditions favorable for establishment may exist at some period of time and not at others, and frequent application increases the probability that some individuals will be at the right place at the right time.

3. *Regulatory conditions to prevent microorganisms used for R&D from increasing beyond small quantities.* EPA's proposed standards at §§ 725.234 (containment and recordkeeping) and 725.235 (employee notification) are designed to reduce the probability of establishment by reducing the number and frequency of viable microorganisms emitted from a facility. The reduced probability of establishment increases the probability that a microorganism will remain a small quantity.

EPA is proposing performance-based standards for this exemption. EPA's approach relies on the experience and judgement of the TQI, and EPA will not generally substitute its own judgement for that of the TQI. The approach recognizes that many different kinds of microorganisms displaying a wide range of characteristics could potentially be used in research, and that for certain microorganisms, emission of only a few viable individuals could cause an effect, while emission of large quantities of viable microorganisms of another type would not. It also recognizes that the type of controls (e.g., procedural, mechanical, and/or engineering) appropriate for one microorganism might have limited relevance to other microorganisms. EPA expects that the TQI will be cognizant of these factors when selecting containment and inactivation controls appropriate to the microorganism(s) being utilized.

EPA does not believe the documentation requirements proposed for this exemption will be overly burdensome. EPA believes that for most cases, laboratory notebooks normally kept in the course of research will contain most of the information required by this proposal. Control measures selected could be indicated by reference to existing standards (e.g., one of the containment levels described in the NIH Guidelines). The TQI would simply record the reasons for choosing particular measures. With regard to the requirement that records document use of the selected controls, EPA is relying on the TQI to prepare and retain the appropriate degree of documentation. The amount of documentation would be correlated with the characteristics of the research microorganism and standard practices employed to address risk. Thus, documentation could range from general documentation of routine standard operating procedures, to specific notations in laboratory notebooks, to daily log entries for microorganisms that present the greatest risk concerns. If the NIH Guidelines are used as guidance, the TQI's notebook should indicate the level of containment recommended by the Guidelines and that this guidance was selected and used. EPA believes that persons following the NIH Guidelines would keep adequate records as part of normal procedures for informing their Institutional Biosafety Committee of the contained research.

With respect to the certification requirement, many if not most research institutions have Institutional Biosafety Committees (IBCs) as required by the NIH Guidelines, or committees fulfilling a similar role. These committees are charged with assessing the containment selected by the investigator. EPA recognizes the value of this NIH system and would like to make its requirements consistent to the extent possible with such existing systems. The Agency also encourages the active use of such committees.

The provision which indicates that EPA may request these records be sent to EPA for review (see § 725.234(d)(3) of the regulatory text) is a restatement of the authority EPA has under TSCA section 11 to request and review information. It is also similar to provisions used by EPA in other exemptions. In the three exemptions from PMN reporting under part 723 that currently exist for traditional chemicals, one of the conditions for eligibility for the exemptions gives EPA access to the records demonstrating eligibility for the exemptions. EPA can require a company to produce the records upon EPA's written request.

EPA does not plan to routinely review such records, although it may choose periodically to select some records for review. Should the institution or researcher receive a request for records review, the status of the research as exempt would not *a priori* be affected. Technical staff with experience reviewing TERA and MCAN submissions would examine the records. This provision allows EPA and the researcher to discuss what constitutes appropriate control measures and appropriate implementation and use. Under this provision, EPA may, upon review of the records, offer recommendations concerning what it considers appropriate control measures for the specific microorganisms used in the research. These recommendations would be non-binding. If EPA determines, however, that the control measures selected and used are so inadequate as to present an unreasonable risk, EPA can issue an order directed at modifying the control measures it finds problematic. Refusal to comply with an order would result in loss of eligibility for the exemption for the research in question. The researcher would then be subject to the notification requirements of TSCA section 5.

EPA's criteria at proposed §§ 725.234 and 725.235 are designed to reduce the probability of establishment by reducing the number of viable microorganisms emitted from a facility. However, EPA's proposed approach also takes into consideration factors such as the physiological condition of the microorganisms and how this might affect the ability of microorganisms to establish in the environment. Microorganisms used in laboratory research are more likely to be debilitated with regard to their ability to compete in the environment against wild type relatives. Thus, they may be less likely to prevail in the struggle in nature for limited resources. In general, incidental releases of microorganisms from research facilities are less likely to occur under conditions which favor the establishment of the microorganism. Incidentally released microorganisms may be physiologically debilitated by aerosolization or other process procedures, and may be less likely to find an environment that favors their survival and persistence than those microorganisms that are specifically tested in an environment where they are intended to survive, at least long enough to perform a specific function.

EPA recognizes that parts of the rationale offered for exempting research conducted under the conditions set forth in proposed § 725.234 can be applied to some small-scale field tests involving microorganisms. The rationale cannot, however, be applied to small scale field tests as a class. Microorganisms intentionally tested in the environment are more likely to be acclimated to the environment into which they are introduced, be physiologically fit enough to be competitive in that environment for a significant period of time, and be placed in an area suitable for growth and persistence. Because of the lessons learned with biocontrol microorganisms, researchers will purposefully apply large enough numbers to ensure that the microorganism persists long enough and competes well enough to perform the function the researcher intends to study. In general, the probability that these types of microorganisms, used under these conditions, will establish is thus higher than the probability associated with incidental emissions from facilities employing EPA's proposed criteria.

4. *Alternative reasons for the research exemption.* An alternative rationale would hold that the small quantities exemption in section 5(h)(3) does not apply to microorganisms as a class, because some microorganisms, whether they are released through intentional testing or incidental emission, can establish even though the initial inoculum is very small. For some microorganisms, a single microorganism may be a sufficient inoculum for establishment to occur. Thus, for microorganisms as a class, there can be no concept of "small quantities" similar to that envisioned for other chemicals.

EPA would find, however, that research conducted under the criteria specified in §§ 725.234 and 725.235 could be exempted under TSCA section 5(h)(4). EPA's authority under TSCA § 5(h)(4) is discussed in Unit III.C. of this preamble. In situations where the EPA criteria at §§ 725.234 and 725.235 are followed, EPA believes that the resulting reduction in the number of microorganisms emitted from R&D facilities will reduce the probability that a microorganism will establish in the environment. This reduced probability of establishment leads directly to a reduction in risk. If a microorganism does not establish, its ability to present risk is far less likely to be expressed. If the microorganism is not able to establish, any adverse effects that might be associated with that microorganism will probably be spatially and temporally limited.

EPA recognizes that some research activities may present special considerations; e.g., when the research utilizes microorganisms that can successfully establish from a very small inoculum. In such cases, incidental emission from the facility may have to be much more stringently controlled to reduce risk. EPA believes that its requirement that a technically qualified individual (TQI) select and validate procedures appropriate to the microorganism addresses this concern. That person should select, validate, and follow procedures that would ensure that insufficient numbers of viable microorganisms are emitted from the facility for establishment to occur.

EPA believes that any potential risk presented by incidental releases from research facilities that might occur, even when its criteria for reducing the number of microorganisms emitted from the facility are followed, is outweighed by the benefits to society of biotechnology research. EPA can use its limited resources, which otherwise would be used to review these low risk research activities for microorganisms, for reviewing higher risk activities and microorganisms. Industry, by having this exemption, can develop and test microorganisms in the early stages of the product development process (e.g., laboratory) without having to be reviewed by EPA. This would reduce the time and cost for industry in developing new products. More time and resources could be allotted for actual R&D and less time and resources allotted to EPA notifications. This should assist the development of this industry and the emergence of new, useful products, and thus not present an unreasonable risk of injury to human health and the environment.

5. *Alternative methods of reducing the number of microorganisms emitted.* EPA believes its proposed approach to reducing the number of microorganisms emitted from research facilities is preferable to more prescriptive approaches which have been suggested. The suggested approaches include setting a specific numerical standard for the number of microorganisms that

might be incidentally released to the environment from a research facility, prescribing a single standard based on one of the containment levels described in the NIH Guidelines, or an approach wherein several increasingly stringent levels of containment are described and specific microorganisms are matched to specific levels. These three approaches would be complex and unwieldy to implement. Because of their prescriptive nature, such approaches would result in EPA regulating the containment standards rather than exempting the research. This would unnecessarily restrict research contrary to the intent of TSCA. Each change to a prescriptive standard would have to be incorporated into the standards through rule amendments or variance procedures. Establishing prescriptive standards could restrict advances in technology for controlling microorganisms and stifle individual initiative at the research level.

C. Section 5(h)(4) Exemptions

1. *Introduction*—a. *Statutory background.* Section 5(h)(4) of TSCA provides that EPA may exempt by rule the manufacture of any new chemical substance from all or part of the requirements of section 5, if it is determined that activities involving the substance will not present an unreasonable risk of injury to health or the environment. A section 5(h)(4) rule must be promulgated under the procedures set forth in TSCA sections 6(c)(2) and (3), which generally require preparation of a rulemaking record and an administrative hearing. EPA is proposing to use section 5(h)(4) to support various exemptions from the notification requirements of the rule.

The term "unreasonable risk" is not defined in TSCA. Section 6(c) of TSCA lists considerations for determining whether a chemical substance presents an unreasonable risk for purposes of promulgating regulations under TSCA section 6. These considerations include the effects of the substance on human health and on the environment and the magnitude of exposure to the substance, the benefits of the substance for various uses, the availability of substitutes for such uses, and the reasonably ascertainable economic consequences of the potential regulatory action, considering effects on the national economy, small business, technological innovation, the environment, and public health. EPA believes it is reasonable to consider these factors in determining whether a risk is unreasonable under section 5(h)(4).

TSCA offers no further direct guidance on what constitutes unreasonable risk. In particular, TSCA does not discuss how each of the section 6(c) considerations are to be weighed in relation to each other. The legislative history, therefore, needs to be considered. The House Report (H.R. Rep. 94-1341, 94th Cong., 2d Sess. at 13-15, 32) provides the most useful pertinent explanation. First, the standard under TSCA is "unreasonable" risk, not a decision to eliminate all risk (House Report at 15). For an activity that is of some value to society, some level of risk may be acceptable. With respect to section 5(h)(4), granting an exemption does not require a showing that there will be no risk, only that there will be no unreasonable risk.

The House Report states that the unreasonable risk standard cannot be defined in precise terms but, instead, requires exercise of judgment by the decisionmaker. The House Report describes the finding of unreasonable risk as involving a balancing of the probability that harm will occur, and the magnitude and severity (potential consequences) of that harm, against the effects (social and economic) of proposed action on society.

According to the House Report, these evaluations of harm often must be based on considerations of "scientific theories, projections of trends from currently available data, modeling using reasonable assumptions, and extrapolations from limited data" (House Report at 32). The unreasonable risk standard recognizes that, as a practical matter, all the scientific evidence is uncertain to some degree and that EPA can consider such factors as the strength of the evidence on toxicity, the nature of the effects that may occur (e.g., death vs. reversible effects), and the likely numbers of individuals exposed and the levels of exposure.

The House Report points out that the unreasonable risk standard is flexible enough to allow EPA to calibrate the stringency of a regulatory measure to the levels of risks and benefits. Thus, a testing rule, because it does not deprive the public of the benefits of a chemical, requires a lesser showing of harm compared to a rule which may remove a substance from the market or impose other restrictions on its availability. Similarly, a stronger showing would be required to ban an activity than to impose lesser restrictions on use or a requirement, such as labelling, that does not restrict directly.

The greater the probability and the more severe the potential harm presented by an activity EPA may allow, the less likely a no unreasonable risk finding can be made. Similarly, the greater the benefit of the activity, the greater the risk to be tolerated. Determinations of whether an exemption should be partial or full will depend on the probability and severity of the harm and the benefits to be derived from the activity. Less restrictions should apply if there are substantial benefits from the activity and the probability of harm appears to be lower or the consequences are of low concern.

b. *Summary of section 5(h)(4) exemptions.* EPA is proposing to use its authority under TSCA section 5(h)(4) to establish six separate types of exemptions. These are partial exemptions that involve limited reporting and/or recordkeeping for new microorganisms that meet the eligibility requirements of the specific exemptions. Five of these exemptions specifically relate to R&D activities. The sixth case is a tiered exemption for general commercial use.

Because each exemption involves a different set of issues, each exemption requires a different weighing of risks and product benefits. The remainder of this unit sets out the no unreasonable risk findings for each of the exemptions. For each exemption, a review of the relevant scientific risk considerations is followed by a discussion of the social and economic benefits resulting from microbiological products. The extent to which both risks and benefits are considered is dependent on the breadth of the exemption.

2. *Alternative finding of no unreasonable risk for microorganisms used for R&D in contained structures.* The reasoning for this alternative finding relies on the factors discussed in Unit III.B. of this preamble for research that meets the criteria at proposed §§ 725.234 and 725.235 for R&D conducted in contained structures. See Unit III.B. of this preamble for a full discussion of the rationale for exempting research in contained structures.

3. *Deferral to other Federal authorities for oversight of R&D.* Unit II.D. of this preamble describes a proposed exemption from this regulation for research controlled by other federal authorities. This section provides EPA's reasons for establishing this exemption. The exemption is based on the general policy that TSCA should not apply to research adequately overseen by other federal authorities.

TSCA jurisdiction is discussed in Unit I.C. of this preamble. Generally microorganisms controlled by other Federal agency authorities, other than those microorganisms regulated under FIFRA or FDA authorities, are also

subject to TSCA. Agencies, such as the Animal and Plant Health Inspection Service (APHIS) of the U.S. Department of Agriculture (USDA), have regulatory authority that overlaps TSCA authority for microorganisms. Research subject to TSCA may also be funded by Federal agencies, such as the Department of Defense (DOD), the Department of Energy (DOE), the National Institutes of Health (NIH), the National Science Foundation (NSF), USDA's APHIS or its Office of Science and Education (S&E), or EPA's own Office of Research and Development (EPA/ORD).

On November 23, 1976, all Federal agencies represented on the Federal Interagency Committee endorsed the NIH Guidelines. Departments which support or conduct laboratory rDNA research agreed to abide by the Guidelines in June 1983 (48 FR 24577). Because of the 1983 agreement, as a condition for Federal funding of rDNA laboratory research, institutions must ensure that all rDNA research conducted at or sponsored by the institution, regardless of the source of the funding, complies with the Guidelines.

a. *Finding of no unreasonable risk for R&D in contained structures subject to the authority of other Federal agencies.* This proposed rule would provide an exemption for research in contained structures (principally laboratories) covered by the NIH Guidelines. EPA considers the NIH Guidelines to provide the primary standard for laboratory research. EPA's rules are designed to provide complementary oversight of those activities not covered by NIH. As a result, EPA is proposing a complete exemption under TSCA section 5(h)(4) for research on new microorganisms in contained structures, if the researcher is required to comply with the NIH Guidelines. This may be achieved through direct regulatory authority or through requiring recipients of Federal funds to comply with the NIH Guidelines. Without this exemption, the recordkeeping and employee notification requirements of proposed §§ 725.234 and 725.235 would apply to this research. EPA's summary analysis of the NIH Guidelines may be found in the docket which supports this rulemaking.

EPA proposes under TSCA section 5(h)(4) to exempt from the requirements described in proposed §§ 725.234 and 725.235 the manufacturers, producers and importers of new microorganisms for R&D in contained structures, if the research is regulated or funded by a Federal agency which has agreed to abide by the NIH Guidelines.

The pertinent parts of EPA's regulations applying to R&D in contained structures are § 725.234(b) and (d). They require a technically qualified individual (TQI) to maintain documentation that describes the selection of containment and inactivation procedures and ensures the procedures are followed. The TQI's selections must be approved and certified by an authorized official of the institution conducting the experiment (§ 725.234(d)(2)). EPA may request the records, review containment/inactivation controls and may order changes in containment/inactivation procedures (§ 725.234(d)(3) and (d)(4)).

These provisions are designed to complement the NIH Guidelines and extend their benefits, without imposing an overly rigid regulatory regime. EPA's regulation is in the same spirit as the NIH Guidelines in that it is also based on the fact that all conceivable experiments cannot be foreseen and that it is the responsibility of the experimenting institution to devise appropriate containment. Like NIH, EPA emphasizes the importance of the motivation and good judgment of the investigators.

Because the NIH Guidelines are very well entrenched in the research community, EPA expects that the procedures chosen by the TQI will very closely follow the Guidelines. In addition, any EPA review of records will rely heavily on the Guidelines. Thus, by establishing the provisions of proposed § 725.234(d), EPA would effectively apply Guideline principles to those institutions, primarily commercial facilities, that are not required to abide by them. This would complement the NIH request for voluntary compliance.

Further, the NIH Guidelines apply directly only to those microorganisms, and categories of microorganisms, that have been listed in the Guidelines and, in particular, Guideline Appendices A through F. Other microorganisms would require specific review by NIH. EPA regulations extend the benefits of the NIH Guidelines by effectively applying their principles to microorganisms other than those specifically mentioned in the Guidelines.

At the same time, by not incorporating the Guidelines directly into regulations, EPA would avoid overly rigid adherence to Guidelines that are, themselves, meant to be flexible. EPA, however, retains sufficient control to protect against risk by the review procedures in proposed § 725.234(d)(3) and (d)(4).

Requiring researchers to adhere to the proposed requirements of §§ 725.234 and 725.235 as well as to the requirements of these other federal authorities would be a duplication of oversight and enforcement that would unnecessarily restrict potentially beneficial research without any incremental reduction in potential risk. Thus, there would be no increase in risk from removing the TSCA section 5 restrictions placed on contained structure R&D. Further, costs will be reduced, because there would be no costs incurred in complying with TSCA. R&D would be encouraged without an attendant increase in risk. Therefore, the risks of exempting this research from the TSCA section 5 contained structure R&D restrictions are far outweighed by the costs saved. Accordingly, EPA finds there will be no unreasonable risk from this exemption.

b. *Federal agency R&D subject to TERA reporting.* EPA has also considered how it might use its TSCA section 5(h)(4) exemption authority to minimize duplicative reviews of environmental release tests that are also subject to other Federal agencies. EPA has determined that a different exemption process should apply to experiments in the environment than to contained experiments. While the NIH Guidelines are recognized as a standard for contained R&D, the same situation does not pertain to R&D activities involving releases to the environment. Accordingly, EPA is planning to propose the procedures outlined below for exemptions from the TERA process for deliberate release experiments reviewed by other Federal agencies.

With agencies that have clear regulatory authority, EPA would propose to exempt from TSCA section 5 requirements intentional environmental testing of new microorganisms and to defer to the other Federal agency's review, when EPA determines that the other Federal agency's review addresses criteria equivalent to those which would be evaluated under TSCA section 5. When EPA develops such an exemption involving deferral to another Federal agency, it will propose the exemption using notice and comment rulemaking. EPA is currently working with USDA-APHIS to develop an exemption for R&D field tests reviewed by APHIS under the Federal Plant Pest Act and the Plant Quarantine Act and implementing regulations at 7 CFR part 340 and hopes to include such an exemption when the rule is promulgated.

4. *Finding of no unreasonable risk for TERA approval of new microorganisms*—a. *Background.* EPA recognizes that many small-scale tests will not present unreasonable risks and that requirements restricting R&D could stifle innovation contrary to the intent

of TSCA. Therefore, under section 5(h)(4) EPA is proposing to conditionally exempt from MCAN notification R&D involving certain new microorganisms. The exemption is conditional, since researchers must submit a TERA.

EPA's current experience with reviewing PMNs for microorganisms used for R&D in the environment under the 1986 Policy Statement has indicated that EPA could more efficiently review these activities. While the current process provides an adequate mechanism, R&D activities present a very different risk assessment situation than general commercial use. Differences in exposure, the ability to apply procedures for controlling routes of exposure or dissemination and the procedures for controlling potential risks, and the need for flexibility in R&D comprise different risk assessment scenarios than found in general commercial use. As a result, in light of these different scenarios, a more straightforward and flexible approach to reviewing experiments for new microorganisms is indicated. The TERA provisions of this proposed rule will provide such an approach.

A TERA provides for submission of information commensurate with the nature of the R&D process, because the review is focused on a specific R&D activity. Therefore, not as much information is required compared to a MCAN. For example, persons who submit a TERA would not have to include information on all commercial manufacture, processing, transport, use, and disposal activities that may involve the new microorganism as is the case for a MCAN.

The more flexible deadlines and procedures for the TERA would avoid unnecessary delays or restrictions on experiments. TSCA imposes a 90–day waiting period for section 5(a)(1) screening; and persons who submit MCANs must wait at least 90 days before an activity can begin, even if EPA should determine no unreasonable risk is posed by the activity before the 90–day review period expires. A similar waiting period may not be appropriate for experiments when more rapid decisions can be made. If TERA review shows that an experiment poses little or no risk, EPA could notify the submitter to proceed at any time during the review period prior to expiration of the review clock.

b. *No unreasonable risk determination.* EPA has decided that case-by-case review is required to determine the potential risk presented by a microorganism which may establish in the environment during the course of a field trial. The review would allow EPA to determine if it would be necessary to set limitations to minimize the probability of establishment and dissemination in the environment. Microorganisms intentionally tested in the environment are more likely to be acclimated to the environment into which they are introduced, be physiologically fit enough to be competitive in that environment for a significant period of time, and be placed in an area suitable for growth and persistence. Researchers generally apply large numbers of microorganisms to ensure that they persist long enough and compete well enough to perform the function the researcher intends to study. This fact increases the probability that microorganisms used under these conditions could establish and possibly pose a risk or result in significant exposure. Therefore EPA has concluded that R&D which involves intentional testing of microorganisms in the environment should be subject to some review.

EPA has balanced a number of considerations to determine that experiments reviewed under a TERA will not present an unreasonable risk to health or the environment and should be exempt from MCAN requirements. First, TERA review should result in no greater risks than those that might occur as a result of the MCAN process, because the no unreasonable risk criteria for approval are the same for either process. Second, TERA review may even reduce risks in some instances by allowing EPA to focus resources on activities that may pose the greatest potential for risk. Third, TERA review will reduce reporting costs by eliminating Agency need for information and procedures that are unnecessary for R&D. Fourth, when compared to the MCAN process, TERAs should encourage technological innovation and have a beneficial effect on small businesses engaged in R&D utilizing new microorganisms.

5. *Finding of no unreasonable risk for microorganisms proposed for exemption from TERA reporting.* EPA recognizes that some field experiments with new microorganisms do not need to be reviewed at all. EPA therefore intends to exempt from review some R&D experiments with certain new microorganisms. EPA will, however, still review any general commercial uses of these new microorganisms through the MCAN process. The no unreasonable risk finding for exemption from TERA reporting is based on the interaction of three principal criteria addressing the recipient species, the introduced genetic material, and procedures for limiting exposure during experimental use. The three criteria must be considered in concert, because any potential concerns raised in one set of criteria may be balanced or compensated by other criteria. These criteria are discussed in more detail in Unit III.C.7. of this preamble.

EPA requests comment on whether this approach should be used to exempt from TERA screening certain new microorganisms. EPA is proposing certain intergeneric strains of *Bradyrhizobium japonicum* and *Rhizobium meliloti* as candidates for exemption from TERA review, based on reviews of voluntary PMNs submitted under the 1986 Policy Statement and field test data generated in these field trials. Persons possessing information which they believe would support an exemption from TERA reporting for other new microorganisms may use the procedures in proposed § 725.67 to apply for such an exemption.

EPA proposes to list *Bradyrhizobium japonicum* and *Rhizobium meliloti* as acceptable recipient species. Both are well-characterized taxonomically and have been used in the environment for over 80 years to improve nitrogen fixation in specific agricultural crops. There is extensive information on these two species documenting the lack of adverse effects in the environment, and no reports exist that they are pathogenic to humans or animals. In addition, EPA has reviewed field test data from several experiments which have demonstrated that the intergeneric strains are similar to the unmodified parental strains in colonization, survival, nodulation and effects on plant growth. The public dockets pertaining to the reviews of *B. japonicum* (six strains: P88–1275 through 1278, and P89–340 and 341) and *R. meliloti* (18 strains: P87–568 through 570, P88–1115 through 1122, P89–280, P90–339, and P92–399 through 403), along with the field test data, are incorporated into the docket for this rulemaking. These strains were modified in antibiotic resistance traits, and some were modified for nitrogen fixation traits as well. In the course of these reviews, EPA evaluated general and specific information in the open scientific literature concerning these species, and BSAC subcommittees were convened to discuss general issues associated with the proposed R&D experiments with these strains.

Modification of traits, the second criterion, limits the source of the introduced genetic material to the genera of *Rhizobium* and *Bradyrhizobium* but allows the introduction of antibiotic resistance traits from any source organism. In

addition, the introduced genetic material must be poorly mobilizable. The introduction of genetic material for traits other than antibiotic resistance is limited to *Bradyrhizobium* and *Rhizobium* species, because EPA is most familiar with these two genera.

Based on the results of the field tests with these strains, EPA proposes to exempt the use of well-characterized, limited in size, and poorly mobilizable antibiotic resistance markers in *Bradyrhizobium japonicum* and *Rhizobium meliloti*. EPA believes that there would be no significant risk resulting from small-scale field tests with the resulting microorganisms containing antibiotic resistance, because broad antibiotic resistance already exists in naturally occurring microorganisms of these two species (as demonstrated in the data submitted for PMNs P88–1115 (rhizobia) and P88–1275 (bradyrhizobia). In addition, higher levels of antibiotic resistance can be easily induced in these microorganisms by mutation or selection. EPA requests comment on the appropriateness of exempting antibiotic resistance traits.

EPA is proposing that these exemptions would only apply to test sites of 10 acres or less. This test area limit for *Bradyrhizobium japonicum* and *Rhizobium meliloti* is based on the field data reviewed by EPA which show that such releases have remained small-scale, with the modified strains exhibiting survival and persistence similar to their unmodified parental strains. The TQI must select appropriate methods to limit dissemination of these modified rhizobial species in order to maintain the small-scale nature of the field tests. Also, this proposal is based on the lack of adverse effects observed in humans and animals resulting from use of these naturally occurring rhizobial species.

EPA is proposing to exempt intergeneric strains of these two rhizobia species, in order to facilitate research using these microorganisms and to encourage development of products that could increase crop productivity while decreasing dependance on chemical fertilizers. These experiments could generate important information that will increase understanding of the environmental fate of intergeneric microorganisms. Information from these field tests would advance the understanding of microbial ecology, which could facilitate review of commercial products. The possible risks due to exempting these two rhizobia species from review at small-scale will be balanced by the innovation and development of safer, environmentally sound products to promote crop production.

6. *Finding of no unreasonable risk for specific alternative exemption for low risk field tests.* Unit II.D. of this preamble describes an alternative exemption from TERA reporting for certain R&D field tests. While EPA acknowledges that parts of the rationale offered in Unit III.B. of this preamble for exempting research conducted under the proposed contained structures exemption could be applied to some small-scale field tests involving microorganisms, EPA does not believe that the rationale can be applied to small-scale field tests as a class. Therefore, it was suggested that EPA define a class of small-scale field tests which would be expected to pose low risks and be exempt from TERA reporting. The no unreasonable risk finding for this alternative exemption from TERA reporting is based on the interaction of three primary criteria which consider the safety of the parent microorganism, the role of the traits that have been modified, and the scale of the field tests. If the parent microorganism is shown to have a history of safe use, introduced genetic material meeting the specified criteria would be unlikely to significantly increase the potential for adverse effects. EPA would expect that TQIs would use the criteria discussed in III.C.7. of this preamble for the recipient microorganism and the introduced genetic material as guidance in determining that their new microorganisms would be eligible for this exemption. As in the contained structures exemption for R&D, EPA is relying on the experience and judgement of the TQI to select appropriate methods to limit dissemination of the new microorganisms in order to maintain the small-scale nature of the field tests. Reliance on the judgement of the TQI is discussed further in Unit III.B. of this preamble. EPA believes that the criteria it has specified circumscribe a category of field tests which can be considered low risk. In addition, should EPA receive a notice for a planned field test which did not appear to be low risk, EPA could require the submission of a TERA in order to review more completely the proposal.

EPA believes that the field tests potentially eligible for this alternative exemption could generate important information which will generally advance the understanding of microbial ecology and specifically facilitate EPA's review of intergeneric microorganisms. The low risks posed by the field tests will be balanced by benefits in the form of reduction in reporting burden for researchers and the encouragement of innovation in the development of environmentally sound products. EPA would like to receive public comment on whether the benefits of this exemption outweigh the potential risks posed by small-scale field tests eligible for the exemption.

Although field tests which meet the proposed criteria would be considered to pose low risks, additional concerns could be raised for unlimited uses of the same microorganisms at the general commercial use stage. Once development of these microorganisms moves beyond R&D to general commercial use, they would be subject to the MCAN reporting requirements discussed in Unit II.C. of this preamble.

7. *Finding of no unreasonable risk for new microorganisms eligible for tiered commercial use exemption.* EPA recognizes that some microorganisms present a low risk when used under specific conditions at general commercial use. Therefore, EPA is proposing expedited processes for certain microorganisms at the general commercial use stage. The requirements and processes for the Tier I and Tier II exemptions are discussed in Unit II.C. of this preamble. The criteria for Tier I and Tier II exemptions address: (1) The recipient microorganism; (2) the introduced genetic material; and (3) performance based standards for minimizing the numbers of microorganisms emitted from the manufacturing facility.

To evaluate the potential for unreasonable risk to human health or the environment in developing these exemptions, EPA focused primarily on the characteristics of the recipient microorganisms. If the recipient is shown to have little or no potential for adverse effects, introduced genetic material meeting the specified criteria would not likely significantly increase potential for adverse effects. As further assurance that risks would be low, EPA is also specifying procedures for minimizing numbers of organisms emitted from the facility. When balanced against resource savings for society and expected product benefits, these exemptions will not present unreasonable risks.

a. *The recipient microorganism.* Six criteria were used to determine eligibility of recipient microorganisms for the tiered exemption. First, it should be possible to clearly identify and classify the microorganism. Available genotypic and phenotypic information should allow the microorganism to be assigned without confusion to an existing taxon which is easily recognized. Second, information should

be available to evaluate the relationship of the microorganism to any other closely related microorganisms which have a potential for adverse effects on human health or the environment. Third, there should be a history of safe commercial use for the microorganism. Fourth, the commercial uses should indicate that the microorganism products might be subject to TSCA jurisdiction. Fifth, studies are available which indicate the potential for the microorganism to cause adverse effects on human health and the environment. Sixth, studies are available which indicate the survival characteristics of the microorganism in the environment. EPA requests comment on whether these are the appropriate criteria to consider to determine the eligibility of recipient microorganisms for the tiered exemption. After each microorganism was reviewed using the six evaluation criteria, a decision was made to place the microorganism on the list in proposed § 725.420. Summaries of the individual risk assessments, are discussed below. The full risk assessments for the recipient microorganisms are in the docket for this proposed rulemaking.

(i) *Acetobacter aceti* is an obligate aerobic bacterium naturally found in the restrictive niche of fermenting fruit, where it can tolerate and utilize ethanol as a nutrient. This species has no recorded pathogenicity on plants, humans, or animals and has a history of safe industrial use. *A. aceti* is well-defined taxonomically and clearly distinguished from other *Acetobacter* species known to cause the browning of processed fruit. While it can be expected to survive in the environment, *A. aceti* is unlikely to cause any significant environmental effects.

(ii) *Aspergillus niger* is an asexual fungus commonly found degrading organic matter in nature. This organism has a history of safe use for the production of citric acid and several enzymes. It has been shown to be an opportunistic human pathogen and to damage several species of plants. While production of certain mycotoxins has been associated with strains of *A. niger*, companies have been using naturally occurring strains of *A. niger* to produce a variety of products for many years without reports of toxic effects of workers. The limited in size constraints as well as the restriction on vertebrate toxins imposed on introduced genetic material by the criteria for the tiered exemption should reduce the likelihood of increased production or exposure to malformins A and C, the two most potent mycotoxins potentially produced by *A. niger* strains. In general, the restrictions placed on the introduced DNA and containment mean that the recombinant *A. niger* strains eligible for the tiered exemption should pose no greater risks than naturally occurring strains of *A. niger*.

(iii) *Aspergillus oryzae* is an asexual fungus found in nature and used for hundreds of years in the production of soy sauce, miso and sake without recorded incidents. This fungus has no reported adverse effects on either plants or animals. It has been suggested that genetic engineering of *A. oryzae* might inadvertently produce an aflatoxigenic strain. Naturally occurring strains of *A. oryzae* are not known to produce aflatoxins; however, some scientists believe that *A. oryzae* is a domesticated version of *A. flavus* and may possess dormant genes for aflatoxin production. It is likely that companies have already been using genetically modified strains of *A. oryzae*, but these strains have not yet met the PMN reporting requirements, that is, they are not intergeneric. The limitations placed by the tiered exemption on the introduced genetic material, in particular the well-characterized and limited in size restrictions, should reduce the likelihood that any sequences relating to aflatoxin production could be introduced. The containment requirements would limit exposure to any mycotoxins produced. In addition, *A. oryzae* does not colonize humans. In general, the restrictions placed on the introduced genetic material and containment mean that the recombinant *A. oryzae* strains eligible for the tiered exemption should pose no greater risks than naturally occurring strains of *A. oryzae*.

(iv) *Bacillus licheniformis* is an aerobic sporeforming bacterium that is well defined taxonomically. It can be readily isolated from the environment, where it persists primarily as endospores. Many strains have been tested and shown to have no adverse effects on humans, animals or plants. *B. licheniformis* has been reported as an opportunistic pathogen in livestock; however, it has never been diagnosed as a causal agent. *B. licheniformis* has a history of safe use in large-scale fermentation production of specialty chemicals and substances such as citric acid and detergent enzymes. Although the majority of experience with industrial fermentations employing *B. licheniformis* is with asporogenic strains, all strains of this microorganism are being recommended for the tiered exemption.

(v) *Bacillus subtilis* is an aerobic sporeforming bacterium which is not completely defined at either the genus or species level. This species is commonly found in nature, particularly in terrestrial environments. Many strains have been tested and shown to have no adverse effects on humans, animals or plants. Reports of *B. subtilis* acting as an opportunistic pathogen are few in number and have not been well substantiated. *B. subtilis* has a history of safe use in large-scale fermentation production of specialty chemicals and enzymes and even as a source of single cell protein for human consumption in Asia. Although the majority of experience with industrial fermentations employing *B. subtilis* is with asporogenic strains, all strains of this microorganism are being recommended for the tiered exemption.

(vi) *Clostridium acetobutylicum* is an obligate anaerobic endospore-forming bacterium which has been isolated from soils, sediments, well water, and from animal and human feces. Various strains of *C. acetobutylicum* have a history of safe use industrially or in research for the production of butanol and acetone from various feedstocks. While *C. acetobutylicum* may survive in the environment, it is not likely to cause any significant environmental effects. Although the current taxonomic classification of *Clostridium* species is not well-defined, *C. acetobutylicum* can be distinguished from closely related species which are known to be human pathogens. In general, the restrictions placed on the introduced genetic material and containment mean that the recombinant *C. acetobutylicum* strains eligible for the tiered exemption should pose not greater risks that the naturally occurring strains of *C. acetobutylicum* which have been used in industry without reports of adverse effects to workers or the environment.

(vii) *Escherichia coli* K-12 is a strain which is well defined taxonomically, although the genus Escherichia as a whole is not. *E. coli* K-12 strains can be readily distinguished from those close relatives that are pathogens. *E. coli* K-12 is a debilitated bacterium which does not normally colonize the human intestine. It has also been shown to survive poorly in the environment, has a history of safe commercial use, and is not known to have adverse effects on humans, microorganisms, or plants. Although some K-12 substrains produce low levels of toxins, toxin expression by these substrains is mitigated by *E. coli* K-12's poor survival in the environment and its inability to colonize normal human or animal hosts.

(viii) *Penicillium roqueforti* is an asexual fungus which decomposes organic materials in nature. Most strains of *P. roqueforti*, including those used in

cheese production, have been shown capable of producing a variety of mycotoxins. *P. roqueforti's* long history of use in the production of blue cheese has shown no adverse effects. *P. roqueforti* is generally considered to be a benign organism, but it does raise concerns because of its ability to produce mycotoxins under certain conditions. Despite these concerns, the organism has a history of use without noted reports of adverse effects to workers or the environment. In general, the restrictions placed on the introduced genetic material and containment mean that the recombinant *P. roqueforti* strains eligible for the tiered exemption should pose no greater risk than naturally occurring strains of *P. roqueforti*.

(ix) *Saccharomyces cerevisiae* is a yeast that occurs commonly in the environment. Although it is not well defined taxonomically and survives well in the environment, it has a history of safe use in the commercial production of many products (e.g., beer). Further, it is not known to cause pathological effects on humans, plants, or animals. *S. cerevisiae* has no known effects on microorganisms, other than possible effects on strains of its own species.

(x) *Saccharomyces uvarum* is a yeast capable of fermenting a variety of sugars into ethanol. *S. uvarum* has a long history of safe use in production of alcoholic beverages and industrial ethanol. Although it is expected to survive in the environment, it is not expected to cause any adverse environmental effects. While *S. uvarum* has been used industrially for years, specific strains have not been distinguished.

b. *The introduced genetic material.* In order to qualify for either Tier I or Tier II exemption, any introduced genetic material must be limited in size, well-characterized, free of certain nucleotide sequences, and poorly mobilizable.

(i) *Limited in size.* Introduced genetic material must be limited in size to those segments required to perform the intended function, as described at proposed § 725.421(a). This criterion reduces uncertainty by excluding the introduction into a recipient of extraneous and potentially uncharacterized genetic material. The requirement that the regulatory sequences permit the expression solely of the structural gene(s) of interest reduces risk by preventing expression of genes downstream of the inserted genetic material. The limitation on the vector sequences that are components of the introduced genetic material prevents the introduction of novel traits beyond those associated with the gene(s) of interest. The overall result of the limited in size criterion is improved ability to predict the behavior of the resulting microorganism. EPA requests comment on the usefulness of this criterion in reducing uncertainty about the behavior of the new microorganism and any difficulties researchers may have in isolating the genetic material required to perform the intended functions.

(ii) *Well-characterized.* The requirement at proposed § 725.421(b) that the introduced genetic material be well-characterized also contributes to improved ability to predict the behavior of the resulting microorganism. Well characterized includes knowledge of the function of the introduced sequences and the phenotypic expression associated with the introduced genetic material. Genetic material which has been examined at the restriction map or sequence level, but for which a function or phenotypic trait has not yet been ascribed, is not considered well-characterized.

Well-characterized would include knowing whether multiple reading frames exist within the operon. This relates to whether more than one biological product might be encoded by a single sequence, and addresses the possibility that a modified microorganism could display unpredicted behavior should such multiple reading frames exist and their action not be anticipated.

(iii) *Free of certain sequences.* In addition to improving the ability to predict the behavior of the modified microorganism, the well-characterized requirement ensures that segments encoding for either part or the whole of the toxins listed at proposed § 725.421(d) would not inadvertently be introduced into the recipient microorganism (Refs. 11 and 12).

The toxins listed at proposed § 725.421(d) are polypeptides of relatively high potency. Other types of toxins (e.g., modified amino acids, heterocyclic compounds, complex polysaccharides, glycoproteins, and peptides) are not listed for two reasons. First, their toxicity falls within the range of moderate to low. Second, these types of toxins generally arise from the activity of a number of genes in several metabolic pathways (multigenic).

In order for a microorganism to produce toxins of multigenic origin, a large number of different sequences would have to be introduced and appropriately expressed. It is unlikely that all of the genetic material necessary for metabolizing multigenic toxins would be inadvertently introduced into a recipient microorganism when requirements that the genetic material be limited in size and well-characterized are followed. Should any of the necessary sequences not be introduced, or not be expressed appropriately by the recipient, a toxin of multigenic origin would not be produced. EPA, thus, sees no reason why a manufacturer who wishes to modify a microorganism listed in proposed § 725.420 with a single or a few sequences involved in metabolism of a multigenic toxin should not be allowed to do so. Introduction of a single or a few such sequences into a candidate microorganism should not result in production of a multigenic toxin and thus would not present significant risk.

Similarly, other properties that might present risk concerns result from the interactive expression of a large number of genes. For example, pathogenic behavior is the result of a large number of genes being appropriately expressed. Because of the complex nature of behaviors such as pathogenicity, the probability is low that an insert consisting of well-characterized, limited in size genetic material could transform the microorganisms listed at proposed § 725.420 into microorganisms which display pathogenic behavior. For this reason, with the exception of certain toxins which are listed because of their potency, EPA is not listing at proposed § 725.421(d) sequences that are one of a series of sequences needed in combination in order for a microorganism to display a complex behavior such as pathogenicity. If commenters believe they can identify sequences which present risk concerns which should be addressed and listed at proposed § 725.421(d), EPA requests they inform the Agency of these sequences.

(iv) *Poorly mobilizable.* The requirement, at proposed § 725.421(c), that the introduced genetic material be poorly mobilizable reduces potential for transfer of introduced genetic sequences to other microorganisms in the environment. Such transfers would occur through the interaction of the introduced microorganism with indigenous microorganisms through conjugation, transduction, or transformation. Through such transfers, the introduced genetic material could be transferred to and propagated within different populations of microorganisms, including microorganisms which may never previously have been exposed to this genetic material. It is not possible to predict how the behavior of these potential recipient microorganisms will

be affected after uptake and expression of the genetic material.

Since EPA is not limiting the type of organism that can serve as the source for the introduced genetic material, some limitation is placed on the ability of the introduced genetic material to be transferred. This limitation mitigates risk by significantly reducing the probability that the introduced genetic material would be transferred to and expressed by other microorganisms.

The transfer frequency of 10^{-8} was selected as defining "poorly mobilizable" for four reasons. First, it represents the lower end of the range of transfer frequencies observed in nature. Transfer of plasmids, for example, commonly occurs through conjugation between bacteria at rates ranging from no detectable transfer (typically less than 10^{-8} transfer events per donor) to 10^{-2} transfer events per donor in soil, water and sewage (Ref. 13). A similar range of transfer frequencies has been associated with transduction of chromosomal and plasmid DNA in soil and aquatic microcosms (Refs. 14, 15, and 16). Also, a limited number of studies on natural transformation have documented a range of transformation events from 0.3×10^{-8} to 1×10^{-8} transformants per recipient (Ref. 17). Second, studies of certain genetic traits (e.g., amino acid auxotrophy, resistance to antibiotics) suggest the spontaneous rate of mutation to be within the range of 10^{-5} to 10^{-8} per cell generation (Refs. 18 and 19). A frequency of 10^{-8} appears to represent, therefore, a baseline frequency at which change occurs in genetic material. Third, this frequency sets the technical limit for measurability. Below the rate of spontaneous mutation, it becomes difficult to distinguish gene transfer from mutation. Fourth, the 10^{-8} criterion should not be difficult to meet, and, in fact, is a standard employed in the NIH Guidelines.

The 10^{-8} frequency is attainable given current techniques. Plasmids with transfer rates of 10^{-8} exist or are easily constructed. In bacteria this low rate is readily engineered through the inactivation of the transfer functions of mobile genetic elements, or the inactivation/removal of pilus formation functions of plasmids (Ref. 20). Some of the plasmids most commonly employed as vectors in genetic engineering (e.g., pBR325 and pBR322) have mobilization/transfer frequencies of 10^{-8} or less. The plasmid pBR322 has been used as a vector to construct several microorganisms reviewed by EPA under the 1986 Policy Statement.

The criteria set for "poorly mobilizable" for transduction and transformation should not prevent most microorganisms from meeting the exemption criteria, since the majority of transfer frequencies reported for transduction and natural transformation are less than 10^{-8}. Higher frequencies are likely only if the introduced genetic material has been altered or selected to enhance frequency.

Fungal gene transfer has also been considered in development of the poorly mobilizable criterion. Although mobile genetic elements such as transposons, plasmids, and double stranded RNA exist in fungi and can be readily transferred, this transfer usually is only possible between members of the same species during anastomosis, a process specific to fungi. Since anastomosis only occurs between members of the same species, the introduced genetic material would not be transferred to distantly related fungi as may occur with bacteria.

Based on suggestions made at the July 22, 1991 BSAC Subcommittee meeting, EPA proposes the following definition for "poorly mobilizable": "The ability of the introduced genetic material to be transferred and mobilized is inactivated, with a resulting frequency of transfer of less than 10^{-8} transfer events per recipient." For microorganisms with introduced genetic material associated with conjugative plasmids or conjugative transposons, this criterion can be met by inactivation of transfer or mobilization functions which reduce transfer frequency. In instances where introduced genetic material is located on the chromosome, steps can be taken to insure a low transfer frequency by transduction and transformation by reducing opportunities for illegitimate recombination. EPA requests comment on the appropriateness of its definition of poorly mobilizable and whether there are alternative or additional methods for demonstrating that introduced genetic material is poorly mobilizable that should be included in the definition.

(v) *Effect of introduced genetic material criteria.* The requirements placed on the introduced genetic material, in concert with the level of safety associated with the recipient microorganisms, ensure that the resulting microorganisms present low or negligible risk. The probability is low that the insertion of genetic material meeting EPA's criteria into such microorganisms will change their behavior so that they would acquire the potential for causing adverse effects. Risks would be mitigated by the four criteria placed on the introduced genetic material, the relative safety of the microorganisms listed at proposed § 725.420, and the inactivation criteria specified for the Tier I exemption. In the case of Tier II exemption, risks would be mitigated in light of the four criteria placed on introduced genetic material, the relative safety of the microorganisms listed at proposed § 725.420, and EPA's review of the conditions selected.

c. *Standards for minimizing the number of microorganisms emitted from the facility.* The standards prescribed for Tier I exemption require that the structure(s) be designed and operated to contain the microorganism, that access to the structure be limited to essential personnel, that inactivation procedures shown to be effective in reducing the number of viable microorganisms in liquid and solid wastes be followed prior to disposal of the wastes, that features to reduce microbial concentrations in aerosols and exhaust gases released from the structure be in place, and that general worker hygiene and protection practices be followed.

(i) *Definition of structure.* EPA considers the term "structure" to refer to the building or vessel which effectively surrounds and encloses the microorganism. Vessels may have a variety of forms, e.g., cubic, ovoid, cylindrical, or spherical, and may be the fermentation vessel proper or part of the downstream product separation and purification line. All would perform the function of enclosing the microorganism. In general, the material used in the construction of such structure(s) would be impermeable, resistant to corrosion and easy to clean/sterilize. Seams, joints, fittings, associated process piping, fasteners, and other similar elements would be sealed.

(ii) *Standards to minimize microbial release.* EPA is proposing, for several reasons, a somewhat cautious approach in prescribing standards for minimizing the number of microorganisms emitted through the disposal of waste and the venting of gases. First, a wide range of behaviors can be displayed by microorganisms modified consistent with EPA's standards for the introduced genetic material. Second, EPA will not conduct any review whatsoever for Tier I exemptions. EPA believes the requirement to minimize emissions will provide a measure of risk reduction necessary for making a finding of no unreasonable risk. Taken together, EPA's standards ensure that the number of microorganisms emitted from the structure is minimized.

EPA's proposed standards for minimizing emission specify that liquid and solid waste containing the microorganisms be treated to give a validated decrease in viable microbial populations so that at least 99.9999 percent of the organisms resulting from

the fermentation will be killed. During normal fermentation processes, bacteria generally reach a level of 10^{10} to 10^{11} colony forming units per milliliter (Ref. 21). A simple calculation assuming no dilution of the fermentor broth and a minimum inactivation efficiency of 99.9999 percent (or a 6 log reduction) results in an estimate of the concentration of viable organisms released from the facility of at most approximately 10^5 bacteria per milliliter. This number is likely to be lower, since the required reduction is the minimum validated inactivation and the actual kill is likely to be greater.

Fungi have greater biomass per colony forming unit and therefore are incapable of reaching the high numbers that bacteria in fermentation vats achieve. During the fermentation process, fungal populations frequently reach population densities of 10^6 to 10^7 microorganisms per milliliter (Ref. 21). The proposed level of inactivation would result in almost all fungi from the fermentation process being rendered nonviable. Here too, the actual reduction in number is likely to be greater that the minimum required by EPA.

Since the bacteria used in fermentation processes are usually debilitated, either intentionally or through acclimation to industrial fermentation, the small fraction of microorganisms remaining viable after inactivation treatments will likely have a reduced ability to survive during disposal or in the environment. This is because microorganisms repeatedly cultured in specific growth conditions become adapted to those conditions and often lose the ability to survive in different conditions. This is particularly true when microorganisms are used in industrial fermentations wherein most, if not all, of the microorganism's nutritional and other needs are met to ensure rapid growth and good product yield. Moreover, industrial companies, in an attempt to keep their proprietary microorganisms from competitors and to reduce the microbial numbers to those permitted by local sanitation authorities, modify the microorganisms to increase the ability of their microorganisms to survive and perform their assigned tasks in the fermentor but decrease their ability to survive in the environment external to the fermentor.

When treated wastes are placed in the sanitary sewage line during disposal, factors such as changes in pH, temperature, ionic balance, and dilution adversely affect any microorganisms remaining viable subsequent to inactivation treatment. Similarly, when such wastes are left in the form of cakes for several hours at room temperature, the lack of nutrients and sufficient suitable electron acceptors (oxygen for aerobes, other substances such as an organic compound or sulfur for anaerobes) further reduces viability. Based on these considerations, EPA believes that under its proposed standards, few viable microorganisms will be emitted from the facility through the route of liquid and solid wastes.

EPA requirements also address microorganisms in the exhaust from the fermentor and along the production line. To address exhaust from fermentors, EPA is proposing that the number of microorganisms in fermentor gases be reduced by at least two logs prior to the gases being exhausted from the fermentor. EPA selected this number based on an estimate of the numbers of microorganisms likely to be in the exhaust from an uncontrolled fermentor and common industry practice. Several studies cited by Battelle (Ref. 22) suggest that a typical viable microorganism load in uncontrolled fermentor exhaust is about 5×10^4 organisms per cubic foot. A reduction of two logs would reduce the number to approximately 5×10^2 microorganisms per cubic foot. The actual number is likely to be lower, since the required reduction is a minimum and the number removed may be greater.

The number of microorganisms that remain viable subsequent to being exhausted from the fermentor is likely to be lower still. First, it is generally not common industry practice to run fermentors in an uncontrolled fashion. Second, microorganisms in fermentor exhausts would be within aerosols. Aerosolization is, in general, very stressful for microorganisms, because of the physical pressures associated with aerosol formation and the high probability of dehydration (Refs. 22 and 23). Moreover, microorganisms that are physiologically acclimated to the growth conditions within the fermentor are likely to be compromised in their ability to survive aerosolization. EPA anticipates, therefore, that few microorganisms will survive the stresses of aerosolization associated with being exhausted in a gas from the fermentor. The provision requiring reduction of microorganisms in fermentor exhaust gases contributes to minimizing the number of viable microorganisms emitted from the facility.

EPA requests comment on whether its standards for minimizing releases of microorganisms from facilities are appropriate for this exemption. EPA is particularly interested in whether commenters can suggest reasonable alternative methods for reducing releases from facilities and provide the rationale for these alternatives.

EPA is also proposing that the requirements specify that other systems be in place to control dissemination of microorganisms by other routes. This would include programs to control pests such as insects or rats, since these might serve as vectors for carrying microorganisms out of the fermentation facilities.

(iii) *Worker protection.* The requirement to minimize microbial emissions, in conjunction with the requirement for general worker safety and hygiene procedures, also affords a measure of protection for workers. Potential effects on workers that exist with microorganisms in general (e.g., allergenicity) will be present with the microorganisms qualifying for this exemption. As with other substances that humans may react to (e.g., pollen, chemicals, dust), the type and degree of allergenic responses is determined by the biology of the exposed individual. It is unlikely that a microorganism modified in keeping with EPA's specifications for the introduced genetic material would induce a heightened response. The general worker hygiene procedures specified by EPA should protect most individuals from the allergenic responses associated with microorganisms exhausted from fermentors and/or other substances emitted along the production line. The EPA requirement that entry be limited to essential personnel also addresses this consideration by reducing to a minimum the number of individuals exposed.

(iv) *Guidance for Tier II.* EPA is not specifying standards for minimizing the number of microorganisms emitted from the facility for microorganisms qualifying for Tier II exemption. Rather, the Agency requests that submitters utilize as guidance the standards set forth for Tier I procedures. The procedures proposed by the submitter in a Tier II exemption request will be quickly reviewed by the Agency (45 days). EPA will have the opportunity to evaluate whether the procedures the submitter intends to implement for reducing the number of organisms emitted from the facility are appropriate for that microorganism.

d. *Benefits of the tiered exemption.* Substantial benefits are associated with this proposed exemption. The recipient microorganisms are already widely employed in general commercial uses subject to TSCA reporting. These include microorganisms used to produce enzymes for detergent use or biomass conversion, and production of

specific compounds such as plant or microbial growth promoting factors.

The Agency believes this exemption will result in resource savings both to EPA and industry without compromising the level of risk management afforded by the 90–day MCAN review. The microorganisms named as recipients for the tiered exemption have been assessed for risk, criteria limiting the potential for transfer of and expression of toxin sequences have been provided, and the conditions of use are specified in the exemption (Tier I) or will be reviewed by EPA (Tier II). EPA requirements for minimizing numbers of viable microorganisms emitted are within standard operating procedures for the industry, and both the procedures and the structures specified in the exemption are the type industry uses to protect their products from contamination.

The exemption will result in reduced reporting costs and a decrease in delay associated with reporting requirements. The savings in Agency resources can be directed to reviewing activities and microorganisms which present greater uncertainty.

This exemption should facilitate development and manufacturing of new products and the accumulation of useful information. When balanced by the potential resource savings and many industrial benefits of these microorganisms, the Agency finds the potential benefits of exempting uses of these microorganisms under the specific criteria will not present unreasonable risk.

EPA is considering designating other microorganisms as eligible for this exemption, dependent upon risk assessments for these microorganisms indicating that they present no unreasonable risk under the conditions of use. A list of microorganisms EPA believes are used by industry for TSCA uses appears in a support document in the docket for this rulemaking. EPA plans to evaluate many of these to determine whether they qualify as recipient microorganisms eligible for this exemption. The goal of the evaluation is to ensure that the microorganisms would present no unreasonable risk when used under the conditions of this exemption. Persons possessing information demonstrating no unreasonable risk and thus supporting eligibility for the tiered exemption for these microorganisms or other microorganisms are encouraged to submit such information to EPA to facilitate this process. As noted previously, this information could be submitted using the procedures at proposed § 725.67.

IV. Other Issues

A. Microorganisms Covered in This Rulemaking

1. *Microorganisms included.* In this proposed rule, EPA, on the advice of its BSAC, is including in its definition of "microorganism" those organisms classified in the kingdoms Monera (or Procaryotae), Protista, and Fungi, the Chlorophyta and the Rhodophyta of the Plantae, and viruses and virus-like particles. This definition, which uses the five kingdom classification system of Whittacker (Ref. 24), includes, but is not limited to bacteria, protozoa, fungi, mycoplasmas, mycoplasma-like organisms, spiroplasmas, microphytoplanktons, and green and red algae. Viruses and virus-like particles (e.g viroids, satellites, virusoids) are also considered to be microorganisms by EPA, even though they are classified in a unique classification system described by Francki, et al. (Ref. 25). Should new categories of organisms within the Monera, Protista, Fungi, and the Chlorophyta and the Rhodophyta of the Plantae be identified, these also would be considered microorganisms under this proposed rule. EPA requests comment on its approach to the definition of microorganisms. EPA is particularly interested in comment regarding the appropriateness of including organisms from the Chlorophyta and the Rhodophyta of the Plantae in its microorganism definition.

The organisms belonging to the Monera, Protista and Fungi are primarily unicellular. Members of the Chlorophyta and the Rhodophyta are also primarily unicellular. As members of the Thallophyta, they show little if any tissue differentiation (the entire plant is known as a thallus), the reproductive structures are often unicellular and lack a protective wall or jacket of sterile cells, and the zygotes do not form embryos within a female reproductive organ. The organisms of the Monera, Protista, Fungi, Chlorophyta, and Rhodophyta may be prokaryotes or eukaryotes, and may or may not possess cell walls.

Each type of microorganism can be significantly different, one from another. Some measure of the differences between them can be seen in the fact that the descriptor, "microorganism", spans four of the five kingdoms into which all organisms are classified. These differences present several challenges in constructing a rule.

2. *Inclusion of viruses and virus-like particles.* One important consideration under TSCA revolves around the approach to viruses and virus-like particles. Viruses are included by EPA in the designation "microorganisms." These entities, which are among the smallest of microorganisms, differ from other microorganisms in several ways. First, they are non-cellular entities, lacking a delineating cell membrane and the metabolic machinery for the basic cellular function of energy generation. Second, they contain only one type of genetic informational molecule, either RNA (ribonucleic acid) or DNA (deoxyribonucleic acid). Third, viruses are obligate intracellular inhabitants. They cannot reproduce independently outside of a host cell. For this reason, viruses have historically been identified according to the host they infect, i.e., plant viruses reproduce in plant cells, animal viruses in animal cells, and bacterial viruses in bacterial cells. There are also viruses of fungi, algae, and protozoa. More recently a unique classification system has been developed based on the genome structure and expression, as well as on structural features of the virus particles (Ref. 25). Because their reproduction within cells can result in disruption of the host cell, viruses are generally considered to be pathogens. Viroids are virus-like particles which are also pathogens. These entities are implicated in plant diseases such as potato spindle tuber disease.

When the BSAC Subcommittee met on July 22, 1991, they considered EPA's approach to microorganisms under TSCA. They raised several issues with regard to viruses and virus-like particles. They noted that viruses are by definition pathogens. As viruses in general have smaller genomes than other microorganisms and a greater percentage of the genome is related to pathogenicity, a change in the viral genome is more likely to affect pathogenicity than a change in the genome of microorganisms such as bacteria and fungi. Even when a change occurs solely within a single genome, viruses and virus-like particles may warrant a more cautious approach than other microorganisms. Finally, plant and animal viruses are known to shift host range under *in vitro* tissue culture conditions, other unique conditions, or in non-traditional hosts, and this, in and of itself, is an important risk consideration.

Thus, viruses and virus-like particles, because of their unique characteristics, present different issues than other microorganisms. This is particularly true of the viruses that attack macroorganisms (humans, animals, and plants); and the use of these viruses probably warrants scrutiny regardless of whether the virus is new or existing.

Viruses that infect other microorganisms (e.g., the viruses of protozoa, fungi, and bacteria), may present a somewhat different risk picture from those that infect macroorganisms. Although it appears theoretically possible for a virus of a microorganism (also termed a phage) to permanently eliminate its host microorganism from a habitat, studies done to date do not provide strong evidence that this occurs (Ref. 24), possibly because microorganisms are capable of rapidly developing resistance to phage infection. Phage infections appear rather to result in a temporary fluctuation rather than a permanent change in the numbers of a microorganism in a specific habitat. Moreover, redundancy in function found in natural microbial communities (i.e., many species are capable of performing the same ecological function (Ref. 5)) may cushion the effects of these population fluxes.

To address viruses for this rulemaking, EPA has distinguished between those that infect microorganisms and those that infect macroorganisms. Phages will be considered MGEs and the MGE guidance discussed in Unit I.C. of this preamble will apply to them. Therefore, a phage which has been modified to contain genetic material from a second phage whose host microorganism is in a different genus than the modified phage would be considered a "new" microorganism subject to TSCA section 5 reporting. Similarly, a phage modified to contain genetic material from an organism classified in a different genus than the genus from which the modified (recipient) phage was isolated would be considered intergeneric. Under this interpretation, a phage which has been modified to contain genetic material from a virus of a macroorganism would also be considered a "new" microorganism.

With regard to viruses of macroorganisms, EPA believes that certain viruses of macroorganisms would be subject to TSCA jurisdiction if they were employed in TSCA uses. As discussed in Unit I.C. of this preamble, certain product uses are excluded from coverage under TSCA, the most notable for viruses being the exclusions for pesticides (but not pesticide intermediates) which are covered under FIFRA and for food, drugs, cosmetics, and their intermediates, which are covered by FFDCA. While other uses could potentially be subject to TSCA, EPA has not at this time been able to identify viruses of macroorganisms in uses that might be subject to TSCA. EPA requests comments on whether there are known uses of viruses of macroorganisms that would be subject to TSCA and whether an intergeneric approach such as that used for phages would be appropriate for the viruses of macroorganisms. Comment is also requested on whether EPA's approach for oversight of phages under TSCA section 5 is appropriate.

B. Listing Microorganisms on the Inventory

This Unit describes how EPA proposes to explicitly list microorganisms on the TSCA Inventory after MCAN review and the rationale for the proposed listing.

1. *The components of explicit listing.* EPA proposes to identify microorganisms on the Inventory using a taxonomic designation and a consistent set of supplemental information on phenotypic and genotypic traits necessary to identify the microorganism as precisely as possible. EPA expects that this information would be a portion of the information included in MCAN submissions.

a. *Taxonomic designation.* The taxonomic designations to the strain level, as appropriate, would be provided for the recipient microorganism and the donor(s) of the introduced genetic material. Taxonomic designations may be those assigned by individual submitters or by a culture collection. The designations would be substantiated by a letter from a culture collection verifying the designation, by literature references, or by the results of tests conducted for the purpose of taxonomic classification. Upon request, the data supporting the taxonomic designation should be provided to EPA. Where possible, the genetic history of the recipient microorganism should be documented back to the isolate from which it was derived.

b. *Supplemental information.* Many taxonomic designations at the species level define phenotypically and genotypically diverse groups of microorganisms. Therefore, supplemental information will be used to identify as precisely as possible a specific microorganism on the Inventory. Information on phenotypic and genotypic traits is necessary only to the extent that it assists in the specific identification of the reported microorganism.

(i) *Phenotypic traits.* This information concerns the characteristics that reflect the interaction of a microorganism's genotype and the environment in which it is intended to be used. For example, information on intentionally added biochemical and physiological traits is pertinent, since these traits may affect the behavior and fate of a microorganism in the environment. Where possible, submitters should prioritize phenotypic traits in order of those likely to significantly change the microorganism's behavior and thus its potential risk. Such important phenotypic changes may include a change from asporogeny to spore-forming, an increase in the amount of a specific product for which the microorganism is being used as an intermediate, or the activation of a previously inactive enzyme that is known to have negative human health or ecological effects.

(ii) *Genotypic traits.* This information concerns the distinguishing genotypic characteristics of a microorganism, including the identity of the genetic material that is introduced into the recipient microorganism and the methods used to construct the reported microorganism. For example, information on the vector construct, cellular location, and number of copies of the introduced genetic material is pertinent, since the vector may add genetic material and traits, and the microorganism's phenotypic traits may be affected by the number of copies and location of the introduced genetic material.

c. *Deposit in a culture collection.* Because microorganisms are complex substances and because of the nature of the differences that will be used to distinguish between similar organisms (isolates), EPA is considering requiring that microorganisms listed on the Inventory be deposited in a recognized culture collection. Deposited microorganisms could serve as references for determining whether a related, unreported microorganism, or a subsequently modified, inventoried microorganism is the same as one already listed on the Inventory. Comments on this proposal and alternative suggestions of how to distinguish among closely related microorganisms are requested.

2. *Inventory status of similar and subsequently modified microorganisms.* Since publication of the 1986 Policy Statement, EPA has reviewed several intergeneric microorganism PMNs for general commercial use. As discussed previously, the Agency has received an NOC for most of these microorganisms, and these are listed on the TSCA Inventory. The Agency recognizes that subsequent to listing a microorganism on the Inventory, original submitters may make modifications to the genetic material of the inventoried microorganism or companies other than the original submitter may construct microorganisms which may be

equivalent to inventoried microorganisms. Questions would arise as to whether the modified microorganism is equivalent to the microorganism listed on the Inventory. At this time, EPA has concluded that no *a priori* guidance can be given for determining whether a similar strain will be equivalent to one listed on the Inventory. Manufacturers, producers, or importers should consult with EPA concerning the status of their microorganisms, as discussed in Unit II.B.1. of this preamble.

In making its decision on an individual microorganism, EPA will consider the phenotype of the inventoried microorganism and assess how the subsequent modifications will affect that phenotype. For example, EPA believes that a MCAN may not be required when an inventoried microorganism has undergone certain subsequent modifications of genetic material where these modifications would not be likely to significantly change the microorganism's behavior. The BSAC Subcommittee which met on July 22, 1991, suggested that EPA continue to make these decisions on a case-by-case basis, at least until EPA gains more experience. Although EPA will make its decisions on a case-by-case basis, microorganisms that may be judged by EPA to be equivalent to inventoried microorganisms include those that have experienced deletions, rearrangements, amplifications, point mutations, and/or plasmid loss within a single genome, either spontaneously or through use of chemical or physical mutagens. The Agency recognizes that deletions, rearrangements, amplifications, point mutations, and plasmid loss could occur spontaneously in any microorganism maintained in pure culture, in response to stresses such as freezing or thawing, or as a result of mistakes made during the microorganism's replication of its genetic material.

EPA recommends that potential submitters consult the Agency for clarification of their reporting obligations whenever additional changes are made to inventoried microorganisms. The Agency has reviewed several *bona fide* submissions and has determined on a case-by-case basis that the microorganisms described were equivalent to previous PMN submissions. In one case, the microorganism which was the subject of the *bona fide* submission was derived from the same strain as the inventoried microorganism using similar methods, and intrageneric material encoding the same enzyme function was introduced. Although a small number of base pairs in the intrageneric material had been genetically altered, no new trait was introduced into the *bona fide* microorganism compared to the inventoried microorganism. In a separate case, the *bona fide* microorganism contained genetically modified intrageneric material encoding the same function introduced into the inventoried microorganism as well as a small fragment of non-coding, non-regulatory intergeneric genetic material that had been derived from the same source as that introduced into the inventoried microorganism. Although a small number of base pairs had been altered in this intergeneric material, no new trait was present in the *bona fide* microorganism compared to the inventoried microorganism.

3. *Identification of microorganisms currently listed on the Inventory.* EPA wishes to provide manufacturers and processors who are using microorganisms which were listed on the Inventory prior to the 1986 Policy Statement the opportunity to provide information for a specific, explicit listing, if necessary. In 1978, when EPA compiled its initial TSCA Inventory, 192 microorganisms were reported. These microorganisms are currently described on the Inventory by taxonomic designations only, without any supplemental information describing how they were made. They are listed in the 1985 Edition, Volume V, of the TSCA Inventory. The list of microorganisms is included in the docket for this rulemaking. The list may be obtained upon request at the address included in the FOR FURTHER INFORMATION CONTACT section of this preamble. EPA believes that most, if not all, of the 192 microorganisms would not be considered new under this proposed rule, since the listings appear to describe microorganisms which are not intergeneric. Thus, these microorganisms would be implicitly included on the Inventory and may continue to be manufactured for general commercial use.

However, EPA wishes to ensure that all listed microorganisms are described in a consistent manner. Accordingly, EPA advises manufacturers and importers of any of the 192 listed microorganisms to inform EPA of their status under this proposed rule during the public comment period. Any manufacturers of microorganisms that would be considered new under any final rules will be given the opportunity to provide information to EPA to ensure consistent listing of the microorganisms on the Inventory. If EPA is not notified about a microorganism, the Agency will assume it would be implicitly included because it is not intergeneric, and it will be removed from the Inventory list as an explicit listing under EPA's TSCA section 8(b) authority.

As discussed previously, EPA has reviewed a number of intergeneric microorganism PMNs under the 1986 Policy Statement and has listed the microorganisms on the Inventory. These microorganisms will be retained on the Inventory if the proposal becomes final. If changes are made which require alteration of Inventory listings, EPA will announce them in the **Federal Register**.

C. SNUR Process

EPA is not proposing any significant new use rules (SNURs) in this document. Instead, EPA is proposing, in subpart L of part 725, procedures to enable it to issue SNURs in the future. Microorganisms subject to SNUR reporting would be listed in proposed subpart M of part 725. This Unit discusses the SNUR process that EPA is proposing. This process is adapted from the process in place for traditional chemicals in part 721 with only slight modifications.

1. *SNURs applied to microorganisms.* Although EPA is not proposing SNURs for any microorganisms in this document, it is conceivable that, in the future, certain specific uses of microorganisms may raise concerns for human health or the environment. Because the behavior of a specific microorganism is influenced by the environment into which it is introduced (Refs. 5, 7, 8, and 9), it may be necessary to evaluate the risk of some microorganisms when the environment of use is changed. For example, EPA was asked whether any uses of "Ice +" strains of *Pseudomonas syringae* might be subject to SNUR reporting. At the time, the "Ice +" microorganism was being used for snowmaking at ski resorts. In that situation, EPA decided that terrestrial uses of the microorganism for such activities as snowmaking at ski resorts, icemaking at ice skating rinks, commercial air conditioning, and spray-ice construction applications did not pose significantly different exposures and therefore would not require SNUR reporting to EPA. However, EPA did indicate that because use of the microorganism for cloudseeding would present a significantly different exposure scenario than the terrestrial uses, EPA might require SNUR reporting prior to use of the live microorganism for cloudseeding. In such cases, EPA believes it may be appropriate to use SNUR authority to monitor the commercial development of these substances so that EPA can be apprised

of significant increases in exposure potential or significant changes in exposure patterns. These significant increases may warrant control measures or testing. As noted earlier, the MCAN submission and review process will be used for microorganisms subject to SNUR reporting.

2. *Expedited process for issuing SNURs.* If EPA finds it necessary to issue SNURs for new microorganisms reviewed under the MCAN process, EPA will use, when appropriate, expedited procedures based on those established in part 721, subpart D. The procedures for issuing expedited SNURs for microorganisms are set forth in proposed § 725.980. EPA is not soliciting separate public comment on these procedures, since they have already been adopted by EPA. This section relies on the rationale originally stated in the **Federal Register** notices establishing the expedited SNUR process for other new substances under part 721. The SNUR procedures are discussed here and included in the regulatory text for completeness, so that the public will understand all the regulatory provisions potentially applicable to microorganisms.

A limited amount of toxicity data is typically submitted with premanufacture notifications (PMNs) for chemical substances. Thus, EPA often bases its reviews on structure-activity relationships (SARs). MCANs are expected to present similar problems in data gaps, since current knowledge of microbial ecology is limited, and microorganisms subject to TSCA are expected to be used in an ever-expanding variety of applications and thus a multitude of different exposures. Should the Agency determine it does not possess sufficient information to make a risk judgement, EPA could find under TSCA section 5(e) that it had insufficient information to determine whether the new microorganism presents an unreasonable risk of injury to health or the environment. In most such cases, EPA believes that it is appropriate to negotiate a consent order under section 5(e) with the notice submitter to control human exposure and/or environmental releases until test data or other information sufficient to assess adequately the potential hazard become available. Current experience indicates that section 5(e) consent orders for traditional chemicals have specified a variety of control measures. For microorganisms, EPA may place restrictions on site location or size, production volume or method of application, field or laboratory containment procedures, routine or emergency mitigation procedures, or testing procedures.

Section 5(e) orders are binding on the original notice submitter but do not apply to other manufacturers of the same microorganism. Without additional regulation, other persons can manufacture, import, or process the microorganism without EPA review and without the restrictions imposed on the original MCAN submitter by the section 5(e) order. To limit all manufacturers equally, EPA imposes SNURs.

Currently, EPA uses its SNUR authority to extend limitations in section 5(e) orders to other manufacturers, importers, and processors of chemical substances. This ensures that the original submitter and subsequent manufacturers, importers, and processors are treated in an equivalent manner. SNURs are framed so that noncompliance with the control measures or other restrictions is defined as a "significant new use." Thus, other manufacturers, importers, and processors of the substances must either observe the SNUR restrictions or submit a notice to EPA at least 90 days before initiating activities that deviate from these restrictions. After receiving and reviewing such a notice, EPA would have the option of either permitting the new use or acting under section 5(e) or (f) to regulate the new submitter's activities. EPA intends to use this same process for microorganisms. In addition to assuring that all manufacturers, importers, and processors are subject to similar reporting requirements and restrictions, expedited SNURs assure that EPA would have an opportunity to review and evaluate data and, when necessary, regulate prospective manufacturers, importers, or processors of a listed microorganism before a significant new use of that microorganism occurs.

D. Confidential Business Information

EPA's confidential business information (CBI) policy is designed to provide effective public participation by making meaningful information available. In developing confidentiality provisions for submissions, EPA has balanced the need to provide nonconfidential information to the public in a reasonable period of time, to obtain the information it needs to respond to FOIA requests, and to allow persons to assert CBI claims with the minimum burden. In developing its position for this rulemaking, EPA has considered its experience reviewing PMNs for traditional chemicals and microorganisms and comments received on its February 1989 FR notice. This Unit discusses the requirements proposed in subpart C of part 725 and the rationale for EPA's proposal.

1. *Assertion of CBI claims.* A person may assert a claim of confidentiality for any information submitted to EPA, with certain exceptions. However, submitters are encouraged to minimize the amount of CBI in biotechnology submissions, so that the public may participate as fully as possible in the review process. All CBI claims must be asserted at the time of submission of the information.

2. *Generic information.* Submitters who claim microorganism identity and/or use as CBI also must provide generic information for release to the public. By requiring generic identity and use information, EPA would meet its obligation to provide the public with important information related to the potential risks of new microorganisms without revealing CBI. EPA needs this information to prepare **Federal Register** notices to announce EPA's receipt of submissions or EPA's decisions regarding exemption requests.

The generic designations must reveal the identity and use of the microorganism to the maximum extent possible without revealing proprietary information. Submitters are encouraged to review EPA's "Guidelines for the Preparation of Generic Descriptions of Confidential Microorganism Identity and Use" and consult with EPA regarding appropriate generic information prior to submitting a notice. The guidelines are available from EPA's Environmental Assistance Division (see FOR FURTHER INFORMATION CONTACT Unit). Microorganism identity must be specific enough to allow clear interpretation of any accompanying health and safety data. When the location of the release site is claimed as CBI, a generic description for use must include information regarding the type of environment into which the microorganism will be released.

3. *Identity in health and safety studies.* TSCA section 14(b) states that EPA is not prohibited from disclosing health and safety studies of substances for which TSCA section 5 notification is required, unless disclosure reveals confidential information on process or mixture. Historically, the Agency has considered specific chemical identity to be part of a health and safety study, even when it does not appear in the study. However, during the development of the PMN rule, industry expressed substantial concern about the harm of disclosing confidential chemical identities. At that time EPA explored ways of limiting the commercial harm of such disclosure while still meeting the requirements of TSCA section 14(b) and providing the

public with adequate information about health and safety studies. The CBI requirements in the final PMN rule reflected EPA's desire to balance these needs (48 FR 21722, May 13, 1983).

EPA has determined that the regulations developed to address chemical identity in health and safety studies can also be applied to microorganism identity. In this regard, if any health and safety information has been submitted for the microorganism in question, the specific microorganism identity will be held confidential only if disclosure would reveal confidential process or mixture information or if the specific microorganism identity is not necessary to interpret any of the information.

Under this approach, companies that claim specific microorganism identity confidential in their submissions and wish to argue that knowledge of the specific identity is not necessary to interpret their health and safety information are encouraged to choose generic names which are sufficiently specific to allow interpretation of such information. Sufficiently specific generic names will tend to support arguments that disclosure of the specific microorganism identity is not necessary to understand the health and safety information.

4. *Current policy for substantiation of CBI claims.* EPA currently requires submitters of all PMNs for new microorganisms to be released to the environment to substantiate confidentiality claims at the time of submission. This includes PMNs for environmental releases of new microorganisms for R&D as well as for general commercial use, but it does not require upfront substantiation of CBI claims in PMNs for closed system uses of new microorganisms. This policy will continue in effect, until a final rule is promulgated for microorganisms. Like the chemicals program, EPA requires that CBI claims in NOCs for microorganisms be reasserted and resubstantiated when the NOC is submitted.

5. *Proposed changes for substantiation of CBI claims*—a. *Submissions for general commercial uses of microorganisms.* To balance the competing needs of opening the review of submissions for microorganisms to public scrutiny and participation while protecting legitimate CBI claims, EPA proposes to require upfront substantiation of CBI claims in all submissions for general commercial uses of microorganisms. EPA will not distinguish between closed system uses and other uses of microorganisms. Anyone submitting a MCAN, a TME, or a Tier II exemption request will be required to substantiate CBI claims at the time of submission. Failure to include substantiation of any CBI claims, by submitting written answers to the questions, will render the submission incomplete; and it will be returned to the submitter.

EPA believes that the upfront substantiation requirement for CBI claims will impose little burden on submitters of MCANs, TMEs, and Tier II exemption requests. Because MCAN, TME, and Tier II exemption request submitters are ready to put their products on the market, they should be able to justify why it will continue to be necessary to keep certain information confidential. In addition, given the shorter review period for TMEs and Tier II exemption requests, sufficient information may not be made available to the public if upfront substantiation of CBI claims is not required.

b. *TERA submission.* With respect to upfront substantiation for TERAs, EPA is proposing two options and asking for public comments on both. In comments in response to the 1989 FR notice, industry groups raised the issue of adequate protection for R&D. Pointing out that R&D activities involving microorganisms will be facing regulatory burdens that are not imposed on chemical R&D, industry groups said that additional burdens combined with insufficient CBI protection at the R&D stage could reduce incentives to innovate. While submitters are particularly concerned about protecting information at the R&D stage, the public is most interested in participating in the reviews of the first environmental releases of new microorganisms. Public interest groups commented that upfront substantiation is essential to allow public access to information in time to participate in reviews. Because EPA recognizes the importance of the interests of both parties, EPA is asking for additional comments on how best to resolve this issue for CBI claims in TERAs.

(i) *Option 1: Require upfront substantiation of all CBI claims in TERAs.* EPA is aware that industry believes that this requirement imposes a greater burden on R&D submitters than is necessary. Experience gained by continuing to require upfront substantiation of CBI claims in submissions for R&D activities will help EPA determine whether this requirement improves public access to information. In the meantime, EPA specifically requests comment on how the burden to submitters could be minimized if upfront substantiation of CBI claims in TERAs is promulgated as part of the final rule.

(ii) *Option 2: Do not require upfront substantiation of CBI claims in TERAs.* The second option is to adopt the current requirements for chemical PMNs, that is, require CBI substantiation only after the receipt of a FOIA request. EPA is concerned that given the shorter review period for TERAs, insufficient information may be made available to the public if upfront substantiation of CBI claims is not required. For this reason, EPA specifically requests comment on how public access to information could be improved if submitters were not required to provide upfront substantiation of CBI claims in TERAs.

c. *Substantiation questions.* EPA's general procedures for processing and reviewing confidentiality claims are published at 40 CFR part 2. The basic points that should be covered in CBI substantiation are set out at 40 CFR § 2.204(e)(4)(i) through (ix). To ensure that substantiation responses are appropriate for submissions involving microorganisms, EPA has developed a more specific set of questions based on the points in 40 CFR part 2. These questions, which are delineated in proposed § 725.94, are designed to reduce the burden of substantiation by focussing the inquiry on points relevant to a biotechnology product.

E. User Fees

Section 26(b) of TSCA provides that EPA may by rule establish fees for persons required to submit data under section 4 or 5 to defray the costs of administering TSCA. EPA must take into account the submitter's ability to pay the fee and the cost of reviewing the submitted data. EPA is using this authority to collect fees for notices submitted on microorganisms.

EPA regulations already require persons to remit fees to EPA when a PMN or SNUN is submitted to the Agency for review (40 CFR § 700.45). For MCAN submissions, EPA is proposing to amend part 700 to establish a fee of $100 for notifications submitted by small businesses, and $2,500 for all other businesses. For purposes of this proposed rule, small businesses are defined as companies with total annual sales of less than $40 million. These proposed fees for MCANs are the same as those set for submissions of PMNs for other chemical substances. EPA believes that its costs of reviewing MCAN notifications will equal or exceed the cost of reviewing PMNs for other chemical substances.

EPA is not proposing user fees for other submissions under this proposed

rule, including TERAs and Tier II exemption requests. EPA is not reopening the general issues applicable to the adoption of user fees for comment in this document, since comments on the subject were addressed in a final rule published in the **Federal Register** of August 17, 1988 (53 FR 31248).

F. Section 8(e) Reporting Requirements

Any person who manufactures, imports, processes, or distributes in commerce a TSCA-covered microorganism, whether new or existing, and/or product(s) therefrom (including a person engaged solely in R&D) is reminded about the statutory responsibility to immediately report to EPA any information the person obtains which reasonably supports the conclusion that such microorganism, or a product therefrom, presents a substantial risk of injury to health or the environment, unless the person has actual knowledge that EPA has been adequately informed already about the information. Guidance regarding the section 8(e) reporting requirement is provided in EPA's section 8(e) policy statement ("Statement of Interpretation and Enforcement Policy; Notification of Substantial Risk" 43 FR 11110; March 16, 1978) and its technical amendment (52 FR 20083; May 29, 1987). Additional information regarding TSCA section 8(e) reporting is provided in 56 FR 4128 (February 1, 1991); 56 FR 19514 (April 26, 1991); 56 FR 28458 (June 20, 1991); and 56 FR 49478 (September 30, 1991).

Should EPA receive a section 8(e) substantial risk notice with respect to the manufacture, importation, processing or distribution in commerce of a microorganism, EPA may proceed to regulate the activity causing the risk. If EPA determines, under authority of TSCA section 7, that the activity or microorganism, including its parts or products, on which a section 8(e) notice was received, is "imminently hazardous" to health or the environment, EPA may require immediate suspension of manufacturing, processing or distribution in commerce of the imminently hazardous microorganism. EPA also may require any remediation necessary to obtain permanent relief as may be necessary to protect health or the environment from the unreasonable risks associated with the microorganism. This authority applies to any "imminently hazardous" microorganism or its parts or products, regardless of whether the microorganism is used for R&D or manufactured for general commercial use.

The term "imminently hazardous chemical substance or mixture" in TSCA section 7 means a chemical substance or mixture which presents an imminent and unreasonable risk of serious or widespread injury to health or the environment. Such a risk is considered imminent if the manufacture, processing, distribution in commerce, use or disposal of the substance is likely to result in such injury before a final rule can be issued under TSCA section 6.

G. Export Notification and State Preemption

This Unit discusses two other provisions of TSCA concerning export notification and Federal preemption that may be of some concern to the public in implementing this proposed rule.

1. *General.* Section 12 of TSCA generally provides that the Act does not apply to chemical substances produced for export. However, section 12(b)(2) requires, in pertinent part, that EPA must be notified about the export of any substance in U.S. production that is subject to a rule, an order, or some other relief granted under section 5. EPA must then notify the government of the receiving country. EPA's export notification regulations are codified at 40 CFR part 707.

Section 18(a) provides that TSCA generally does not preempt the authority of any State or local government to regulate a chemical substance. There are some exceptions, however. In particular, section 18(b) states that, if EPA issues a rule or order under section 5 "which is applicable to a chemical substance" and "which is designed to protect against a risk of injury...associated with such substance", no State or local government may issue or continue in effect any requirement designed to protect against the same risk, with certain exceptions. The exceptions are that the State or local requirement may be identical to the Federal requirement, may be issued under authority of another Federal law, or may prohibit use of the substance (other than in the manufacture or processing of another chemical substance or mixture).

2. *Applicability.* EPA interprets the exemption of section 12(a) to apply only to those microorganisms manufactured, processed, or distributed solely for export. If the microorganism is manufactured, processed, or distributed for any use in the United States, it is subject to TSCA (see TSCA section 12(a)(1)(A)). Thus, any R&D in the U.S. is subject to applicable regulations, as are any other activities involving a microorganism that are described in this proposed rule. Similarly, any release of microorganisms to the environment prior to export will not be considered solely for export and is therefore subject to applicable regulations.

Since the rules proposed in this document are either of general applicability and largely procedural, or are exemptions from regulation and only establish procedures to screen against potential risk, neither section 12(b) export notification nor section 18(b) preemption applies at this time.

Sections 12(b) and 18(b) would apply should EPA decide to take regulatory action against a microorganism or class of microorganisms, for example, by issuing an order under TSCA section 5(e). In such cases, section 12(b) export notification would apply automatically. While preemption under section 18(b) would apply by operation of statute, in individual cases EPA could issue rules that specifically require compliance with applicable State or local requirements.

H. Regulatory Text Overview

The regulatory text comprises the language which EPA is proposing to incorporate into the Code of Federal Regulations (CFR). While the preamble to this proposed rule provides the rationale for EPA's preferred approach towards the oversight of certain activities involving new microorganisms, the regulatory text includes all the proposed requirements to which the regulated community would be subject.

The regulatory text amends existing regulations regarding the collection of fees from submitters of notices under section 5 of TSCA (40 CFR part 700), to reflect the fee structure for the notices and applications that have been developed by this proposed rule. Additional amendments to parts 720, 721, and 723 consolidate TSCA section 5 review of microorganisms into part 725.

EPA is proposing to establish a new part 725 of Title 40 of the CFR. EPA believes that consolidating all requirements and procedures applicable to new microorganisms into one part of the CFR is justified because of the differences between microorganisms and other chemical substances.

The consolidation will benefit the public by providing greater clarity. Part 725 is devoted exclusively to the review of microorganisms under section 5 of TSCA and is currently divided into eight subparts. Subparts A, B, and C consolidate provisions primarily adapted from parts 720 and 721. Subpart A, which includes definitions

that are applicable throughout part 725, describes general provisions and applicability. Subpart B describes administrative procedures that are applicable to all submissions under part 725. Subpart C describes confidentiality provisions that are applicable to all submissions under part 725.

Subpart D, which combines the general PMN and SNUN requirements adapted from parts 720 and 721, describes the reporting requirements and review process pertaining to MCANs. Subparts E, F, and G describe the reporting requirements and review processes for applications for exemptions from full MCAN reporting. Subpart E, which is almost entirely new, describes who is eligible to submit a TERA or receive a TERA list exemption, and what criteria must be met to receive an exemption from EPA review for certain types of R&D activities. Subpart F, which is an adaptation of § 720.38, describes the requirements for a test marketing exemption for microorganisms. Subpart G, which is entirely new, describes what criteria must be met in order to qualify for Tier I or Tier II exemptions for certain microorganisms in general commercial use. Subpart L, which is adapted from part 721, describes additional procedures for reporting significant new uses of microorganisms. Although significant new use rules are not being proposed at this time, it is intended that subpart M will list microorganisms and specific significant new uses when they are promulgated.

I. Rulemaking Process and Public Hearings

EPA is conducting this rulemaking under notice and comment rulemaking procedures. Interested persons have the opportunity to submit written comments to the address identified under the ADDRESSES Unit of this preamble. EPA will carefully consider all such comments.

EPA is also providing an opportunity for an informal public hearing on the proposed rule. This hearing will be held only if EPA receives a timely written request for such a hearing.

As a general matter, EPA is not required to hold a public hearing in informal notice and comment rulemaking of this type. However, use of section 5(h)(4) modifies the general rulemaking requirements by referencing TSCA section 6(c)(2) and (3) rulemaking procedures. Under those procedures, EPA must hold an informal public hearing, if requested, and, if properly requested and granted by EPA, allow an opportunity to present rebuttal submissions and conduct cross-examinations related to disputed issues of material fact.

EPA does not anticipate that, even if a hearing is held, there will be a need for rebuttal submissions and crossexamination, because the section 5(h)(4) portion of this proposed rulemaking is based primarily on matters of science policy that do not yield disputed factual issues.

V. Economic Impact and Regulatory Flexibility Analysis

A. Regulatory Impact Analysis

1. *Introduction.* EPA has prepared a Regulatory Impact Analysis (RIA) assessing the costs, benefits, and associated impacts of regulating new microorganisms under TSCA as set forth in the proposed rule. Though direct regulatory costs attributable to the proposed rule were not estimated to be in excess of $100 million annually, EPA has designated the rule as "significant" under Executive Order 12866 because it raises novel policy issues arising out of legal mandates. This unit presents a summary of the RIA's key findings and estimates.

2. *Characteristics of the regulated community.* Although unable to quantify the exact magnitude of activity in biotechnology sectors affected by this rulemaking, the Agency believes that activities involving microorganisms falling within the scope of the proposed rule comprise a modest share of overall activity. EPA estimates that approximately 130 firms may be involved in commercial R&D or in general commercial use of potentially regulated microorganisms. In terms of revenue, the potentially affected universe appears to be divided sharply between large and small firms. EPA estimates roughly one-half of the companies potentially affected to have annual sales of $40 million or more, while most of those remaining are estimated to have sales under $10 million. For many of these firms, however, revenue generated from activities subject to this proposal is believed to represent only a small portion of reported sales. EPA also estimates that approximately 300 universities could be affected by the rulemaking.

3. *Costs to potential submitters.* Due to data limitations and the uncertainties associated with projecting future product development activities in biotechnology application areas subject to the proposed rule, EPA's estimates of the costs of compliance associated with this rulemaking action have been only partially quantified. In cases where the Agency was able to generate quantified estimates of compliance costs, information which would have permitted the development of more accurate estimates was frequently unavailable. In such cases, the best available information was used. Estimates are believed to represent a reasonable approximation of actual costs attributable to the rule.

In assessing the potential cost impact of the proposed rule, EPA focussed on two impact years, the first and fifth years following the time of proposal (assumed to be 1992 and 1996, for the purposes of analysis). This approach was used because of the relative immaturity of the biotechnology sectors potentially subject to the proposed rule and the difficulty in attempting to forecast long-term technological and marketing developments. However, EPA wishes to emphasize that estimated costs could be significantly higher in the long-term, owing to industry growth.

Four major cost areas were identified, based on an analysis of the requirements of the proposed rule. These areas were costs incurred in preparing various types of notification submissions or documentation; costs incurred in complying with any post review requirements for monitoring or controls that may be imposed by EPA as a result of risk concerns and uncertainties; costs incurred in substantiating confidential business information (CBI) claims; and one-time costs attributable to rule familiarization.

Incremental costs to industry (industry-wide costs excluding requirements under current policy) were estimated to fall between $890,000 and $2.2 million in year 1 and between $56,000 and $460,000 in year 5. Year 5 costs account for rule familiarization only in the case of new firms entering the affected market areas, and therefore are much less than year 1 costs, where rule familiarization costs were summed over all affected entities.

Cost impacts on individual products will vary, depending on application area. Submitters qualifying for exemptions in connection with microorganisms intended for general commercial use will realize net savings relative to current reporting requirements. On the other hand, submitters reporting R&D activities involving environmental release may realize an increase in regulatory burden under the proposed rule.

4. *Costs to the Federal government.* EPA estimated the potential costs to government associated with the proposed rule. These costs arise in connection with the Agency's processing of individual notification submissions. In estimating government

cost impacts, EPA included costs estimated to be incurred in reviewing each submission. EPA professionals and members of the Biotechnology Science Advisory Committee were assumed to be involved in such review. In the event that post-review restrictions would be placed on a specific activity, such as monitoring during a field test, additional costs attributable to the drawing up of regulatory documentation would be incurred.

Incremental costs to the government were estimated to fall between $115,000 and $122,000 in year 1, while a net savings to EPA, estimated to fall between $39,000 and $184,000, is expected in year 5. These savings arise in connection with the substantial number of full reviews that will be avoided if the exemption provisions of the proposed rule are promulgated.

5. *Benefits of the proposed rule.* EPA's regulation of new microorganisms under TSCA provides benefits to society through reduction of the potential for adverse impacts on health and the environment resulting from the use of such microorganisms. This benefit is achieved by screening new microorganisms and, when appropriate, imposing controls on microorganism use to protect society from costly and possibly irreversible damages.

For microorganisms in general commercial use, risk reduction attributable strictly to the notification requirements of proposed rule would be marginal, as these requirements are based on current policy. However, the proposed rule enhances and contributes to the overall risk reduction potential of the Agency's program under TSCA by providing for a more efficient regulatory strategy relative to current policy, focussing society's resources on those new microorganisms of greatest concern.

For microorganisms in commercial R&D, a greater proportion of overall risk reduction can be attributed to the proposed rule, since reporting in connection with field experiments has been voluntary since 1986. Although the Agency has been receiving voluntary submissions, EPA is not certain whether this practice is universal or whether those filing voluntarily would continue to do so in the absence of this proposed rule.

Over the long-term, regulation is also likely to encourage development of additional information concerning fate and effects of new microorganisms, to encourage the development of microorganisms which pose low concern for effects on human health and the environment, and to encourage public input into decisions concerning the use of new microorganisms.

Benefits may also be realized through the proposed rule's potential impact on the pace of product development. A more certain regulatory climate could stimulate business activity, as could a more reassured public. The proposed rule may also reduce the possibility of continued regulatory activity at the State and local level. A national system of potentially uncoordinated rulemaking initiatives could lead to market distortion and could hamper competition.

6. *Effects of the proposed rule on innovative activity.* As a result of the proposed rule, members of the regulated community may find product development strategies in connection with certain products to require reassessment. Since impacts of this nature could influence the degree of emphasis a firm places on innovative activity, the potential for innovation impacts was investigated.

Though great uncertainty regarding regulatory costs and the potential for a particular product's commercial success make it impossible to estimate innovation impacts quantitatively, the effects of added regulatory costs and delays on a product's lifetime cash-flow was examined. More specifically, a number of plausible product development scenarios were modeled incorporating assumptions regarding expenditures and returns over the course of a product's useful life from research to obsolescence. Regulatory burdens were then factored into the models, and profit impacts observed. Impacts realized when total regulatory costs were assumed to reach the upper-bound of EPA's estimated range could result in severe profit reductions in some cases. However, in general, EPA's analysis indicated that impacts should not be prohibitive, particularly when incremental costs are considered. Factors such as length of delay related to regulatory review, return rate, and obsolescence rate all play important roles in determining the impact of EPA's program on innovative activity. These factors are expected to be highly variable and product-specific.

7. *Impacts on small business.* EPA survey data suggest that 42 percent of companies potentially affected by the proposed rule may be small businesses. Though data were not available allowing the Agency to employ standard criteria for assessing the magnitude of small business impacts, the finding of a substantial portion of the regulated community to be small businesses prompted EPA to develop options to provide relief to such businesses. The options considered include reducing CBI substantiation requirements and the elimination of the $100 filing fee.

B. Request for Comment on Economic Issues

Based on the analysis presented in the RIA, EPA's preliminary findings are that this proposed rule should not adversely affect either innovation or international competitiveness in biotechnology; to the contrary, EPA believes that this proposed rule will provide needed regulatory and procedural clarity under TSCA to enable the U.S. biotechnology industry to commercialize products while ensuring appropriate oversight to protect public health and the environment.

EPA nevertheless believes that this proposed rule should continue to be evaluated in light of its potential impact on innovation and international competitiveness. To this end, the Agency is requesting public comment regarding the economic impacts associated with this proposed rule. Data or other information are specifically requested in connection with the following: rate of capital acquisition and critical factors affecting R&D capitalization; rate and magnitude of R&D expenditures; data regarding actual submissions under the current policy, e.g., project development costs, regulatory burdens, development schedules and revenues.

VI. Rulemaking Record and Electronic Availability of Documents

A record has been established for this proposed rule under docket number "OPPTS–00049C." A public version of this record which does not include any information claimed as CBI (see Unit VII. of this preamble), is available for inspection from noon to 4 p.m., Monday through Friday, excluding legal holidays. The public record is located in the TSCA Nonconfidential Information Center (NCIC) (also known as the TSCA Public Docket Office), Rm. NE–B607, 401 M St., SW., Washington, DC 20460.

As part of an interagency "streamlining" initiative, EPA is making this proposed rule and certain support documents available electronically. They may be accessed through the Internet at: gopher.epa.gov.

EPA is very interested in learning whether persons have obtained these documents electronically and what their experiences were in doing so. Persons who comment on this proposed rule are encouraged to provide feedback on this electronic availability with their comments.

To obtain further information or to provide feedback on the electronic

availability of these documents, please contact Juanita Geer (Telephone: 202–260–1532; FAX: 202–260–1657; Internet: geer.juanita@epamail.epa.gov). Please be advised that Ms. Geer will accept only feedback on the electronic availability of these documents; all comments on the substance of the proposed rule must be submitted to the docket above.

VII. Public Record

EPA has established a public record for this rulemaking (docket control number OPPTS–00049C). The record includes all information considered by EPA in developing this proposed rule. The record now includes the following items:

1. All prior Federal Register Notices, and supporting public dockets, relating to the regulation of microbial products of biotechnology under TSCA. These include:

a. The 1984 Proposed Policy Statement (49 FR 50856, December 31, 1984).

b. The 1986 Policy Statement (51 FR 23302, June 26, 1986).

c. "Biotechnology; Request for Comment on Regulatory Approach", 54 FR 7027, February 15, 1989).

2. Public comments submitted in response to each of the above Notices, including the comments received at the September 1989 Meeting which was held to discuss TSCA regulatory options for oversight of R&D.

3. "Principles for Federal Oversight of Biotechnology: Planned Introduction Into the Environment of Organisms With Modified Hereditary Traits", Office of Science and Technology Policy, 55 FR 31118, July 31, 1990.

4. Reports of all BSAC meetings pertaining to this proposed rule.

5. The Regulatory Impact Analysis for this proposed rule.

6. Support documents and reports.

7. Records of all communications between EPA personnel and persons outside EPA pertaining to the development of this proposed rule. (This does not include any inter- or intra-agency memoranda, unless specifically noted in the Index of this docket.)

8. The docket also includes published literature that is cited in this document.

EPA will accept additional materials for inclusion in the record at any time between the date of publication of this proposed rule and the designation of the complete record. EPA will identify the complete rulemaking record by the date of promulgation of the final rule.

Comments received on this proposed rule, along with a complete Index of the docket for this rulemaking, is available to the public for inspection from noon to 4 p.m., Monday through Friday, except legal holidays, in the TSCA Nonconfidential Information Center, Rm. NE–102, 401 M St., SW., Washington, DC 20460. Only nonconfidential versions of documents are included in the public record.

VIII. References

The following books, articles, and reports were used in preparing this notice and were cited in this notice by the number indicated below:

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(2) U.S. Congress, Subcommittee on Investigations and Oversight, House Science, Space and Technology Committee. 1986. "Issues in the Federal Regulation of Biotechnology: from Research to Releases." Washington, DC.

(3) U.S. Environmental Protection Agency, Office of General Counsel, Pesticides and Toxic Substances Division. 1983. "Status of recombinant DNA and new life forms under Toxic Substances Control Act (TSCA). Washington, DC.

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IX. Regulatory Assessment Requirements

A. Executive Order 12866

Under Executive Order 12866 (58 FR 51735, October 4, 1993), the Agency must determine whether the regulatory action is "significant" and therefore subject to review by the Office of Management and Budget (OMB) and the requirements of the Executive Order. Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.

Pursuant to the terms of this Executive Order, EPA has determined that this proposed rule is "significant" because it raises novel policy issues arising out of legal mandates. As such, this action was submitted to OMB for review, and any comments or changes made in response to OMB suggestions or recommendations have been documented in the public record.

B. Regulatory Flexibility Act

Under the Regulatory Flexibility Act (5 U.S.C. 605(b)), EPA has analyzed the economic impact of this proposed rule on small businesses. A summary of this analysis appears in Unit V. of this preamble. This proposed rule does not exempt small businesses. Preliminary analysis of the impacts of this proposed rule on small businesses indicates that the compliance costs may have a significant impact. Despite the uncertainties and data gaps faced by EPA in developing this analysis, EPA believes that it is prudent public policy to assume that the requirements of the Regulatory Flexibility Act (Pub. L. 96–354) have been triggered. EPA believes that review of certain new microorganisms under TSCA is important to ensure that there are no unreasonable risks to health and the environment, and that the mechanisms outlined in this proposed rule will lessen impacts on small business as much as possible.

The Regulatory Impact Analysis section on small business impacts (Section VIII of the RIA, which is part of the public record for this rulemaking) serves as the Initial Regulatory Flexibility Analysis required by the Regulatory Flexibility Act. EPA intends to revise this analysis prior to promulgation of the final rule. EPA requests comments on the methodology employed in this analysis and the results of this analysis.

C. Paperwork Reduction Act

The Office of Management and Budget (OMB) has approved the current Premanufacture Notification and SNUR program under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 et seq. and has assigned OMB control number 2070–0012. This proposed rule, when promulgated, would modify those information collection requirements; an information collection request addressing these modifications has been submitted to OMB under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 et seq.

Public reporting burden for this collection of information is estimated to average 473 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to Chief, Information Policy Branch, 2136, U.S. Environmental Protection Agency, 401 M St., SW., Washington, DC 20460, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503, marked "Attention: Desk Officer for EPA." The final rule will respond to any OMB or public comments on the information collection requirements contained in this proposal.

List of Subjects in 40 CFR Parts 700, 720, 721, 723, and 725

Environmental protection, Administrative practice and procedure, Biotechnology, Chemicals, Hazardous substances, Imports, Labeling, Microorganisms, Occupational safety and health, Reporting and recordkeeping requirements

Dated: August 19, 1994.

Carol M. Browner,

Administrator.

Therefore, it is proposed that 40 CFR Chapter I be amended as follows:

PART 700—[AMENDED]

1. In part 700:

a. The authority citation for part 700 would continue to read as follows:

Authority: 15 U.S.C. 2625.

b. In § 700.43, by revising the introductory text and the definition of "Section 5 notice" and adding two definitions to read as follows:

§ 700.43 Definitions.

Definitions in section 3 of the Act (15 U.S.C. 2602), as well as definitions contained in § § 704.3, 720.3, and 725.3 of this chapter, apply to this subpart unless otherwise specified in this section. In addition, the following definitions apply:

Consolidated microbial commercial activity notice or consolidated MCAN means any MCAN submitted to EPA that covers more than one microorganism (each being assigned a separate MCAN number by EPA) as a result of a prenotice agreement with EPA.

* * * * *

Microbial commercial activity notice or *MCAN* means any notice for microorganisms submitted to EPA pursuant to section 5(a)(1) of the Act in accordance with subpart D of part 725 of this chapter.

* * * * *

Section 5 notice means any PMN, consolidated PMN, intermediate PMN, significant new use notice, exemption notice, exemption application, any MCAN or consolidated MCAN submitted under section 5 of TSCA.

* * * * *

c. In § 700.45 by adding paragraphs (b)(2)(vi), (e)(4)(iv), (e)(5)(iv), (f)(4), and revising paragraphs (c) and (f)(3) to read as follows:

§ 700.45 Fee payments.

* * * * *

(b) * * *

(2) * * *

(vi) *MCAN and consolidated MCAN.* Persons shall remit a fee of $2,500 for each MCAN or consolidated MCAN submitted.

(c) *No fee required.* Persons are exempt from remitting any fee for submissions under §§ 720.38, 723.50, and subparts E, F, and G of part 725 of this chapter.

* * * * *

(e) * * *

(4) * * *

(iv) Each person who remits the fee identified in paragraph (b)(1) of this section for a MCAN for a microorganism shall include the words, "The company identified in this notice is a small business concern under 40 CFR 700.43 and has remitted a fee of $100 in accordance with 40 CFR 700.45(d)," in the certification required in § 725.25(b) of this chapter.

(5) * * *

(iv) Each person who remits a fee identified in paragraph (b)(2) of this section for a MCAN for a microorganism shall include the words, "The company identified in this notice has remitted the fee specified in 40 CFR 700.45(b)," in the certification required in § 725.25(b) of this chapter.

(f) * * *

(3) The notice is incomplete under either § 720.65(c) or 725.33, of this chapter.

(4) That as of the date of submission of the notice: the microorganism that is the subject of a MCAN is not a new microorganism; nor is the use involving the microorganism a significant new use.

d. By revising § 700.49 to read as follows:

§ 700.49 Failure to remit fees.

EPA will not consider a section 5 notice to be complete unless the appropriate certification under § 700.45(e) is included and until the appropriate remittance under § 700.45(b) has been sent to EPA as provided in § 700.45(e) and received by EPA. EPA will notify the submitter that the section 5 notice is incomplete in accordance with §§ 720.65(c) and 725.33 of this chapter.

PART 720 — [AMENDED]

2. In part 720:

a. The authority citation for part 720 would continue to read as follows:

Authority: 15 U.S.C. 2604, 2607, and 2613.

b. In § 720.1, by revising the first sentence and adding a sentence to read as follows:

§ 720.1 Scope.

This part establishes procedures for the reporting of new chemical substances by manufacturers and importers under section 5 of the Toxic Substances Control Act, 15 U.S.C. 2604. This part applies to microorganisms only to the extent provided by part 725 of this chapter. * * *

PART 721 — [AMENDED]

3. In part 721:

a. The authority citation for part 721 would continue to read as follows:

Authority: 15 U.S.C. 2604, 2607, and 2625(c).

b. In § 721.1(a), by revising the first sentence to read as follows:

§ 721.1 Scope and applicability.

This part identifies uses of chemical substances, except for microorganisms regulated under part 725 of this chapter, which EPA has determined are significant new uses under the authority of section 5(a)(2) of the Toxic Substances Control Act. * * *

PART 723 — [AMENDED]

4. In part 723:

a. The authority citation for part 723 would continue to read as follows:

Authority: 15 U.S.C. 2604.

b. In § 723.50, by revising paragraph (a)(1) to read as follows:

§ 723.50 Chemical substances manufactured in quantities of 1,000 kilograms or less per year.

(a) *Purpose and scope.* (1) This section grants an exemption from the premanufacture notice requirements of section 5(a)(1)(A) of the Toxic Substances Control Act (15 U.S.C. 2604(a)(1)(A)) for the manufacture of certain chemical substances manufactured in quantities of 1,000 kilograms or less per year. This section does not apply to microorganisms regulated under part 725 of this chapter.

* * * * *

c. In § 723.175, by revising paragraph (a)(1) to read as follows:

§ 723.175 Chemical substances used in or for the manufacture or processing of instant photographic and peel-apart film articles.

(a) *Purpose and scope.* (1) This section grants an exemption from the premanufacture notice requirements of section 5(a)(1)(A) of the Toxic Substances Control Act (15 U.S.C. 2604(a)(1)(A)) for the manufacture and processing of new chemical substances used in or for the manufacture or processing of instant photographic and peel-apart film articles. This section does not apply to microorganisms regulated under part 725 of this chapter.

* * * * *

d. In § 723.250, by revising paragraph (a)(1) to read as follows:

§ 723.250 Polymers.

(a) *Purpose and scope.* (1) This section grants an exemption from the premanufacture notice requirements of section 5(a)(1)(A) of the Toxic Substances Control Act (15 U.S.C. 2604(a)(1)(A)) for the manufacture of certain polymers. This section does not apply to microorganisms regulated under part 725 of this chapter.

* * * * *

5. Part 725 is added to read as follows:

PART 725—REPORTING REQUIREMENTS AND REVIEW PROCESSES FOR MICROORGANISMS

Subpart A—General Provisions and Applicability

Sec.

725.1 Scope and purpose.
725.3 Definitions.
725.8 Coverage of this part.
725.12 Identification of microorganisms for Inventory and other listing purposes.
725.15 Determining applicability when microorganism identity or use is confidential or uncertain.
725.17 Consultation with EPA.

Subpart B—Administrative Procedures

725.20 Scope and purpose.
725.25 General administrative requirements.
725.27 Submissions.
725.28 Notice that submission is not required.
725.29 EPA acknowledgement of receipt of submission.
725.32 Errors in the submission.
725.33 Incomplete submissions.
725.36 New information.
725.40 Notice in the **Federal Register**.
725.50 EPA review.
725.54 Suspension of the review period.
725.56 Extension of the review period.
725.60 Withdrawal of submission by the submitter.
725.65 Recordkeeping.
725.67 Applications to exempt new microorganisms from this part.
725.70 Compliance.
725.75 Inspections.

Subpart C—Confidentiality and Public Access to Information

725.80 General provisions for confidentiality claims.
725.85 Microorganism identity.
725.88 Uses of a microorganism.
725.92 Data from health and safety studies of microorganisms.
725.94 Substantiation requirements.
725.95 Public file.

Subpart D—Microbial Commercial Activities Notification Requirements

725.100 Scope and purpose.

725.105 Persons who must report.
725.110 Persons not subject to this subpart.
725.150 Procedural requirements for this subpart.
725.155 Information to be included in the MCAN.
725.160 Submission of health and environmental effects data.
725.170 EPA review of the MCAN.
725.190 Notice of commencement of manufacture or import.

Subpart E—Exemptions for Research and Development Activities

725.200 Scope and purpose.
725.205 Persons who may report under this subpart.
725.232 Activities subject to the jurisdiction of other Federal programs or agencies.
725.234 Activities conducted inside a structure.
725.235 Conditions of exemption for activities conducted inside a structure.
725.238 Activities conducted outside a structure.
725.239 Use of specific microorganisms in activities conducted outside a structure.
725.250 Procedural requirements for this subpart.
725.255 Information to be included in the TERA.
725.260 Submission of health and environmental effects data.
725.270 EPA review of the TERA.
725.288 Revocation or modification of TERA approval.

Subpart F—Exemptions for Test Marketing

725.300 Scope and purpose.
725.305 Persons who may report under this subpart.
725.350 Procedural requirements for this subpart.
725.355 Information to be included in the TME application.
725.370 EPA review of the TME application.

Subpart G—Exemption for Microorganisms in General Commercial Use

725.400 Scope and purpose.
725.420 Recipient microorganisms.
725.421 Introduced genetic material.
725.422 Physical containment and control technologies.
725.424 Requirements for the Tier I exemption.
725.426 Liability of the manufacturer or importer who uses the Tier I exemption.
725.428 Requirements for the Tier II exemption.
725.450 Procedural requirements for the Tier II exemption.
725.455 Information to be included in the Tier II exemption request.
725.470 EPA review of the Tier II exemption request.

Subparts H—K [Reserved]

Subpart L—Additional Procedures Applicable to Reporting on Significant New Uses of Microorganisms

725.900 Scope and purpose.
725.910 Persons excluded from reporting of significant new uses.
725.912 Exemptions.
725.920 Exports and imports.
725.950 Additional recordkeeping requirements for reporting of significant new uses.
725.975 EPA approval of alternative control measures.
725.980 Expedited procedures for issuing significant new use rules for microorganisms subject to section 5(e) orders.
725.984 Modification or revocation of certain notification requirements.

Subpart M—Significant New Uses for Specific Microorganisms—[Reserved]

Authority: 15 U.S.C. 2604, 2607, 2613, and 2625.

Subpart A—General Provisions and Applicability

§ 725.1 Scope and purpose.

(a) This part establishes reporting requirements under section 5 of TSCA for manufacturers, importers, and processors of microorganisms for commercial purposes.

(b) TSCA section 5 covers chemical substances as defined under TSCA section 3. Because EPA interprets the section 3 definition to include microorganisms, section 5 also covers microorganisms. Unless otherwise specifically stated in the Code of Federal Regulations, TSCA section 5 authority over microorganisms (as distinguished from other chemical substances) will be implemented under this part.

(c) Microorganisms subject to reporting as new microorganisms will be those which are intergeneric. In addition, any microorganism subject to TSCA jurisdiction may be subject to reporting, if EPA determines by rule that the microorganism is being manufactured, imported, or processed for a significant new use.

(d) This subpart A describes the general organization for this part and contains definitions generally applicable to this part.

(e) Subpart B of this part describes general administrative procedures applicable to microorganisms subject to this part.

(f) Subpart C of this part establishes requirements for handling confidential business information (CBI) and public access to information submitted under this part.

(g) Subpart D of this part describes the persons and microorganisms subject to Microorganism Commercial Activity Notices (MCANs), prescribes the content of MCANs, and establishes procedures for reviewing MCANs.

(h) Subpart E of this part establishes reporting requirements and EPA review procedures for the TSCA Experimental Release Application (TERA) for microorganisms intentionally tested in the environment during commercial research and development activities. Subpart E of this part also identifies microorganisms and classes of microorganisms exempt from research and development reporting.

(i) Subpart F of this part establishes procedures for obtaining test marketing exemptions (TMEs) for microorganisms.

(j) Subpart G of this part identifies microorganisms in general commercial use under certain conditions of containment that are eligible for Tier I and Tier II exemptions from subpart D reporting. Subpart G of this part establishes reporting requirements and procedures for expedited review of the Tier II exemption request.

(k) Subpart L of this part describes additional requirements applicable to reporting on microorganisms subject to significant new use rules under TSCA section 5(a)(2). All significant new uses of microorganisms are subject to the MCAN requirements in subpart D of this part.

(l) Subpart M of this part identifies specific significant new uses of microorganisms subject to subpart D reporting.

§ 725.3 Definitions.

Definitions in section 3 of the Act (15 U.S.C. 2602), as well as definitions contained in § § 704.3, 720.3, and 721.3 of this chapter, apply to this part unless otherwise specified in this section. In addition, the following definitions apply to this part:

Consolidated microbial commercial activity notice or *consolidated MCAN* means any MCAN submitted to EPA that covers more than one microorganism (each being assigned a separate MCAN number by EPA) as a result of a prenotice agreement with EPA.

Containment and/or inactivation controls means any combination of engineering, mechanical, procedural, or biological controls designed and operated to restrict environmental release of viable microorganisms from a structure.

Director means the Director of the EPA Office of Pollution Prevention and Toxics.

Exemption request means any application submitted to EPA under subparts E, F, or G of this part.

General commercial use means use for commercial purposes other than research and development.

Genome means the sum total of chromosomal and extrachromosomal genetic material of an isolate and any descendants derived under pure culture conditions from that isolate.

Health and safety study of a microorganism or *health and safety study* means any study of any effect of a microorganism or microbial mixture on health or the environment or on both, including underlying data and epidemiological studies, studies of occupational exposure to a microorganism or microbial mixture, toxicological, clinical, and ecological, or other studies of a microorganism or microbial mixture, and any test performed under the Act. Microorganism identity is always part of a health and safety study of a microorganism.

(1) It is intended that the term "health and safety study of a microorganism" be interpreted broadly. Not only is information which arises as a result of a formal, disciplined study included, but other information relating to the effects of a microorganism or microbial mixture on health or the environment is also included. Any data that bear on the effects of a microorganism on health or the environment would be included.

(2) Examples include:

(i) Tests for ecological or other environmental effects on invertebrates, fish, or other animals, and plants, including: Acute toxicity tests, chronic toxicity tests, critical life stage tests, behavioral tests, algal growth tests, seed germination tests, plant growth or damage tests, microbial function tests, bioconcentration or bioaccumulation tests, and model ecosystem (microcosm) studies.

(ii) Long- and short-term tests of mutagenicity, carcinogenicity, or teratogenicity; dermatoxicity; cumulative, additive, and synergistic effects; and acute, subchronic, and chronic effects.

(iii) Assessments of human and environmental exposure, including workplace exposure, and impacts of a particular microorganism or microbial mixture on the environment, including surveys, tests, and studies of: Survival and transport in air, water, and soil; ability to exchange genetic material with other microorganisms, ability to colonize human or animal guts, and ability to colonize plants.

(iv) Monitoring data, when they have been aggregated and analyzed to measure the exposure of humans or the environment to a microorganism.

(v) Any assessments of risk to health and the environment resulting from the manufacture, processing, distribution in commerce, use, or disposal of the microorganism.

Inactivation means that living microorganisms are rendered nonviable. "Introduced genetic material" means genetic material that is added to, and remains as a component of, the genome of the recipient.

Intergeneric microorganism means a microorganism that is formed by the deliberate combination of genetic material from organisms of different taxonomic genera, including mobile genetic elements. The term "intergeneric microorganism" does not include a microorganism which contains genetic material consisting of only well-characterized, non-coding regulatory regions from another genus.

Introduced genetic material means genetic material that is added to, and remains as a component of, the genome of the recipient.

Manufacture, import, or process for commercial purposes means: (1) To import, produce, manufacture, or process with the purpose of obtaining an immediate or eventual commercial advantage for the manufacturer, importer, or processor, and includes, among other things, "manufacture" or "processing" of any amount of a microorganism or microbial mixture:

(i) For commercial distribution, including for test marketing.

(ii) For use by the manufacturer, including use for product research and development or as an intermediate.

(2) The term also applies to substances that are produced coincidentally during the manufacture, processing, use, or disposal of another microorganism or microbial mixture, including byproducts that are separated from that other microorganism or microbial mixture and impurities that remain in that microorganism or microbial mixture. Byproducts and impurities without separate commercial value are nonetheless produced for the purpose of obtaining a commercial advantage, since they are part of the manufacture or processing of a microorganism for commercial purposes.

Microbial commercial activity notice or *MCAN* means a notice for microorganisms submitted to EPA pursuant to subpart D of this part.

Microbial mixture means any combination of microorganisms or microorganisms and other chemical substances, if the combination does not occur in nature and is not an article.

Microorganism means an organism classified in the kingdoms Monera (or Procaryotae), Protista, Fungi, and the Chlorophyta and the Rhodophyta of the Plantae, and a virus or virus-like particle.

Mobile genetic element or *MGE* means an element of genetic material that has the ability to move genetic material within and between organisms. "Mobile genetic elements" include all plasmids, viruses, transposons, insertion sequences, and other classes of elements with these general properties.

New microorganism means a microorganism not included on the TSCA Inventory.

Small quantities solely for research and development (or "small quantities solely for purposes of scientific experimentation or analysis or research on, or analysis of, such substance or another substance, including such research or analysis for development of a product") means quantities of a microorganism manufactured, imported, or processed or proposed to be manufactured, imported, or processed solely for research and development that meet the requirements of § 725.234.

Structure means a building or vessel which effectively surrounds and encloses the microorganism and includes features designed to restrict the microorganism from leaving.

Submission means any MCAN or exemption request submitted to EPA under this part.

Technically qualified individual means a person or persons (1) Who, because of education, training, or experience, or a combination of these factors, is capable of understanding the health and environmental risks associated with the microorganism which is used under his or her supervision, (2) who is responsible for enforcing appropriate methods of conducting scientific experimentation, analysis, or microbiological research to minimize such risks, and (3) who is responsible for the safety assessments and clearances related to the procurement, storage, use, and disposal of the microorganism as may be appropriate or required within the scope of conducting a research and development activity.

TSCA Experimental Release Application or *TERA* means an exemption request for a research and development activity, which is not eligible for a full exemption from reporting under § 725.232, 725.234, or 725.238 of this part, submitted to EPA in accordance with subpart E of this part.

Well-characterized, non-coding regulatory region means a segment of genetic material for which:

(1) The exact nucleotide base sequences of the regulatory region and any inserted flanking nucleotides are known and documented.

(2) The regulatory region and any inserted flanking nucleotides do not code for protein, peptide, or functional ribonucleic acid molecules.

(3) The regulatory region solely controls the activity of other regions that

code for protein or peptide molecules or act as recognition sites for the initiation of nucleic acid or protein synthesis.

§ 725.8 Coverage of this part.

(a) *Microorganisms subject to this part.* Only microorganisms which are manufactured, imported, or processed for commercial purposes, as defined in § 725.3 of this part, are subject to the requirements of this part.

(b) *Microoganisms automatically included on the Inventory.* Microorganisms that are not intergeneric are automatically included on the TSCA Inventory.

(c) *Microorganisms not subject to this part.* The following microorganisms are not subject to this part, either because they are not subject to TSCA jurisdiction or are not subject to reporting under TSCA section 5.

(1) Any microorganism which would be excluded from the definition of "chemical substance" in section 3 of TSCA and § 720.3(e) of this chapter.

(2) Any microbial mixture as defined in § 725.3 of this part. This exclusion applies only to a microbial mixture as a whole and not to any microorganisms and other chemical substances which are part of the microbial mixture.

(3) Any microorganism that is manufactured and processed solely for export if the following conditions are met:

(i) The microorganism is labeled in accordance with section 12(a)(1)(B) of TSCA, when the microorganism is distributed in commerce.

(ii) The manufacturer and processor can document at the commencement of manufacturing or processing that the person to whom the microorganism will be distributed intends to export it or process it solely for export as defined in § 721.3 of this chapter.

§ 725.12 Identification of microorganisms for Inventory and other listing purposes.

To identify and list microorganisms on the Inventory, both taxonomic designations and supplemental information will be used. The supplemental information required in paragraph (b) of this section will be used to specifically describe an individual microorganism on the Inventory. Submitters must provide the supplemental information required by paragraph (b) of this section to the extent necessary to enable a microorganism to be accurately and unambiguously identified on the Inventory.

(a) *Taxonomic designation.* The taxonomic designation of a microorganism must be provided for the donor organism and the recipient microorganism to the level of strain, as appropriate. These designations must be substantiated by a letter from a culture collection, literature references, or the results of tests conducted for the purpose of taxonomic classification. Upon EPA's request to the submitter, data supporting the taxonomic designation must be provided to EPA. The genetic history of the recipient microorganism should be documented back to the isolate from which it was derived.

(b) *Supplemental information.* The supplemental information described in paragraphs (b)(1) and (b)(2) of this section is required to the extent that it enables a microorganism to be accurately and unambiguously identified.

(1) *Phenotypic information.* Phenotypic information means pertinent traits that result from the interaction of a microorganism's genotype and the environment in which it is intended to be used and may include intentionally added biochemical and physiological traits.

(2) *Genotypic information.* Genotypic information means the pertinent and distinguishing genotypic characteristics of a microorganism, such as the identity of the introduced genetic material and the methods used to construct the reported microorganism. This also may include information on the vector construct, the cellular location, and the number of copies of the introduced genetic material.

§ 725.15 Determining applicability when microorganism identity or use is confidential or uncertain.

(a) *Consulting EPA.* Persons intending to conduct activities involving microorganisms may determine their obligations under this part by consulting the TSCA Inventory or the microorganisms and uses specified in § 725.239 or subpart M of this part. This section establishes procedures for EPA to assist persons in determining whether the microorganism or the use is listed on the Inventory or in § 725.239 or subpart M of this part.

(1) Confidential identity or use. In some cases it may not be possible to directly determine if a specific microorganism is listed, because portions of that entry may contain generic information to protect confidential business information (CBI). If any portion of the microorganism's identity or use has been claimed CBI, that portion does not appear on the public version of the Inventory, in § 725.239 or in subpart M of this part. Instead, it is contained in a confidential version held in EPA's Confidential Business Information Center (CBIC). The public versions contain generic information which masks the confidential business information. A person who intends to conduct an activity involving a microorganism or use whose entry is described with generic information will need to inquire of EPA whether the unreported microorganism or use is on the confidential version.

(2) Uncertain microorganism identity. The current state of scientific knowledge leads to some imprecision in describing a microorganism. As the state of knowledge increases, EPA will be developing policies to determine whether one microorganism is equivalent to another. Persons intending to conduct activities involving microorganisms may inquire of EPA whether the microorganisms they intend to manufacture, import, or process are equivalent to specific microorganisms described on the Inventory, in § 725.239 or subpart M of this part.

(b) *Requirement of bona fide intent.* (1) EPA will answer the inquiries described in paragraph (a) of this section only if the Agency determines that the person has a *bona fide* intent to conduct the activity for which reporting is required or for which any exemption may apply.

(2) To establish a *bona fide* intent to manufacture, import, or process a microorganism, the person who intends to manufacture, import, or process the microorganism must submit the following information in writing to the Office of Pollution Prevention and Toxics, Document Control Officer, 7407, 401 M St., SW., Washington, DC 20460, ATTN: BIOTECH *bona fide* submission.

(i) Taxonomic designations and supplemental information required by § 725.12.

(ii) A signed statement certifying that the submitter intends to manufacture, import, or process a microorganism for commercial purposes.

(iii) A description of research and development activities conducted with the microorganism to date, demonstration of the submitter's ability to produce or obtain the microorganism from a foreign manufacturer, and the purpose for which the person will manufacture, import, or process the microorganism.

(iv) An indication of whether a related microorganism was previously reviewed by the Agency to the extent known by the submitter.

(c) If an importer or processor cannot provide all the information required by paragraph (b) of this section, because it is claimed as confidential business information by its foreign manufacturer

or supplier, the foreign manufacturer or supplier may supply the information directly to EPA.

(d) EPA will review the information submitted by the manufacturer, importer, or processor under this paragraph to determine whether that person has shown a *bona fide* intent to manufacture, import, or process the microorganism. If necessary, EPA will compare this information to the information requested for the confidential microorganism under § 725.85(b)(3)(iii).

(e) In order for EPA to make a conclusive determination of the microorganism's status, the proposed manufacturer, importer, or processor must show a *bona fide* intent to manufacture, import, or process the microorganism and must provide sufficient information to establish identity unambiguously. After sufficient information has been provided, EPA will inform the manufacturer, importer, or processor whether the microorganism is subject to this part and if so, which sections of this part apply.

(f) If the microorganism is found on the confidential version of the Inventory, in § 725.239 or subpart M of this part, EPA will notify the person(s) who originally reported the microorganism that another person (whose identity will remain confidential, if so requested) has demonstrated a *bona fide* intent to manufacture, import, or process the microorganism and therefore was told that the microorganism is subject to this part.

(g) A disclosure to a person with a bona fide intent to manufacture, import, or process a particular microorganism that the microorganism is subject to this part will not be considered a public disclosure of confidential business information under section 14 of the Act.

(h) EPA will answer an inquiry on whether a particular microorganism is subject to this part within 30 days after receipt of a complete submission under paragraph (b) of this section.

§ 725.17 Consultation with EPA.

Persons may consult with EPA, either in writing or by telephone, about their obligations under this part. Written consultation is preferred. Written inquiries should be sent to the following address: Environmental Assistance Division (7408), Office of Pollution Prevention and Toxics, U.S. Environmental Protection Agency, 401 M St., SW., Washington, DC 20460, ATTN: Biotechnology Notice Consultation. Persons wishing to consult with EPA by telephone should call (202) 554–1404; hearing impaired TDD (202) 554–0551.

Subpart B—Administrative Procedures

§ 725.20 Scope and purpose.

This subpart describes general administrative procedures applicable to all persons who submit MCANs and exemption requests to EPA under section 5 of the Act for microorganisms.

§ 725.25 General administrative requirements.

(a) *General.* (1) Each person who is subject to the notification provisions of this part must complete, sign, and submit a MCAN or exemption request containing the information as required for the appropriate submission under this part. Except as otherwise provided, each submission must include all referenced attachments. All information in the submission (unless certain attachments appear in the open scientific literature) must be in English. All information submitted must be true and correct.

(2) In addition to specific information required, the submitter should submit all information known to or reasonably ascertainable by the submitter that would permit EPA to make a reasoned evaluation of the human health and environmental effects of the microorganism and any microbial mixture or article that may contain the microorganism.

(b) *Certification.* Persons submitting MCANs and exemption requests to EPA under this part, and material related to their reporting obligations under this part, must attach the following statement to any information submitted to EPA:

> I certify that to the best of my knowledge and belief: The company named in this submission intends to manufacture, import, or process for a commercial purpose, other than in small quantities solely for research and development, the microorganism identified in this submission. All information provided in this submission is complete and truthful as of the date of submission. I am including with this submission all test data in my possession or control and a description of all other data known to or reasonably ascertainable by me as required by 40 CFR 725.160 or 725.260.

This statement must be signed and dated by an authorized official of the submitter.

(c) *Where to submit information under this part.* Persons submitting MCANs and exemption requests to EPA under this part, and material related to their reporting obligations under this part, must send them to: TSCA Document Processing Center (7407), Rm. L–100, Office of Pollution Prevention and Toxics, U.S. Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

(d) *General requirements for submission of data.* (1) Submissions under this part must include the information described in § 725.155, 725.255, 725.355, or 725.455, as appropriate, to the extent such information is known to or reasonably ascertainable by the submitter.

(2) In accordance with § 725.160 or 725.260, as appropriate, the submission must also include any test data in the submitter's possession or control and descriptions of other data which are known to or reasonably ascertainable by the submitter and which concern the health and environmental effects of the microorganism.

(e) *Agency or joint submissions.* (1) A manufacturer or importer may designate an agent to submit the MCAN or exemption request. Both the manufacturer or importer and the agent must sign the certification required in paragraph (b) of this section.

(2) A manufacturer or importer may authorize another person (e.g., a foreign manufacturer or supplier, or a toll manufacturer) to report some of the information required in theMCAN or exemption request to EPA on its behalf. If separate portions of a joint submission are not submitted together, the submitter must indicate which information will be supplied by another person and identify that person. The manufacturer or importer and any other person supplying the information must sign the certification required by paragraph (b) of this section.

(3) If EPA receives a submission which does not include the information required, which the submitter indicates that it has authorized another person to provide, the review period will not begin until EPA receives all of the required information.

(f) *Microorganisms subject to a section 4 test rule.* (1) Except as provided in paragraph (f)(3) of this section, if (i) A person intends to manufacture or import a new microorganism which is subject to the notification requirements of this part, and (ii) the microorganism is subject to a test rule promulgated under section 4 of the Act before the notice is submitted, section 5(b)(1) of the Act requires the person to submit the test data required by the testing rule with the notice. The person must submit the data in the form and manner specified in the test rule and in accordance with § 725.160. If the person does not submit the test data, the submission is incomplete and EPA will follow the procedures in § 725.33.

(2) If EPA has granted the submitter an exemption under section 4(c) of the Act from the requirement to conduct tests and submit data, the person may not file a MCAN or TERA until EPA receives the test data.

(3) If EPA has granted the submitter an exemption under section 4(c) of the Act and if another person previously has submitted the test data to EPA, the exempted person may either submit the test data or provide the following information as part of the notice:

(i) The name, title, and address of the person who submitted the test data to EPA.

(ii) The date the test data were submitted to EPA.

(iii) A citation for the test rule.

(iv) A description of the exemption and a reference identifying it.

(g) *Microorganisms subject to a section 5(b)(4) rule.* (1) If a person (i) Intends to manufacture or import a microorganism which is subject to the notification requirements of this part and which is subject to a rule issued under section 5(b)(4) of the Act; and (ii) is not required by a rule issued under section 4 of the Act to submit test data for the microorganism before the filing of a submission, the person must submit to EPA data described in paragraph (g)(2) of this section at the time the submission is filed.

(2) Data submitted under paragraph (g)(1) of this section must be data which the person submitting the notice believes show that the manufacture, processing, distribution in commerce, use, and disposal of the microorganism, or any combination of such activities, will not present an unreasonable risk of injury to health or the environment.

(h) *Data that need not be submitted.* Specific data requirements are listed in subparts D, E, F, G, and L of this part. The following is a list of data that need not be submitted under this part:

(1) Data previously submitted to EPA. (i) A person need not submit any data previously submitted to EPA with no claims of confidentiality if the new submission includes: the office or person to whom the data were submitted; the date of submission; and, if appropriate, a standard literature citation as specified in §725.160(a)(3)(ii).

(ii) For data previously submitted to EPA with a claim of confidentiality, the person must resubmit the data with the new submission and any claim of confidentiality, under § 725.80.

(2) Efficacy data. This part does not require submission of any data related solely to product efficacy. However, including efficacy data will improve EPA's ability to assess the benefits of the use of the microorganism. This does not exempt a person from submitting any of the data specified in § 725.160 or 725.260.

(3) Non-U.S. exposure data. This part does not require submission of any data which relates only to exposure of humans or the environment outside the United States. This does not exclude nonexposure data such as data on health effects (including epidemiological studies), ecological effects, physical and chemical properties, or environmental fate characteristics.

§ 725.27 Submissions.

Each person who is required to submit information under this part must submit the information in the form and manner set forth in the appropriate subpart.

(a) Requirements specific to MCANs are described in § § 725.150 through 725.160.

(b) Requirements specific to TERAs are described in § § 725.250 through 725.260.

(c) Requirements specific to test marketing exemptions (TMEs) are described in § § 725.350 and 725.355.

(d) Requirements specific to Tier I and Tier II exemptions for certain general commercial uses are described in § § 725.424 through 725.460.

(e) Additional requirements specific to significant new uses for microorganisms are described at § 725.950.

§ 725.28 Notice that submission is not required.

When EPA receives a MCAN or exemption request, EPA will review it to determine whether the microorganism is subject to the requirements of this part. If EPA determines that the microorganism is not subject to these requirements, EPA will notify the submitter that section 5 of the Act does not prevent the manufacture, import, or processing of the microorganism and that the submission is not needed.

§ 725.29 EPA acknowledgement of receipt of submission.

(a) EPA will acknowledge receipt of each submission by sending the submitter a letter that identifies the number assigned to the new microorganism and the date on which the review period begins. The review period will begin on the date the MCAN or exemption request is received by the Office of Pollution Prevention and Toxics Document Control Officer.

(b) The acknowledgement does not constitute a finding by EPA that the submission is in compliance with this part.

§ 725.32 Errors in the submission.

(a) Within 30 days of receipt of the submission, EPA may request that the submitter remedy errors in the submission. The following are examples of such errors:

(1) Failure to date the submission.

(2) Typographical errors that cause data to be misleading or answers to any questions to be unclear.

(3) Contradictory information.

(4) Ambiguous statements or information.

(b) In the request to correct the submission, EPA will explain the action which the submitter must take to correct the submission.

(c) If the submitter fails to correct the submission within 15 days of receipt of the request, EPA may extend the review period.

§ 725.33 Incomplete submissions.

(a) A submission under this part is not complete, and the review period does not begin, if:

(1) The wrong person files the submission.

(2) The submitter does not attach and sign the certification statement as required by § 725.25(b).

(3) Some or all of the information in the submission or any attachments are not in English, except for published scientific literature.

(4) The submitter does not provide information that is required by sections 5(d)(1)(B) and (C) of the Act and § 725.160 or 725.260, as appropriate.

(5) The submitter does not provide information required by § 725.25, 725.155, 725.255, 725.355, or 725.455, as appropriate, or indicate that it is not known to or reasonably ascertainable by the submitter.

(6) The submitter has asserted confidentiality claims and has failed to:

(i) Submit a second copy of the submission with all confidential information deleted for the public file, as required by § 725.80(b)(2).

(ii) Comply with the substantiation requirements as described in § 725.94.

(7) The submitter does not include any information required by section 5(b)(1) of the Act and pursuant to a rule promulgated under section 4 of the Act, as required by § 725.25(f).

(8) The submitter does not submit data which the submitter believes show that the microorganism will not present an unreasonable risk of injury to health or the environment, if EPA has listed the microorganism under section 5(b)(4) of the Act, as required in § 725.25(g).

(9) For MCANs, the submitter does not remit the fees required by § 700.45(b)(1) or (b)(2)(vi) of this chapter.

(b)(1) If EPA receives an incomplete submission under this part, the Director, or a designee, will notify the submitter within 30 days of receipt that the submission is incomplete and that the review period will not begin until EPA receives a complete submission.

(2) If EPA obtains additional information during the review period for any submission that indicates the original submission was incomplete, the Director, or a designee, may declare the submission incomplete within 30 days after EPA obtains the additional information and so notify the submitter.

(c) The notification that a submission is incomplete under paragraph (b) of this section will include:

(1) A statement of the basis of EPA's determination that the submission is incomplete.

(2) The requirements for correcting the incomplete submission.

(3) Information on procedures under paragraph (d) of this section for filing objections to the determination or requesting modification of the requirements for completing the submission.

(d) Within 10 days after receipt of notification by EPA that a submission is incomplete, the submitter may file written objections requesting that EPA accept the submission as complete or modify the requirements necessary to complete the submission.

(e)(1) EPA will consider the objections filed by the submitter. The Director, or a designee, will determine whether the submission was complete or incomplete, or whether to modify the requirements for completing the submission. EPA will notify the submitter in writing of EPA's response within 10 days of receiving the objections.

(2) If the Director, or a designee, determines, in response to the objection, that the submission was complete, the review period will be deemed suspended on the date EPA declared the submission incomplete, and will resume on the date that the submission is declared complete. The submitter need not correct the submission as EPA originally requested. If EPA can complete its review within the review period beginning on the date of the submission, the Director, or a designee, may inform the submitter that the running of the review period will resume on the date EPA originally declared it incomplete.

(3) If the Director, or a designee, modifies the requirements for completing the submission or concurs with EPA's original determination, the review period will begin when EPA receives a complete submission.

(f) Materially false or misleading statements. If EPA discovers at any time that a person submitted materially false or misleading statements in information submitted under this part, EPA may find that the submission was incomplete from the date it was submitted, and take any other appropriate action.

§ 725.36 New information.

(a) During the review period, if a submitter possesses, controls, or knows of new information that materially adds to, changes, or otherwise makes significantly more complete the information included in the MCAN or exemption request, the submitter must send that information to the address listed in § 725.25(c) within 10 days of receiving the new information, but no later than 5 days before the end of the review period.

(b) The new submission must clearly identify the submitter, the MCAN or exemption request to which the new information is related, and the number assigned to that submission by EPA, if known to the submitter.

(c) If the new information becomes available during the last 5 days of the review period, the submitter must immediately inform the EPA contact for that submission by telephone of the new information.

§ 725.40 Notice in the Federal Register.

(a) *Filing of Federal Register notice.* After EPA receives a MCAN or an exemption request under this part, EPA will issue a notice in the **Federal Register** including the information specified in paragraph (b) of this section.

(b) *Contents of notice.* (1) In the public interest, the specific microorganism identity listed in the submission will be published in the **Federal Register** unless the submitter has claimed the microorganism identity confidential. If the submitter claims confidentiality, a generic name will be published in accordance with § 725.85.

(2) The categories of use of the microorganism will be published as reported in the submission unless this information is claimed confidential. If confidentiality is claimed, the generic information which is submitted under § 725.88 will be published.

(3) A list of information submitted in accordance with § 725.160(a), 725.255, 725.260, 725.355, or 725.455, as appropriate, will be published.

(4) The submitter's identity will be published, unless the submitter has claimed it confidential.

(c) *Publication of exemption decisions.* Following the expiration of the appropriate review period for the exemption request, EPA will issue a notice in the **Federal Register** indicating whether the request has been approved or denied and the reasons for the decision.

§ 725.50 EPA review.

(a) *MCANs.* The review period specified in section 5(a) of the Act for MCANs runs for 90 days from the date the Document Control Officer receives a complete submission, or the date EPA determines the submission is complete under § 725.33, unless the Agency extends the review period under section 5(c) of TSCA and § 725.56.

(b) *Exemption requests.* The review period starts on the date the Document Control Officer receives a complete exemption request, or the date EPA determines the request is complete under § 725.33, unless the Agency extends the review period under § 725.56. The review periods for exemption requests run as follows:

(1) *TERAs.* The review period for TERAs is 60 days.

(2) *TMEs.* The review period for TMEs is 45 days.

(3) *Tier II exemption requests.* The review period for Tier II exemption requests is 45 days.

§ 725.54 Suspension of the review period.

(a) A submitter may voluntarily suspend the running of the review period if the Director, or a designee, agrees. If the Director does not agree, the review period will continue to run, and EPA will notify the submitter. A submitter may request a suspension at any time during the review period. The suspension must be for a specified period of time.

(b) A request for suspension may be made in writing to the address listed in § 725.25(c). The suspension also may be made orally, including by telephone, to the submitter's EPA contact for that submission. EPA will send the submitter a written confirmation that the suspension has been granted.

(1) An oral request may be granted for no longer than 15 days. To obtain a longer suspension, the Document Control Officer for the Office of Pollution Prevention and Toxics must receive written confirmation of the oral request. The review period is suspended as of the date of the oral request.

(2) If the submitter has not made a previous oral request, the running of the review period is suspended as of the date of receipt of the written request by the Document Control Officer for the Office of Pollution Prevention and Toxics.

§ 725.56 Extension of the review period.

(a) At any time during the review period, EPA may unilaterally determine that good cause exists to extend the review period specified for MCANs, or the exemption requests.

(b) If EPA makes such a determination, EPA:

(1) Will notify the submitter that EPA is extending the review period for a specified length of time and state the reasons for the extension.

(2) For MCANS, may issue a notice for publication in the Federal Register which states that EPA is extending the review period and gives the reasons for the extension.

(c) The total period of the extension may be for a period of up to the same length of time as specified for each type of submission in § 725.50. If the initial extension is for less than the total time allowed, EPA may make additional extensions. However, the sum of the extensions may not exceed the total allowed.

(d) The following are examples of situations in which EPA may find that good cause exists for extending the review period:

(1) EPA has reviewed the submission and is seeking additional information.

(2) EPA has received significant additional information during the review period.

(3) The submitter has failed to correct a submission after receiving EPA's request under § 725.32.

(4) EPA has reviewed the submission and determined that there is a significant possibility that the microorganism will be regulated under section 5(e) or section 5(f) of the Act, but EPA is unable to initiate regulatory action within the initial review period.

§ 725.60 Withdrawal of submission by the submitter.

(a) A submitter may withdraw a submission during the review period. A statement of withdrawal must be made in writing to the address listed in § 725.25(c). The withdrawal is effective upon receipt of the statement by the Document Control Officer.

(b) If a manufacturer or importer who withdrew a submission later resubmits a submission for the same microorganism, a new review period begins.

§ 725.65 Recordkeeping.

(a) *General provisions.* (1) Any person who files under this part must retain documentation of information in the submission, including (i) any data in the submitter's possession or control; and (ii) records of production volume for the first 3 years of manufacture, import, or processing.

(2) Any person who files under this part must retain documentation of the date of commencement of testing, manufacture, import, or processing.

(3) Any person who is exempt from some or all of the reporting requirements of this part must retain documentation that supports the exemption.

(4) All information required by this section must be retained for 3 years from the date of commencement of each activity for which records are required under this part.

(b) *Specific requirements.* In addition to the requirements of paragraph (a) of this section, specific recordkeeping requirements included in certain subparts must also be followed.

(1) Additional recordkeeping requirements for activities conducted inside a structure are set forth in § 725.235(h).

(2) Additional recordkeeping requirements for TERAs are set forth in § 725.250(f).

(3) Additional recordkeeping requirements for TMEs are set forth in § 725.350(c).

(4) Additional recordkeeping requirements for Tier I exemptions under subpart G of this part are set forth in § 725.424(a)(5).

(5) Additional recordkeeping requirements for Tier II exemptions under subpart G of this part are set forth in § 725.450(d).

(6) Additional recordkeeping requirements for significant new uses of microorganisms reported under subpart L of this part are set forth in § 725.850. Recordkeeping requirements may also be included when a microorganism and significant new use are added to subpart M of this part.

§ 725.67 Applications to exempt new microorganisms from this part.

(a) *Submission.* (1) Any manufacturer or importer of a new microorganism may request, under TSCA section 5(h)(4), an exemption, in whole or in part, from this part by sending a Letter of Application to the Director, Chemical Control Division, Office of Pollution Prevention and Toxics, U.S. Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

(2) The Letter of Application should provide information to show that any activities affected by the requested exemption will not present an unreasonable risk of injury to health or the environment. This information should include data described in the following paragraphs.

(i) The effects of the new microorganism on health and the environment.

(ii) The magnitude of exposure of human beings and the environment to the new microorganism.

(iii) The benefits of the new microorganism for various uses and the availability of substitutes for such uses.

(iv) The reasonably ascertainable economic consequences of granting or denying the exemption, including effects on the national economy, small business, and technological innovation.

(b) *Processing of the Letter of Application by EPA—(1) Grant of the Application.* If, after consideration of the Letter of Application and any other relevant information available to the Agency, the Assistant Administrator for Prevention, Pesticides and Toxic Substances makes a preliminary determination that the new microorganism will not present an unreasonable risk of injury to health or the environment, the Assistant Administrator will propose a rule to grant the exemption using the applicable procedures in part 750 of this chapter.

(2) *Denial of the application.* If the Assistant Administrator decides that the preliminary determination described in paragraph (b)(1) of this section cannot be made, the application will be denied by sending the applicant a written statement with the Assistant Administrator's reasons for denial.

(c) *Processing of the exemption—(1) Unreasonable risk standard.* Granting a TSCA section 5(h)(4) exemption requires a determination that there will be no unreasonable risk.

(i) An unreasonable risk determination under TSCA is an administrative judgment that requires balancing of the harm to health or the environment that a chemical substance may cause and the magnitude and severity of that harm, against the social and economic effects on society of Agency action to reduce that harm.

(ii) A determination of unreasonable risk under TSCA section 5(h)(4) will examine the reasonably ascertainable economic and social consequences of granting or denying the exemption after consideration of the effect on the national economy, small business, technological innovation, the environment, and public health.

(2) *Grant of the exemption.* The exemption will be granted if the Assistant Administrator determines, after consideration of all relevant evidence presented in the rulemaking proceeding described in paragraph (b)(1) of this section, that the new microorganism will not present an unreasonable risk of injury to health or the environment.

(3) *Denial of the exemption.* The exemption will be denied if the Assistant Administrator determines, after consideration of all relevant evidence presented in the rulemaking proceeding described in paragraph (b)(1) of this section, that the determination described in paragraph (c)(2) of this section cannot be made. A final decision terminating the rulemaking proceeding will be published in the **Federal Register**.

§ 725.70 Compliance.

(a) Failure to comply with any provision of this part is a violation of section 15 of the Act (15 U.S.C. 2614).

(b) A person who manufactures or imports a microorganism before a MCAN is submitted and the MCAN review period expires is in violation of section 15 of the Act even if that person was not required to submit the MCAN under § 725.105.

(c) Using a microorganism which a person knew or had reason to know was manufactured, processed, or distributed in commerce in violation of section 5 of the Act or this part is a violation of section 15 of the Act (15 U.S.C. 2614).

(d) Failure or refusal to establish and maintain records or to permit access to or copying of records, as required by the Act, is a violation of section 15 of the Act (15 U.S.C. 2614).

(e) Failure or refusal to permit entry or inspection as required by section 11 of the Act is a violation of section 15 of the Act (15 U.S.C. 2614).

(f) Violators may be subject to the civil and criminal penalties in section 16 of the Act (15 U.S.C. 2615) for each violation. Persons who submit materially misleading or false information in connection with the requirements of any provision of this part may be subject to penalties calculated as if they never filed their submissions.

(g) EPA may seek to enjoin the manufacture or processing of a microorganism in violation of this part or act to seize any microorganism manufactured or processed in violation of this part or take other actions under the authority of section 7 of the Act (15 U.S.C. 2606) or section 17 of the Act (15 U.S.C. 2616).

§ 725.75 Inspections.

EPA will conduct inspections under section 11 of the Act to assure compliance with section 5 of the Act and this part, to verify that information required by EPA under this part is true and correct, and to audit data submitted to EPA under this part.

Subpart C—Confidentiality and Public Access to Information

§ 725.80 General provisions for confidentiality claims.

(a) A person may assert a claim of confidentiality for any information submitted to EPA under this part.

(1) Any person who asserts a claim of confidentiality for portions of the specific microorganism identity must provide the information as described in § 725.85.

(2) Any person who asserts a claim of confidentiality for a use of a microorganism must provide the information as described in § 725.88.

(3) Any person who asserts a claim of confidentiality for information contained in a health and safety study of a microorganism must provide the information described in § 725.92.

(b) Any claim of confidentiality must accompany the information when it is submitted to EPA.

(1) When a person submits any information under this part, including any attachments, the claim(s) must be asserted by circling the specific information which is claimed as confidential and marking the page on which that information appears with an appropriate designation such as "trade secret," "TSCA CBI," or "confidential business information."

(2) If any information is claimed confidential, the person must submit two copies of the information.

(i) One copy of the information must be complete. In that copy, the submitter must mark the information which is claimed as confidential in the manner prescribed in paragraph (b)(1) of this section.

(ii) The second copy must be complete except that all information claimed as confidential in the first copy must be deleted. EPA will place the second copy in the public file.

(iii) If the submitter does not provide the second copy, the submission is incomplete and the review period does not begin to run until EPA receives the second copy, in accordance with § 725.33.

(iv) Any information contained within the copy submitted under paragraph (b)(2)(ii) of this section which has been in the public file for more than 30 days will be presumed to be in the public domain, notwithstanding any assertion of confidentiality made under this section.

(c) Any person asserting a claim of confidentiality under this part must substantiate each claim in accordance with the requirements in § 725.94.

(d) EPA will disclose information that is subject to a claim of confidentiality asserted under this section only to the extent permitted by the Act, this subpart, and part 2 of this title.

(e) If a submitter does not assert a claim of confidentiality for information at the time it is submitted to EPA, EPA may make the information public and place it in the public file without further notice to the submitter.

§ 725.85 Microorganism identity.

(a) *Claims applicable to the period prior to commencement of manufacture or import for general commercial use—*(1) *When to make a claim.* (i) A person who submits information to EPA under this part may assert a claim of confidentiality for portions of the specific microorganism identity at the time of submission of the information. This claim will apply only to the period prior to the commencement of manufacture or import for general commercial use.

(ii) A person who submits information to EPA under this part must reassert a claim of confidentiality and substantiate the claim each time the information is submitted to EPA. If a person claims certain information confidential in a TERA submission and wishes the same information to remain confidential in a subsequent TERA or MCAN submission, the person must reassert and resubstantiate the claim in the subsequent submission.

(2) *Assertion of claim.* (i) A submitter may assert a claim of confidentiality only if the submitter believes that public disclosure prior to commencement of manufacture or import for general commercial use of the fact that anyone is initiating research and development activities pertaining to the specific microorganism or intends to manufacture or import the specific microorganism for general commercial use would reveal confidential business information. Claims must be substantiated in accordance with the requirements of § 725.94(a).

(ii) If the submission includes a health and safety study concerning the microorganism and if the claim for confidentiality with respect to the specific identity is denied in accordance with § 725.92(c), EPA will deny a claim asserted under paragraph (a) of this section.

(3) *Development of generic name.* Any person who asserts a claim of confidentiality for portions of the specific microorganism identity under this paragraph must provide one of the following items at the time the submission is filed:

(i) The generic name which was accepted by EPA in the prenotice

consultation conducted under paragraph (a)(4) of this section.

(ii) One generic name that is only as generic as necessary to protect the confidential identity of the particular microorganism. The name should reveal the specific identity to the maximum extent possible. The generic name will be subject to EPA review and approval.

(4) *Determination by EPA.* (i) Any person who intends to assert a claim of confidentiality for the specific identity of a new microorganism may seek a determination by EPA of an appropriate generic name for the microorganism before filing a submission. For this purpose, the person should submit to EPA:

(A) The specific identity of the microorganism.

(B) A proposed generic name(s) which is only as generic as necessary to protect the confidential identity of the new microorganism. The name(s) should reveal the specific identity of the microorganism to the maximum extent possible.

(ii) Within 30 days, EPA will inform the submitter either that one of the proposed generic names is adequate or that none is adequate and further consultation is necessary.

(5) *Use of generic name.* If a submitter claims microorganism identity as confidential under paragraph (a) of this section, and if the submitter complies with paragraph (a)(2) of this section, EPA will issue for publication in the Federal Register notice described in § 725.40 the generic name proposed by the submitter or one agreed upon by EPA and the submitter.

(b) *Claims applicable to the period after commencement of manufacture or import for general commercial use*—(1) *Maintaining claim.* Any claim of confidentiality under paragraph (a) of this section is applicable only until the microorganism is manufactured or imported for general commercial use and becomes eligible for inclusion on the inventory. To maintain the confidential status of the microorganism identity when the microorganism is added to the Inventory, a submitter must reassert the confidentiality claim and substantiate the claim in the notice of commencement of manufacture required under § 725.190.

(i) A submitter may not claim the microorganism identity confidential for the period after commencement of manufacture or import for general commercial use unless the submitter claimed the microorganism identity confidential under paragraph (a) of this section in the MCAN submitted for the microorganism.

(ii) A submitter may claim the microorganism identity confidential for the period after commencement of manufacture or import for general commercial use if the submitter did not claim the microorganism identity confidential under paragraph (a) of this section in any TERA submitted for the microorganism, but subsequently did claim microorganism identity confidential in the MCAN submitted for the microorganism.

(2) *Assertion of claim.* (i) A person who believes that public disclosure of the fact that anyone manufactures or imports the microorganism for general commercial use would reveal confidential business information may assert a claim of confidentiality under paragraph (b) of this section.

(ii) If the notice includes a health and safety study concerning the new microorganism, and if the claim for confidentiality with respect to the microorganism identity is denied in accordance with § 725.92(c), EPA will deny a claim asserted under paragraph (b) of this section.

(3) *Requirements for assertion.* Any person who asserts a confidentiality claim for microorganism identity must:

(i) Comply with the requirements of paragraph (a)(3) of this section regarding submission of a generic name.

(ii) Agree that EPA may disclose to a person with a *bona fide* intent to manufacture or import the microorganism the fact that the particular microorganism is included on the confidential Inventory for purposes of notification under section 5(a)(1)(A) of the Act.

(iii) Have available and agree to furnish to EPA upon request the taxonomic designations and supplemental information required by § 725.12.

(iv) Provide a detailed written substantiation of the claim, in accordance with the requirements of § 725.94(b).

(4) *Denial of claim.* If the submitter does not meet the requirements of paragraph (b) of this section, EPA will deny the claim of confidentiality.

(5) *Acceptance of claim.* (i) EPA will publish a generic name on the public Inventory if:

(A) The submitter asserts a claim of confidentiality in accordance with this paragraph.

(B) No claim for confidentiality of the microorganism identity as part of a health and safety study has been denied in accordance with part 2 of this title or § 725.92.

(ii) Publication of a generic name on the public Inventory does not create a category for purposes of the Inventory. Any person who has a bona fide intent to manufacture or import a microorganism which is described by a generic name on the public Inventory may submit an inquiry to EPA under § 725.15(b) to determine whether the particular microorganism is included on the confidential Inventory.

(iii) Upon receipt of a request described in § 725.15(b), EPA may require the submitter who originally asserted confidentiality for a microorganism to submit to EPA the information listed in paragraph (b)(3)(iii) of this section.

(iv) Failure to submit any of the information required under paragraph (b)(3)(iii) of this section within 10 calendar days of receipt of a request by EPA under paragraph (b) of this section will constitute a waiver of the original submitter's confidentiality claim. In this event, EPA may place the specific microorganism identity on the public Inventory without further notice to the original submitter.

(6) *Use of generic name on the public Inventory.* If a submitter asserts a claim of confidentiality under paragraph (b) of this section, EPA will examine the generic microorganism name proposed by the submitter.

(i) If EPA determines that the generic name proposed by the submitter is only as generic as necessary to protect the confidential identity of the particular microorganism, EPA will place that generic name on the public Inventory.

(ii) If EPA determines that the generic name proposed by the submitter is more generic than necessary to protect the confidential identity, EPA will propose in writing, for review by the submitter, an alternative generic name that will reveal the identity of the microorganism to the maximum extent possible.

(iii) If the generic name proposed by EPA is acceptable to the submitter, EPA will place that generic name on the public Inventory.

(iv) If the generic name proposed by EPA is not acceptable to the submitter, the submitter must explain in detail why disclosure of that generic name would reveal confidential business information and propose another generic name which is only as generic as necessary to protect the confidential identity of the microorganism. If EPA does not receive a response from the submitter within 30 days after the submitter receives the proposed name, EPA will place EPA's chosen generic name on the public Inventory. If the submitter does provide the information requested, EPA will review the response. If the submitter's proposed generic name is acceptable, EPA will publish that generic name on the public

Inventory. If the submitter's proposed generic name is not acceptable, EPA will notify the submitter of EPA's choice of a generic name. Thirty days after this notification, EPA will place the chosen generic name on the public Inventory.

§ 725.88 Uses of a microorganism.

(a) *Assertion of claim.* A person who submits information to EPA under this part on the categories or proposed categories of use of a microorganism may assert a claim of confidentiality for this information.

(b) *Requirements for claim.* A submitter that asserts such a claim must:

(1) Report the categories or proposed categories of use of the microorganism.

(2) Provide, in nonconfidential form, a description of the uses that is only as generic as necessary to protect the confidential business information. The generic use description will be included in the **Federal Register** notice described in § 725.40.

(c) *Generic use description.* The person must submit the information required by paragraph (b) of this section by describing the uses as precisely as possible, without revealing the information which is claimed confidential, to disclose as much as possible how the use may result in human exposure to the microorganism or its release to the environment.

§ 725.92 Data from health and safety studies of microorganisms.

(a) *Information other than specific microorganism identity.* Except as provided in paragraph (b) of this section, EPA will deny any claim of confidentiality with respect to information included in a health and safety study of a microorganism, unless the information would disclose confidential business information concerning:

(1) Processes used in the manufacture or processing of a microorganism.

(2) Information which is not in any way related to the effects of a microorganism on human health or the environment, such as, the name of the submitting company, cost or other financial data, product development or marketing plans, and advertising plans, for which the person submits a claim of confidentiality in accordance with § 725.80.

(b) *Microorganism identity*—(1) *Claims applicable to the period prior to commencement of manufacture or import for general commercial use.* A claim of confidentiality for the period prior to commencement of manufacture or import for general commercial use for the specific identity of a microorganism for which a health and safety study was submitted must be asserted in conjunction with a claim asserted under § 725.85(a). The submitter must substantiate each claim in accordance with the requirements of § 725.94(a).

(2) *Claims applicable to the period after commencement of manufacture or import for general commercial use.* To maintain the confidential status of the specific identity of a microorganism for which a health and safety study was submitted after commencement of manufacture or import for general commercial use, the claim must be reasserted and substantiated in conjunction with a claim under § 725.85(b). The submitter must substantiate each claim in accordance with the requirements of § 725.94(b).

(c) *Denial of confidentiality claim.* EPA will deny a claim of confidentiality for microorganism identity under paragraph (b) of this section, unless:

(1) The information would disclose processes used in the manufacture or processing of a microorganism.

(2) The microorganism identity is not necessary to interpret a health and safety study.

(d) *Use of generic names.* When EPA discloses a health and safety study containing a microorganism identity, which the submitter has claimed confidential, and if the Agency has not denied the claim under paragraph (c) of this section, EPA will identify the microorganism by the generic name selected under § 725.85.

§ 725.94 Substantiation requirements.

(a) *Claims applicable to the period prior to commencement of manufacture or import for general commercial use*—(1) *MCAN, TME, Tier I certification, and Tier II exemption request requirements.* Any person who submits a MCAN, TME, Tier I certification, or Tier II exemption request should strictly limit confidentiality claims to that information which is confidential and proprietary to the business.

(i) If any information in the submission is claimed as confidential business information, the submitter must substantiate each claim by submitting written answers to the questions in paragraphs (c), (d), and (e) of this section at the time the person submits the information.

(ii) If the submitter does not provide written substantiation as required in paragraph (a)(1)(i) of this section, the submission will be considered incomplete and the review period will not begin in accordance with § 725.33.

(2) *TERA requirements.* Any person who submits a TERA, should strictly limit confidentiality claims to that information which is confidential and proprietary to the business.

(i) If any information in such a submission is claimed as confidential business information, the submitter must substantiate each of those claims by submitting written answers to the questions in paragraphs (d) and (e) of this section at the time the person submits the information.

(ii) If the submitter does not provide written substantiation as required in paragraph (a)(2)(i) of this section, the submission will be considered incomplete and the TERA review period will not begin.

(b) *Claims applicable to the period after commencement of manufacture or import for general commercial use.* (1) If a submitter claimed portions of the microorganism identity confidential in the MCAN and wants the identity to be listed on the confidential Inventory, the claim must be reasserted and substantiated at the time the Notice of Commencement (NOC) is submitted. Otherwise, EPA will list the specific microorganism identity on the public Inventory.

(2) The submitter must substantiate the claim for confidentiality of the microorganism identity by answering all of the questions in paragraphs (c), (d), and (e) in this section. In addition, the following questions must be answered:

(i) What harmful effects to the company or institution's competitive position, if any, would result if EPA publishes on the Inventory the identity of the microorganism? How could a competitor use such information given the fact that the identity of the microorganism otherwise would appear on the TSCA Inventory with no link between the microorganism and the company or industry? How substantial would the harmful effects of disclosure be? What is the causal relationship between the disclosure and the harmful effects?

(ii) Has the identity of the microorganism been kept confidential to the extent that competitors do not know it is being manufactured or imported for general commercial use by anyone?

(c) *General questions.* The following questions must be answered in detail for each confidentiality claim:

(1) For what period of time is a claim of confidentiality being asserted? If the claim is to extend until a certain event or point in time, indicate that event or time period. Explain why the information should remain confidential until such point.

(2) Briefly describe any physical or procedural restrictions within the company or institution relating to the use and storage of the information

claimed as confidential. What other steps, if any, apply to use or further disclosure of the information?

(3) Has the information claimed as confidential been disclosed to individuals outside of the company or institution? Will it be disclosed to such persons in the future? If so, what restrictions, if any, apply to use or further disclosure of the information?

(4) Does the information claimed as confidential appear, or is it referred to, in any of the following:

(i) Advertising or promotional materials for the microorganism or the resulting end product.

(ii) Material safety data sheets or other similar materials for the microorganism or the resulting end product.

(iii) Professional or trade publications.

(iv) Any other media available to the public or to your competitors.

(v) Patents.

(vi) Local, State, or Federal agency public files.

If the answer is yes to any of these questions, indicate where the information appears and explain why it should nonetheless be treated as confidential.

(5) Has EPA, another Federal agency, a Federal court, or a State made any confidentiality determination regarding the information claimed as confidential? If so, provide copies of such determinations.

(6) For each type of information claimed confidential, describe the harm to the company or institution's competitive position that would result if this information were disclosed. Why would this harm be substantial? How could a competitor use such information? What is the causal connection between the disclosure and harm?

(7) If EPA disclosed to the public the information claimed as confidential, how difficult would it be for the competitor to enter the market for the resulting product? Consider such constraints as capital and marketing cost, specialized technical expertise, or unusual processes.

(d) *Microorganism identity and production method.* If confidentiality claims are asserted for the identity of the microorganism or information on how the microorganism is produced, the following questions must be answered:

(1) Has the microorganism or method of production been patented in the U.S. or elsewhere? If so, why is confidentiality necessary?

(2) Does the microorganism leave the site of production or testing in a form which is accessible to the public or to competitors? What is the cost to a competitor, in time and money, to develop appropriate use conditions? What factors facilitate or impede product analysis?

(3) For each additional type of information claimed as confidential, explain what harm would result from disclosure of each type of information if the identity of the microorganism were to remain confidential.

(e) *Health and safety studies of microorganisms.* If confidentiality claims are asserted for information in a health or safety study of a microorganism, the following questions must be answered:

(1) Would the disclosure of the information claimed confidential reveal: (i) Confidential process information, or (ii) information unrelated to the effects of the microorganism on human health and the environment. Describe the causal connection between the disclosure and harm.

(2) Does the company or institution assert that disclosure of the microorganism identity is not necessary to interpret any health and safety studies which have been submitted? If so, explain how a less specific identity would be sufficient to interpret the studies.

§ 725.95 Public file.

All information submitted, including any health and safety study of a microorganism and other supporting documentation, will become part of the public file for that submission, unless such materials are claimed confidential. In addition, EPA may add materials to the public file, unless such materials are claimed confidential. Any of the nonconfidential material described in this subpart will be available for public inspection in the TSCA Public Docket Office, Rm. NE–B607, 401 M St., SW., Washington, DC, between the hours of 8 a.m. and noon and 1 p.m. to 4 p.m., Monday through Friday, excluding legal holidays.

Subpart D—Microbial Commercial Activities Notification Requirements

§ 725.100 Scope and purpose.

(a) This subpart establishes procedures for submission of a notice to EPA under section 5(a) of TSCA for persons who manufacture, import, or process microorganisms for commercial purposes. This notice is called a Microbial Commercial Activity Notice (MCAN). It is expected that MCANs will in general only be submitted for microorganisms intended for general commercial use.

(b) Persons subject to MCAN submission are described in § 725.105.

(c) Exclusions and exemptions specific to MCAN submissions are described in § 725.110.

(d) Submission requirements applicable specifically to MCANs are described at § 725.150.

(e) Data requirements for MCANs are set forth in § § 725.155 and 725.160.

(f) EPA review procedures specific to MCANs are set forth in § 725.170.

(g) Subparts A through C of this part apply to any MCAN submitted under this subpart.

§ 725.105 Persons who must report.

(a) *Manufacturers of new microorganisms.* (1) MCAN submission is required for any person who intends to manufacture for general commercial use in the United States a new microorganism. Exclusions are described in § 725.110.

(2) If a person contracts with a manufacturer to produce or process a new microorganism and (i) The manufacturer produces or processes the microorganism exclusively for that person, and (ii) that person specifies the identity of the microorganism, and controls the total amount produced and the basic technology for the plant process, then that person must submit the MCAN. If it is unclear who must report, EPA should be contacted to determine who must submit the MCAN.

(3) Only manufacturers that are incorporated, licensed, or doing business in the United States may submit a MCAN.

(b) *Importers of new microorganisms.* (1) MCAN submission is required for a person who intends to import into the United States for general commercial use a new microorganism. Exclusions are described in § 725.110.

(2) When several persons are involved in an import transaction, the MCAN must be submitted by the principal importer. If no one person fits the principal importer definition in a particular transaction, the importer should contact EPA to determine who must submit the MCAN for that transaction.

(3) Except as otherwise provided in paragraph (b)(4) of this section, the provisions of this subpart D apply to each person who submits a MCAN for a new microorganism which such person intends to import for a general commercial use. In addition, each importer must comply with paragraph (b)(4) of this section.

(4) EPA will hold the principal importer, or the importer that EPA determines must submit the MCAN when there is no principal importer under paragraph (b)(2) of this section, liable for complying with this part, for

completing the MCAN, and for the completeness and truthfulness of all information which it submits.

(c) *Manufacturers, importers, or processors of microorganisms who intend to use or distribute the microorganism for a significant new use.* MCAN submission is required for any person who intends to manufacture, import, or process for commercial purposes a microorganism identified as having one or more significant new uses in subpart M of this part, and who intends either to engage in a significant new use of the microorganism or intends to distribute it in commerce. Persons excluded from reporting on significant new uses of microorganisms and additional procedures for reporting are described in subpart L of this part.

§ 725.110 Persons not subject to this subpart.

Persons are not subject to the requirements of this subpart for the following activities:

(a) Manufacturing, importing, or processing solely for research and development microorganisms that meet the requirements for an exemption under subpart E of this part.

(b) Manufacturing, importing, or processing microorganisms for test marketing activities which have been granted an exemption under subpart F of this part.

(c) Manufacturing or importing microorganisms under the conditions of a Tier I or Tier II exemption under subpart G of this part.

§ 725.150 Procedural requirements for this subpart.

General requirements for all MCANs under this part are contained in § 725.25. In addition, the following requirements apply to MCANs submitted under this subpart:

(a) *When to submit a MCAN.* A MCAN must be submitted at least 90 calendar days prior to manufacturing or importing a new microorganism and at least 90 calendar days prior to manufacturing, importing, or processing a microorganism for a significant new use.

(b) *Section 5(b) of TSCA.* The submitter must comply with any applicable requirement of section 5(b) of TSCA.

(c) *Contents of a MCAN.* Each person who submits a MCAN under this subpart must provide the information and test data described in § § 725.155 and 725.160.

(d) *Recordkeeping.* Each person who submits a MCAN under this subpart must comply with the recordkeeping requirements of § 725.65.

§ 725.155 Information to be included in the MCAN.

(a) Each person who is required by this part to submit a MCAN must provide EPA in writing with all information known to or reasonably ascertainable by the person that would permit EPA to make a reasoned evaluation of the human health and environmental effects of the microorganism, or any microbial mixture or article, including information on its effects on humans, animals, plants, and other microorganisms, and in the environment. However, no person is required to include information which relates solely to exposure of humans or ecological populations outside of the United States. The information to be submitted under this subpart includes, but is not limited to, the information listed in paragraphs (c) through (h) of this section. All information submitted must be true and correct.

(b) When specific information is not submitted, an explanation of why such information is not available or not applicable must be included.

(c) *Submitter identification.* (1) The name and headquarters address of the submitter.

(2) The name, address, and office telephone number (including area code) of the principal technical contact representing the submitter.

(d) *Microorganism identity information.* Persons must submit sufficient information to allow the microorganism to be accurately and unambiguously identified for listing purposes as required by § 725.12.

(1) *Description of the recipient microorganism(s) and the new microorganism.* (i) Data substantiating the taxonomy of the recipient microorganism(s) and the new microorganism(s) to the level of strain, as appropriate. In lieu of data, EPA will accept a letter from a culture collection substantiating taxonomy, provided EPA, upon request to the submitter, may have access to the data supporting the taxonomic designation.

(ii) Information on the morphological and physiological features of the new microorganism(s).

(iii) Other specific data by which the new microorganism(s) may be uniquely identified for Inventory purposes.

(2) *Genetic construction of the new microorganism(s).* (i) Data substantiating the taxonomy of the donor organism(s). In lieu of data, EPA will accept a letter from a culture collection substantiating taxonomy, provided EPA, upon request to the submitter, may have access to the data supporting the taxonomic designation.

(ii) Description of the traits for which the new microorganism(s) has been selected or developed and other traits known to have been added or modified.

(iii) A detailed description of the genetic construction of the new microorganism, including the technique used to modify the microorganism (e.g., fusion of cells, injection of DNA, electroporation or chemical poration, or methods used for induced mutation and selection). The description should include, for example, function of the introduced genetic material, including any changes predicted to alter function; how the introduced genetic material is expected to affect behavior; expression, alteration, and stability of the introduced genetic material; methods for vector construction and introduction; and a description of the regulatory and structural genes that are components of the introduced genetic material, including genetic maps of the introduced sequences.

(3) *Phenotypic and ecological characteristics.* (i) Habitat, geographical distribution, and source of the recipient microorganism(s).

(ii) Survival and dissemination under relevant environmental conditions including a description of methods for detecting the microorganism(s) in the environment and the sensitivity limit of detection for these techniques.

(iii) A description of anticipated biological interactions with and effects on target organisms and other organisms such as competitors, prey, hosts, symbionts, parasites, and pathogens; a description of host range; a description of pathogenicity, infectivity, toxicity, virulence, or action as a vector of pathogens; and capacity for genetic transfer under laboratory and relevant environmental conditions.

(iv) A description of anticipated involvement in biogeochemical or biological cycling processes, involvement in rate limiting steps in mineral or nutrient cycling, or involvement in inorganic compounds cycling (such as possible sequestration or transformation of heavy metals).

(e) *Byproducts.* A description of the byproducts resulting from the manufacture, processing, use, and disposal of the new microorganism(s).

(f) *Total production volume.* The estimated maximum amount of the new microorganism(s) intended to be manufactured or imported during the first year of production and the estimated maximum amount to be manufactured or imported during any consecutive 12–month period during the first 3 years of production. This estimate may be by weight or volume and should include an estimation of

viability (i.e., viable cells per unit volume or colony forming units per unit dry weight).

(g) *Use information.* A description of intended categories of use by function and application, the estimated percent of production volume devoted to each category of use, and the percent of the new microorganism(s) in the formulation for each commercial or consumer use.

(h) *Worker exposure and environmental release.* (1) For sites controlled by the submitter:

(i) The identity of sites where the new microorganism(s) will be manufactured, processed, or used. For purposes of this section, the site for a person who imports a new microorganism is the site of the operating unit within the person's organization which is directly responsible for importing the new microorganism and which controls the import transaction. The import site may in some cases be the organization's headquarters office in the United States.

(ii) A process description of each manufacture, processing, and use operation, which includes a diagram of the major unit operations and conversions, the identity and entry point of all feedstocks, and the identity of any possible points of release of the new microorganism from the process, including a description of all controls, including engineering controls, used to prevent such releases.

(iii) Worker exposure information, including worker activities, physical form of process streams which contain the new microorganism to which workers may be exposed, the number of workers, and the duration of activities.

(iv) Information on release of the new microorganism to the environment, including the quantity and media of release and type of control technology used.

(v) A narrative description of the intended transport of the new microorganism, including the means of transport, containment methods to be used during transport, and emergency containment procedures to be followed in case of accidental release.

(vi) Procedures for disposal of any articles, waste, clothing, or other equipment involved in the activity, including procedures for inactivation of the new microorganism, containment, disinfection, and disposal of contaminated items.

(2) For sites not controlled by the submitter, a description of each type of processing and use operation involving the new microorganism, including identification of the estimated number of processing or use sites, situations in which worker exposure to and/or environmental release of the new microorganism will occur, the number of workers exposed and the duration of exposure; procedures for transport of the new microorganism and for disposal, including procedures for inactivation of the new microorganism; and control measures which limit worker exposure and environmental release.

§ 725.160 Submission of health and environmental effects data.

(a) *Test data on the new microorganism in the possession or control of the submitter.* (1) Except as provided in § 725.25(h), and in addition to the information required by § 725.155(d)(3), each MCAN must contain all test data in the submitter's possession or control which are related to the effects on health or the environment of any manufacture, processing, distribution in commerce, use, or disposal of the new microorganism or any microbial mixture or article containing the new microorganism, or any combination of such activities. This includes test data concerning the new microorganism in a pure culture or formulated form as used in one of the activities listed above.

(2) A full report or standard literature citation must be submitted for the following types of test data:

(i) Health effects data.

(ii) Ecological effects data.

(iii) Physical and chemical properties data.

(iv) Environmental fate characteristics.

(v) Monitoring data and other test data related to human exposure to or environmental release of the new microorganism.

(3)(i) If the data do not appear in the open scientific literature, the submitter must provide a full report. A full report includes the experimental methods and materials, results, discussion and data analysis, conclusions, references, and the name and address of the laboratory that developed the data.

(ii) If the data appear in the open scientific literature, the submitter need only provide a standard literature citation. A standard literature citation includes author, title, periodical name, date of publication, volume, and page numbers.

(4)(i) If a study, report, or test is incomplete when a person submits a MCAN, the submitter must identify the nature and purpose of the study; name and address of the laboratory developing the data; progress to date; types of data collected, significant preliminary results; and anticipated completion date.

(ii) If a test or experiment is completed before the MCAN review period ends, the person must submit the study, report, or test to the address listed in § 725.25(c), as specified in paragraph (a)(3)(i) of this section, within 10 days of receiving it, but no later than 5 days before the end of the review period. If the test or experiment is completed during the last 5 days of the review period, the submitter must immediately inform its EPA contact for that submission by telephone.

(5) For test data in the submitter's possession or control which are not listed in paragraph (a)(2) of this section, a person is not required to submit a complete report. The person must submit a summary of the data. If EPA so requests, the person must submit a full report within 10 days of the request, but no later than 5 days before the end of the review period.

(6) All test data described under paragraph (a) of this section are subject to these requirements, regardless of their age, quality, or results.

(b) *Other data concerning the health and environmental effects of the new microorganism that are known to or reasonably ascertainable by the submitter.* (1) Except as provided in § 725.25(h), and in addition to the information required by § 725.155(c)(3), any person who submits a MCAN must describe the following data, including any data from a health and safety study of a microorganism, if the data are related to effects on health or the environment of any manufacture, processing, distribution in commerce, use, or disposal of the microorganism, of any microbial mixture or article containing the new microorganism, or of any combination of such activities:

(i) Any data, other than test data, in the submitter's possession or control.

(ii) Any data, including test data, which are not in the submitter's possession or control, but which are known to or reasonably ascertainable by the submitter. For the purposes of this section, data are known to or reasonably ascertainable by the submitter if the data are known to any of its employees or other agents who are associated with the research and development, test marketing, or commercial marketing of the microorganism.

(2) Data that must be described include data concerning the new microorganism in a pure culture or formulated form as used in one of the activities listed in paragraph (b)(1) of this section.

(3) The description of data reported under paragraph (b) of this section must include:

(i) If the data appear in the open scientific literature, a standard literature citation, which includes the author, title, periodical name, date of publication, volume, and pages.

(ii) If the data are not available in the open scientific literature, a description of the type of data and summary of the results, if available, and the names and addresses of persons the submitter believes may have possession or control of the data.

(4) All data described by paragraph (b) of this section are subject to these requirements, regardless of their age, quality, or results; and regardless of whether they are complete at the time the MCAN is submitted.

§ 725.170 EPA review of the MCAN.

General procedures for review of all submissions under this part are contained in § § 725.28 through 725.60. In addition, the following procedures apply to EPA review of MCANs submitted under this subpart:

(a) Length of the review period. The MCAN review period specified in section 5(a) of the Act runs for 90 days from the date the Document Control Officer for the Office of Pollution Prevention and Toxics receives a complete MCAN, or the date EPA determines the MCAN is complete under § 725.33, unless the Agency extends the period under section 5(c) of the Act and § 725.56.

(b) Notice of expiration of MCAN review period. (1) EPA will notify the submitter that the MCAN review period has expired or that EPA has completed its review of the MCAN. Expiration of the review period does not constitute EPA approval or certification of the new microorganism, and does not mean that EPA may not take regulatory action against the microorganism in the future.

(2) After expiration of the MCAN review period, in the absence of regulatory action by EPA under section 5(e), 5(f), or 6(a) of the Act, the submitter may manufacture or import the microorganism even if the submitter has not received notice of expiration.

(3) Early notification that EPA has completed its review does not permit commencement of manufacture or import prior to the expiration of the 90–day MCAN review period.

(c) Any person submitting a MCAN in response to the requirements of this subpart shall not manufacture, import, or process a microorganism subject to this subpart until the review period, including all extensions and suspensions, has expired.

§ 725.190 Notice of commencement of manufacture or import.

(a) *Applicability.* Any person who commences the manufacture or import of a new microorganism for nonexempt, general commercial use for which that person previously submitted a section 5(a) notice under this part must submit a notice of commencement (NOC) of manufacture or import.

(b) *When to report.* (1) If manufacture or import for nonexempt, general commercial use begins on or after [insert date 44 days after date of publication in the **Federal Register** of the final rule], the submitter must submit the NOC to EPA no later than 30 calendar days after the first day of such manufacture or import.

(2) If manufacture or import for nonexempt, general commercial use began or will begin before [insert date 44 days after date of publication in the **Federal Register** of the final rule], the submitter must submit the NOC by [insert date 44 days after date of publication in the **Federal Register** of the final rule].

(3) Submission of an NOC prior to the commencement of manufacture or import is a violation of TSCA section 15.

(c) *Information to be reported.* The NOC must contain the following information: Specific microorganism identity, MCAN number, and the date when manufacture or import commences. If the person claimed microorganism identity confidential in the MCAN, and wants the identity to be listed on the confidential Inventory, the claim must be reasserted and resubstantiated in accordance with § 725.85(b). Otherwise, EPA will list the specific microorganism identity on the public Inventory.

(d) *Where to submit.* NOCs should be submitted to the address listed in § 725.25(c).

Subpart E—Exemptions for Research and Development Activities

§ 725.200 Scope and purpose.

(a) This subpart describes exemptions from the reporting requirements under subpart D of this part for research and development activities involving microorganisms.

(b) In lieu of complying with subpart D of this part, persons described in § 725.205 may submit a TSCA Experimental Release Application (TERA) for research and development activities involving microorganisms.

(c) Exemptions from part 725 are provided at § § 725.232, 725.234, and 725.238.

(d) Submission requirements specific for TERAs are described at § 725.250.

(e) Data requirements for TERAs are set forth in § § 725.255 and 725.260.

(f) EPA review procedures specific for TERAs are set forth in § § 725.270 and 725.288.

(g) Subparts A through C of this part apply to any submission under this subpart.

§ 725.205 Persons who may report under this subpart.

(a) Certain research and development activities involving microorganisms subject to TSCA jurisdiction are exempt from reporting under this part. A person conducting research and development activities which do not meet the conditions for the exemptions described in § 725.232, 725.234, or 725.238 may report under this subpart.

(b) A person may report under this subpart for the following research and development activities:

(1) A person who intends to manufacture or import for commercial purposes a new microorganism.

(2) A person who intends to manufacture, import, or process for commercial purposes a microorganism identified in subpart M of this part as a significant new use. Additional reporting requirements for significant new uses are described in subpart L of this part.

§ 725.232 Activities subject to the jurisdiction of other Federal programs or agencies.

This part does not apply to any research and development activity that meets all of the following conditions.

(a) Meets the requirements of § 725.234(a) and (c).

(b) Is receiving research funds from another Federal agency which controls the research in accordance with applicable portions of the NIH "Guidelines for Research Involving Recombinant DNA Molecules." This control may be exercised through direct regulatory authority or through requiring compliance with the NIH Guidelines as a condition of receiving funds.

§ 725.234 Activities conducted inside a structure.

A person who manufactures, imports, or processes a microorganism is not subject to the reporting requirements under subpart D of this part if all of the following conditions are met:

(a) The microorganism is manufactured, imported, or processed solely for research and development activities.

(b) The microorganism is used by, or directly under the supervision of, a technically qualified individual, as defined in § 725.3. The technically

qualified individual must maintain documentation of the procedures selected to comply with paragraph (d) of this section and must ensure that the procedures are used.

(c) There is no intentional testing of a microorganism outside of a structure, as structure is defined in § 725.3.

(d) Containment and/or inactivation controls. (1) Selection and use of containment and/or inactivation controls inside a structure for a particular microorganism shall take into account the following:

(i) Factors relevant to the organism's ability to survive in the environment.

(ii) Potential routes of release in air, solids and liquids; in or on waste materials and equipment; in or on people, including maintenance and custodial personnel; and in or on other organisms, such as insects and rodents.

(iii) Procedures for transfer of materials between facilities.

(2) The TQI's selection of containment and/or inactivation controls shall be approved and certified by an authorized official (other than the TQI) of the institution that is conducting the test prior to the commencement of the test.

(3) Records shall be developed and maintained describing the selection and use of the containment and/or inactivation controls, including contingency plans for emergency clean-up or test termination, that will be used during the test. These records, which must be maintained at the location where the research and development activity is being conducted, shall be submitted to the Agency at the Agency's written request and within the time frame specified in the Agency's request.

(4) Subsequent to Agency review of records in accordance with paragraph (d)(3) of this section, changes to the containment/inactivation controls selected under paragraph (d)(1) of this section must be made upon Agency order. Failure to comply with the Agency's order shall result in automatic loss of eligibility for an exemption under this section.

(e) The manufacturer, importer, or processor notifies all persons in its employ or to whom it directly distributes the microorganism, who are engaged in experimentation, research, or analysis on the microorganism, including the manufacture, processing, use, transport, storage, and disposal of the microorganism associated with research and development activities, of any risk to health, identified under § 725.235(a), which may be associated with the microorganism. The notification must be made in accordance with § 725.235(b).

§ 725.235 Conditions of exemption for activities conducted inside a structure.

(a) *Determination of risks.* (1) To determine whether notification under § 725.234(e) is required, the manufacturer, importer, or processor must review and evaluate the following information to determine whether there is reason to believe there is any risk to health which may be associated with the microorganism:

(i) Information in its possession or control concerning any significant adverse reaction of persons exposed to the microorganism which may reasonably be associated with such exposure.

(ii) Information provided to the manufacturer, importer, or processor by a supplier or any other person concerning a health risk believed to be associated with the microorganism.

(iii) Health and environmental effects data in its possession or control concerning the microorganism.

(iv) Information on health effects which accompanies any EPA rule or order issued under section 4, 5, or 6 of the Act that applies to the microorganism and of which the manufacturer, importer, or processor has knowledge.

(2) When the research and development activity is conducted solely inside a laboratory and exposure to the microorganism is controlled through the implementation of prudent practices for handling microorganisms of unknown human health or environmental effects and any distribution, except for purposes of disposal, is to other such laboratories for further research and development activity, the information specified in paragraph (a)(1) of this section need not be reviewed and evaluated. (For purposes of this paragraph (a)(2), a laboratory is defined as a contained research facility, where relatively small quantities of microorganisms are used on a non-production basis, and where activities involve the use of containers for reactions, transfers, and other handling of microorganisms designed to be easily manipulated by a single individual.)

(b) *Notification to employees.* (1) The manufacturer, importer, or processor must notify the persons identified in § 725.234(e) by means of a container labeling system, conspicuous placement of notices in areas where exposure may occur, written notification to each person potentially exposed, or any other method of notification which adequately informs persons of health risks which the manufacturer, importer, or processor has reason to believe may be associated with the microorganism, as determined under paragraph (a)(1) of this section.

(2) If the manufacturer, importer, or processor distributes a microorganism manufactured, imported, or processed under this section to persons not in its employ, the manufacturer, importer, or processor must in written form:

(i) Notify those persons that the microorganism is to be used only for research and development purposes.

(ii) Provide the notice of health risks specified in paragraph (b)(1) of this section.

(3) The adequacy of any notification under this section is the responsibility of the manufacturer, importer, or processor.

(c) *No applicability to general commercial use.* A microorganism is not exempt from reporting under subpart D of this part if any amount of the microorganism, including as part of a mixture, is processed, distributed in commerce, or used, for any commercial purpose other than research and development, except where the microorganism is processed, distributed in commerce, or used only as an impurity or as part of an article.

(d) *Waste disposal.* Quantities of the inactivated microorganism, or mixtures or articles containing the inactivated microorganism, remaining after completion of research and development activities may be disposed of as a waste in accordance with applicable Federal, State, and local regulations.

(e) *Impurities and articles.* Quantities of research and development microorganisms existing solely as impurities in a product or incorporated into an article, in accordance with paragraph (c) of this section, are not subject to the requirements of § 725.234 and paragraphs (a) and (b) of this section, once research and development activities have been completed.

(f) *Pesticide uses.* A person who manufactures, imports, or processes a microorganism solely for research and development is not required to comply with the requirements of this section if the person's exclusive intention is to perform research and development activities solely for the purpose of determining whether the microorganism can be used as a pesticide.

(g) *Recordkeeping.* A person who manufactures, imports, or processes a microorganism under this section must retain the following records:

(1) Records describing selection and use of containment and/or inactivation controls required by § 725.234(d)(3) and certification by an authorized official required by § 725.234(d)(2) for each microorganism.

(2) Copies or citations to information reviewed and evaluated under paragraph (a)(1) of this section to determine the need to make any notification of risk.

(3) Documentation of prudent laboratory practices used instead of notification and evaluation under paragraph (a)(2) of this section.

(4) Documentation of the nature and method of notification under paragraph (b)(1) of this section, including copies of any labels or written notices used.

(5) The names and addresses of any persons other than the manufacturer, importer, or processor to whom the substance is distributed, the identity of the microorganism, the amount distributed, and copies of the notifications required under paragraph (b)(2) of this section.

§ 725.238 Activities conducted outside a structure.

(a) *Exemption.* (1) Research and development activities involving intentional testing in the environment of certain microorganisms listed in § 725.239 may be conducted without prior review by EPA if all of the conditions of this section and § 725.239 are met.

(2) The research and development activity involving a microorganism listed in § 725.239 must be conducted by, or directly under the supervision of, a technically qualified individual, as defined in § 725.3.

(b) *Certification.* To be eligible for the exemption under this section, a manufacturer or importer must submit to EPA prior to initiation of the activity a document signed by an authorized official containing the following information:

(1) Name, address and phone number of the manufacturer or importer

(2) Location, estimated duration, and planned start date of the test

(3) Certification of the following:

(i) Compliance with the conditions of the exemption specified for the microorganism in § 725.239.

(ii) Notification of the appropriate Federal and state authorities of the planned test.

(c) *Recordkeeping.* Persons who conduct research and development activities under this section must comply with the recordkeeping requirements of § 725.65 and retain documentation that supports their compliance with the requirements of this section and the specific requirements for the microorganism listed in § 725.239.

§ 725.239 Use of specific microorganisms in activities conducted outside a structure.

(a) *Bradyrhizobium japonicum.* To qualify for an exemption under this section, all of the following conditions must be met for a test involving *Bradyrhizobium japonicum*:

(1) *Characteristics of recipient microorganism.* The recipient microorganism is limited to strains of *Bradyrhizobium japonicum.*

(2) *Modification of traits.* (i) The introduced genetic material must meet the criteria for poorly mobilizable listed in § 725.421(c).

(ii) The introduced genetic material must consist only of the following components:

(A) The structural gene(s) of interest, which have the following limitations:

(*1*) For antibiotic resistance, the structural gene may originate from any source.

(*2*) For traits other than antibiotic resistance, the structural gene must be limited to the genera *Bradyrhizobium* and *Rhizobium.*

(B) The regulatory sequences permitting the expression of solely the gene(s) of interest.

(C) Associated nucleotide sequences needed to move genetic material, including linkers, homopolymers, adaptors, transposons, insertion sequences, and restriction enzyme sites.

(D) The vector nucleotide sequences needed for vector transfer.

(E) The vector nucleotide sequences needed for vector maintenance.

(3) *Limitations on exposure.* (i) The test site area must be no more than 5 terrestrial acres.

(ii) The technically qualified individual must select appropriate methods to limit the dissemination of modified *Bradyrhizobium japonicum.*

(b) *Rhizobium meliloti.* To qualify for an exemption under this section, all of the following conditions must be met for a test involving *Rhizobium meliloti*:

(1) *Characteristics of recipient microorganism.* The recipient microorganism is limited to strains of *Rhizobium meliloti.*

(2) *Modification of traits.* (i) The introduced genetic material must meet the criteria for poorly mobilizable listed in § 725.421(c) of this part.

(ii) The introduced genetic material must consist only of the following components:

(A) The structural gene(s) of interest, which have the following limitations:

(*1*) For antibiotic resistance, the structural gene may originate from any source.

(*2*) For traits other than antibiotic resistance, the structural gene must be limited to the genera *Bradyrhizobium* and *Rhizobium.*

(B) The regulatory sequences permitting the expression of solely the gene(s) of interest.

(C) Associated nucleotide sequences needed to move genetic material, including linkers, homopolymers, adaptors, transposons, insertion sequences, and restriction enzyme sites.

(D) The vector nucleotide sequences needed for vector transfer.

(E) The vector nucleotide sequences needed for vector maintenance.

(3) *Limitations on exposure.* (i) The test site area must be no more than 5 terrestrial acres.

(ii) The technically qualified individual must select appropriate methods to limit the dissemination of modified *Rhizobium meliloti.*

§ 725.250 Procedural requirements for this subpart.

General requirements for all submissions under this part are contained in § 725.25. In addition, the following requirements apply to applications submitted under this subpart:

(a) When to submit the TERA. Each person who is eligible to submit a TERA under this subpart must submit the TERA at least 60 calendar days prior to initiating the proposed research and development activity.

(b) Contents of the TERA. Each person who submits a TERA under this subpart must provide the information and test data described in § § 725.255 and 725.260. In addition, the submitter must supply sufficient information to enable EPA to evaluate the effects of all activities for which approval is requested.

(c) A person described under § 725.205 may submit a TERA for one or more microorganisms and one or more research and development activities, including a research program.

(d) EPA will either approve the TERA, with or without conditions, or disapprove it under procedures established in this subpart.

(e) The manufacturer, importer, or processor who receives a TERA approval must comply with all terms of the approval and remains liable for compliance with all terms, regardless of who conducts the research and development activity. Any person conducting the research and development activity approved under the TERA must comply with all terms of the TERA approval.

(f) Recordkeeping. Persons submitting a TERA must comply with the recordkeeping requirements of § 725.65. In addition, the following requirements apply to TERAs:

(1) Each person submitting a TERA under this part must retain

documentation of information contained in the TERA for a period of 3 years from the date that the results of the study are submitted to the Agency.

(2) Summaries of all data, conclusions, and reports resulting from the conduct of the research and development activity under the TERA must be submitted to the EPA address identified in § 725.25(c) within 1 year of the termination of the activity.

§ 725.255 Information to be included in the TERA.

(a) To review a TERA, EPA must have sufficient information to permit a reasoned evaluation of the health and environmental effects of the planned test in the environment. The person seeking EPA approval must submit all information known to or reasonably ascertainable by the submitter on the microorganism and the research and development activity, including information not listed in paragraphs (c), (d), and (e) of this section that the person believes will be useful for EPA's risk assessment. The TERA must be in writing and must include at least the information described in the following paragraphs.

(b) When specific information is not submitted, an explanation of why such information is not available or not applicable must be included.

(c) Persons applying for a TERA, must include the submitter identification and microorganism identity information required for MCANs in § 725.155(c), (d)(1), and (d)(2).

(d) Persons applying for a TERA must submit phenotypic and ecological characteristics information required in § 725.155(d)(3) as it relates directly to the conditions of the proposed research and development activity.

(e) Persons applying for a TERA must also submit the following information about the proposed research and development activity:

(1) *A detailed description of the proposed research and development activity.* (i) The objectives and significance of the activity and a rationale for testing the microorganisms in the environment.

(ii) Number of cells released (including viability per volume if applicable) and the method(s) of application or release.

(iii) Characteristics of the test site(s), including location, geographical, physical, chemical, and biological features, proximity to human habitation or activity, and description of site characteristics that would influence dispersal or confinement.

(iv) Target organisms (if the microorganism(s) to be tested has an intended target), including identification of each target organism and anticipated mechanism and result of interaction.

(v) Planned start date and duration of each activity.

(vi) Evidence that State authorities have been notified.

(2) *Information on monitoring, confinement, mitigation, and emergency termination procedures.* (i) Confinement procedures for the activity, access and security measures, and procedures for routine termination of the activity.

(ii) Mitigation and emergency procedures.

(iii) Measures to detect and control potential adverse effects.

(iv) Name of principal investigator and chief of site personnel responsible for emergency procedures.

(v) Personal protective equipment, engineering controls, and procedures to be followed to minimize dispersion of the microorganism(s) by people, machinery, or equipment.

(vi) Procedures for disposal of any articles, waste, clothing, machinery, or other equipment involved in the experimental release, including methods for inactivation of the microorganism, containment, disinfection, and disposal of contaminated items.

§ 725.260 Submission of health and environmental effects data.

Each TERA must contain all available data concerning actual or potential effects on human health or the environment of the new microorganism that are in the possession or control of the submitter and a description of other data known to or reasonably ascertainable by the submitter that will permit a reasoned evaluation of the planned test in the environment. The data must be reported in the manner described in § 725.160(a)(3) and (b)(3).

§ 725.270 EPA review of the TERA.

General procedures for review of all submissions under this part are contained in § § 725.28 through 725.60. In addition, the following procedures apply to EPA review of applications submitted under this subpart:

(a) *Length of the review period.* (1) The review period for the TERA will be 60 days from the date the Document Control Officer for the Office of Pollution Prevention and Toxics receives a complete TERA, or the date EPA determines the TERA is complete under § 725.33, unless EPA finds good cause for an extension under § 725.56.

(2) A submitter shall not proceed with the research and development activity described in the TERA unless and until EPA provides written approval of the TERA. A submitter may receive early approval if a review is completed in less than 60 days.

(b) *EPA decision regarding proposed TERA activity.* (1) A decision concerning a TERA under this subpart will be made by the Administrator, or a designee.

(2) If EPA determines that the proposed research and development activity for the microorganism does not present an unreasonable risk of injury to human health or the environment, EPA will notify the submitter that the TERA is approved and that the submitter can proceed with the proposed research and development activity described in the TERA.

(3) EPA may include conditions in its approval of the TERA that would be stated in a TERA agreement under paragraph (c) of this section.

(4) If EPA concludes that the proposed research and development activity may present an unreasonable risk of injury to human health or the environment, EPA will deny the TERA and will provide reasons for the denial in writing.

(c) *TERA agreement.* (1) The TERA agreement is legally binding on the TERA submitter and the Agency. The TERA submitter agrees to be bound by the requirements set out in the agreement and also certifies that all data submitted to the Agency is true and correct.

(2) If EPA approves a TERA, the submitter must conduct the research and development activity only as described in the TERA agreement and in accordance with any conditions set forth by EPA in its approval of the TERA agreement.

(3) Any person who fails to comply with any requirement or condition of the TERA agreement shall be in violation of sections 5 and 15 of TSCA and so subject to civil and criminal penalties under section 16 of TSCA.

§ 725.288 Revocation or modification of TERA approval.

(a) *Significant questions about risk.* (1) If, after approval of a TERA under this subpart, EPA receives information which raises significant questions about the Agency's determination that the activity does not present an unreasonable risk of injury to human health or the environment, EPA will notify the submitter in writing of those questions.

(2) The submitter may, within 10 days of receipt of EPA's notice, provide in writing additional information or arguments concerning the significance of the questions and whether EPA

should modify or revoke the approval of the TERA.

(3) After considering any such information and arguments, EPA will decide whether to change its determination regarding approval of the TERA.

(i) If EPA determines that it will continue to approve the TERA, it will notify the submitter in writing. In continuing to approve a TERA, EPA may prescribe additional conditions which must be followed by the submitter. In this case, EPA may reserve the right to review the test data and revoke the TERA approval after some time period.

(ii) If EPA concludes that it can no longer approve the TERA, it will notify the submitter in writing and state its reasons. In that event, the submitter must terminate the research and development activity within 48 hours of receipt of the notice in accordance with directions provided by EPA in the notice.

(b) *Evidence of unreasonable risk.* (1) If, after approval of a TERA under this subpart, EPA receives information which indicates that the proposed research and development activity will present an unreasonable risk of injury to human health or the environment, EPA will notify the submitter in writing and state its reasons.

(2) The submitter must provide additional safeguards or terminate the research and development activity in accordance with directions provided by EPA in the notice.

(3) The submitter may then submit additional information or arguments concerning the matters raised by EPA and whether EPA should modify or revoke the approval of the TERA in accordance with paragraph (a)(2) of this section.

(4) EPA will consider the information and arguments under paragraph (a)(3) of this section.

(5) The submitter may resume the activity only upon written notice from EPA that EPA has approved resumption of the activity. In approving resumption of an activity, EPA may prescribe additional conditions which must be followed by the submitter.

(c) *Modifications.* If, after approval of a TERA under this subpart, the submitter concludes that it is necessary to alter the conduct of the research and development activity in a manner which would result in the activity being different from that described in the TERA agreement and any conditions EPA prescribed in its approval, the submitter must inform the EPA contact for the TERA and may not modify the activity without the approval of EPA.

Subpart F—Exemptions for Test Marketing

§ 725.300 Scope and purpose.

(a) This subpart describes exemptions from the reporting requirements under subpart D of this part for test marketing activities involving microorganisms.

(b) In lieu of complying with subpart D of this part, persons described in § 725.305 may submit an application for a test marketing exemption (TME).

(c) Submission requirements specific for TME applications are described at § 725.350.

(d) Data requirements for TME applications are set forth in § 725.355.

(e) EPA review procedures specific for TMEs are set forth in § 725.370.

(f) Subparts A through C of this part apply to any submission under this subpart.

§ 725.305 Persons who may report under this subpart.

A person identified in this section may apply for a test marketing exemption. EPA may grant the exemption if the person demonstrates that the microorganism will not present an unreasonable risk of injury to health or the environment as a result of the test marketing. A person may report under this subpart for the following test marketing activities:

(a) A person who intends to manufacture or import for commercial purposes a new microorganism.

(b) A person who intends to manufacture, import, or process for commercial purposes a microorganism identified in subpart M of this part as a significant new use.

§ 725.350 Procedural requirements for this subpart.

General requirements for all submissions under this part are contained in § 725.25. In addition, the following requirements apply to applications submitted under this subpart:

(a) *Prenotice consultation.* EPA strongly suggests that for a TME, the submitter contact the Agency for a prenotice consultation regarding eligibility for a TME.

(b) *When to submit a TME.* Each manufacturer or importer who is eligible to submit a TME under this subpart must submit the TME at least 45 calendar days before commencing the test marketing activity.

(c) *Recordkeeping.* Each person who is granted a TME must comply with the recordkeeping requirements of § 725.65. In addition, any person who obtains a TME must retain documentation of compliance with any restrictions imposed by EPA when it grants the TME. This information must be retained for 3 years from the final date of manufacture or import under the exemption.

§ 725.355 Information to be included in the TME application.

(a) To review a TME application, EPA must have sufficient information to permit a reasoned evaluation of the health and environmental effects of the planned test marketing activity. The person seeking EPA approval must submit all information known to or reasonably ascertainable by the submitter on the microorganism and the test marketing activity, including information not listed in paragraphs (c), (d), and (e) of this section that the person believes will demonstrate that the microorganism will not present an unreasonable risk of injury to health or the environment as a result of the test marketing. The TME application must be in writing and must include at least the information described in paragraphs (b), (c), (d), and (e) of this section.

(b) When specific information is not submitted, an explanation of why such information is not available or not applicable must be included.

(c) Persons applying for a TME must submit the submitter identification and microorganism identity information required for MCANs in § 725.155(c), (d)(1), and (d)(2).

(d) Persons applying for a TME must submit phenotypic and ecological characteristics information required in § 725.155(d)(3) as it relates directly to the conditions of the proposed test marketing activity.

(e) Persons applying for a TME must also submit the following information about the proposed test marketing activity:

(1) *Proposed test marketing activity.* (i) The maximum quantity of the microorganism which the applicant will manufacture or import for test marketing.

(ii) The maximum number of persons who may be provided the microorganism during test marketing.

(iii) The maximum number of persons who may be exposed to the microorganism as a result of test marketing, including information regarding duration and route of such exposures.

(iv) A description of the test marketing activity, including its duration and how it can be distinguished from full-scale commercial production and research and development activities.

(2) *Health and environmental effects data.* All existing data regarding health and environmental effects of the

microorganism must be reported in accordance with § 725.160.

§ 725.370 EPA review of the TME application.

General procedures for review of all submissions under this part are contained in § § 725.28 through 725.60. In addition, the following procedures apply to EPA review of TME applications submitted under this subpart:

(a) No later than 45 days after EPA receives a TME, the Agency will either approve or deny the application.

(b) A submitter may only proceed with test marketing activities after receipt of EPA approval.

(c) In approving a TME application, EPA may impose any restrictions necessary to ensure that the microorganism will not present an unreasonable risk of injury to health and the environment as a result of test marketing.

Subpart G—Exemption for Microorganisms in General Commercial Use

§ 725.400 Scope and purpose.

(a) This subpart describes exemptions from reporting under subpart D of this part, and from review under this part altogether, for manufacturing and importing of certain new microorganisms for general commercial use.

(b) Recipient microorganisms eligible for the tiered exemption from review under this part are listed in § 725.420.

(c) Criteria for the introduced genetic material contained in the new microorganisms are described in § 725.421.

(d) Physical containment and control technologies are described in § 725.422.

(e) The conditions for the Tier I exemption are listed in § 725.424.

(f) In lieu of complying with subpart D of this part, persons using recipient microorganisms eligible for the tiered exemption may submit a Tier II exemption request. The limited reporting requirements for the Tier II exemption, including data requirements, are described in § § 725.450 and 725.455.

(g) EPA review procedures for the Tier II exemption are set forth in § 725.470.

(h) Subparts A through C of this part apply to any submission under this subpart.

§ 725.420 Recipient microorganisms.

The following recipient microorganisms are eligible for either exemption under this part:

(a) *Acetobacter aceti.*

(b) *Aspergillus niger.*

(c) *Aspergillus oryzae.*

(d) *Bacillus licheniformis.*

(e) *Bacillus subtilis.*

(f) *Clostridium acetobutylicum.*

(g) *Escherichia coli* K-12.

(h) *Penicillium roqueforti.*

(i) *Saccharomyces cerevisiae.*

(j) *Saccharomyces uvarum.*

§ 725.421 Introduced genetic material.

For a new microorganism to qualify for either exemption under this subpart, introduced genetic material must meet all of the criteria listed in this section.

(a) *Limited in size.* The introduced genetic material must consist only of the following:

(1) The structural gene(s) of interest.

(2) The regulatory sequences permitting the expression of solely the gene(s) of interest.

(3) Associated nucleotide sequences needed to move genetic material, including linkers, homopolymers, adaptors, transposons, insertion sequences, and restriction enzyme sites.

(4) The nucleotide sequences needed for vector transfer.

(5) The nucleotide sequences needed for vector maintenance.

(b) *Well characterized.* For introduced genetic material, well characterized means that the following have been determined:

(1) The function of all of the products expressed from the structural gene(s).

(2) The function of sequences that participate in the regulation of expression of the structural gene(s).

(3) The presence or absence of associated nucleotide sequences.

(c) *Poorly mobilizable.* The ability of the introduced genetic material to be transferred and mobilized is inactivated, with a resulting frequency of transfer of less than 10^{-8} transfer events per recipient.

(d) *Free of certain sequences.* The introduced genetic material must not contain any part of the nucleotide sequences that encode the toxins described in this paragraph (d). Although these toxins are listed according to the source organism, it is use of the nucleotide sequences that encode the toxins that are being restricted and not the use of the source organisms. The source organisms are listed to provide specificity in identification of sequences whose use is restricted. Similar or identical sequences may be isolated from organisms other than those listed below. Comparable toxin sequences, regardless of the organism from which they are derived, must not be included in the introduced genetic material. Toxin synonyms are included in parentheses.

(1) *Sequences for protein synthesis inhibitor.*

Sequence Source	Toxin Name
Corynebacterium diphtheriae & *C. ulcerans*	Diphtheria toxin
Pseudomonas aeruginosa	Exotoxin A
Shigella dysenteriae	Shigella toxin (Shiga toxin, Shigella dysenteriae type 1 toxin, Vero cell toxin)
Abrus precatorius, seeds	Abrin
Ricinus communis, seeds	Ricin

(2) *Sequences for neurotoxins*

Sequence Source	Toxin Name
Clostridium botulinum	Neurotoxins A, B, C1, D, E, F G (Botulinum toxins, botulinal toxins)
Clostridium tetani	Tetanus toxin (tetanospasmin)
Proteus mirabilis	Neurotoxin
Staphylococcus aureus	Alpha toxin (alpha lysin)
Yersinia pestis	Murine toxin
Snake toxins	
Bungarus caeruleus	Caeruleotoxin
Bungarus multicinctus	Beta-bungarotoxin (phospholipase)
Crotalus spp.	Crotoxin (phospholipase)
Dendroaspis viridis	Neurotoxin
Naja naja varieties	Neurotoxin
Notechia scutatus	Notexin (phospholipase)
Oxyuranus scutellatus	Taipoxin
Invertebrate toxins	
Chironex fleckeri	Neurotoxin
Androctnus australis	Neurotoxin
Centruroides sculpturatus	Neurotoxin

(3) *Sequences for oxygen labile cytolysins.*

Sequence Source	Toxin Name
Bacillus alve	Alveolysin
Bacillus cereus	Cereolysin
Bacillus laterosporus	Laterosporolysin
Bacillus thuringiensis	Thuringiolysin
Clostridium bifermentans	Lysin
Clostridium botulinum	Lysin
Clostridium caproicum	Lysin
Clostridium chauvoei	Delta-toxin
Clostridium histolyticum	Epsilon-toxin

Sequence Source	Toxin Name
Clostridium novyi	Gamma-toxin
Clostridium oedematiens	Delta-toxin
Clostridium perfringens	Theta-toxin (Perfringolysin)
Clostridium septicum	Delta-toxin
Clostridium sordellii	Lysin
Clostridium tetani	Tetanolysin
Listeria monocytogenes	Listeriolysin (A B)
Streptococcus pneumoniae	Pneumolysin
Streptococcus pyogene	Streptolysin O (SLO)

(4) *Sequences for toxins affecting membrane function.*

Sequence Source	Toxin Name
Bacillus anthracis	Edema factor (Factors I II); Lethal factor (Factors II III)
Bacillus cereus	Enterotoxin (diarrheagenic toxin, mouse lethal factor)
Bordetella pertussis	Adenylate cyclase (Heat-labile factor); Pertussigen (pertussis toxin, islet activating factor, histamine sensitizing factor, lymphocytosis promoting factor)
Clostridium botulinum	C2 toxin
Clostridium difficile	Enterotoxin (toxin A)
Clostridium perfringens	Beta-toxin; Delta-toxin
Escherichia coli & other Enterobacteriaceae spp.	Heat-labile enterotoxins (LT); Heat-stable enterotoxins (STa, ST1 subtypes ST1a ST1b; also STb, STII)
Legionella pneumophila	Cytolysin
Vibrio cholerae & *Vibrio mimicus*	Cholera toxin (choleragen)

(5) Sequences that affect membrane integrity.

Sequence Source	Toxin Name
Clostridium bifermentans & other *Clostridium spp*	Lecithinase
Clostridium perfringens	Alpha-toxin (phospholipase C, lecithinase); Enterotoxin
Corynebacterium pyogenes & other *Corynebacterium spp.*	Cytolysin (phospholipase C), Ovis toxin (sphingomyelinase D)
Staphylococcus aureus	Beta-lysin (beta toxin)

(6) *Sequences that are general cytotoxins.*

Sequence Source	Toxin Name
Adenia digitata	Modeccin
Aeromonas hydrophila	Aerolysin (beta-lysin, cytotoxic lysin)
Clostridium difficile	Cytotoxin (toxin B)
Clostridium perfringens	Beta-toxin; Epsilon-toxin; Kappa-toxin
Escherichia coli & other Enterobacteriaceae spp.	Cytotoxin (Shiga-like toxin, Vero cell toxin)
Pseudomonas aeruginosa	Proteases
Staphylococcus aureus	Gamma lysin (Gamma toxin); Enterotoxins (SEA, SEB, SEC, SED SEE); Pyrogenic exotoxins A B; Toxic shock syndrome toxins (TSST-1)
Staphylococcus aureus & *Pseudomonas aeruginosa*	Leucocidin (leukocidin, cytotoxin)
Streptococcus pyogenes	Streptolysin S (SLS); Erythrogenic toxins (scarlet fever toxins, pyrogenic exotoxins)
Yersinia enterocolitica	Heat-stable enterotoxins (ST)

§ 725.422 Physical containment and control technologies.

All of the following criteria for the physical containment and control technologies of the facility are required for a Tier I exemption and serve as guidance for a Tier II exemption:

(a) The structure is designed and operated to contain the microorganisms.

(b) Limit entry only to those persons whose presence is critical to the reliability or safety of the activity.

(c) Provide written, published, and implemented procedures for the safety of personnel and control of hygiene.

(d) Include inactivation procedures demonstrated and documented to be effective against the new microorganism contained in liquid and solid wastes prior to disposal of the wastes. The inactivation procedures must reduce microbial concentrations by at least 6 logs in liquid and solid wastes.

(e) Provide and document effectiveness of features to reduce microbial concentration by at least 2 logs in aerosols and exhaust gases released from the structure.

(f) Include and document systems for controlling dissemination of the microorganisms through other routes.

(g) Have in place emergency clean-up procedures.

§ 725.424 Requirements for the Tier I exemption.

(a) *Conditions of exemption.* The manufacture or import of a new microorganism for general commercial use is not subject to review under this part if all of the following conditions are met:

(1) The recipient microorganism is listed and meets any requirements specified in § 725.420.

(2) The introduced genetic material meets the criteria under § 725.421.

(3) The physical containment and control technologies of any facility in which the microorganism will be used meet the criteria under § 725.422.

(4) The manufacturer or importer submits a certification described in paragraph (b) of this section to EPA 30 days before commencing initial manufacture or import.

(5) The manufacturer or importer complies with the recordkeeping requirements of § 725.65 and maintains records that verify compliance with the following:

(i) The certifications made in paragraph (b) of this section.

(ii) All the eligibility criteria for the Tier I exemption including the criteria for the recipient microorganism, the introduced genetic material, the physical containment and control technologies.

(b) *Certification.* To be eligible for the exemption under this subpart, a manufacturer or importer must submit to EPA a document signed by a responsible company official containing the information listed in this paragraph.

(1) Name and address of manufacturer or importer.

(2) Date when manufacture or import is expected to begin.

(3) Certification of the following:

(i) The recipient microorganism is one of those listed in § 725.420

(ii) Compliance with the introduced genetic material criteria described in § 725.421.

(iii) Compliance with the containment requirements described in § 725.422, including the provision in paragraph (a)(3) of this section.

(4) The site of waste disposal and the type of permits for disposal, the permit numbers and the institutions issuing the permits.

(5) The certification statement required in § 725.25(b).

§ 725.426 Liability of the manufacturer or importer who uses the Tier I exemption.

The Tier I exemption under § 725.424 applies only to a manufacturer or importer of a new microorganism that certifies that the microorganism will be used in all cases in compliance with § § 725.420, 725.421, and 725.422.

§ 725.428 Requirements for the Tier II exemption.

The manufacturer or importer of a new microorganism for general commercial use may submit to EPA a Tier II exemption request in lieu of a MCAN under subpart D of this part if all of the following conditions are met:

(a) The recipient microorganism is listed and meets any requirements specified in § 725.420.

(b) The introduced genetic material meets the criteria under § 725.421.

(c) The criteria listed under § 725.422 for physical containment and control technologies of facilities should be used as guidance to satisfy the Tier II exemption request data requirements listed at § 725.455(d). EPA will review proposed process and containment procedures as part of the submission for a Tier II exemption under this section.

§ 725.450 Procedural requirements for the Tier II exemption.

General requirements for all submissions under this part are contained in § 725.25. In addition, the following requirements apply to requests submitted under this subpart:

(a) *Prenotice consultation.* EPA strongly suggests that for a Tier II exemption, the submitter contact the Agency for a prenotice consultation regarding eligibility for expedited review.

(b) *When to submit the Tier II exemption request.* Each manufacturer or importer who is eligible to submit a Tier II exemption request under this subpart must submit the request at least 45 calendar days before commencing manufacture or import.

(c) *Contents of the Tier II exemption request.* Each person who submits a request under this subpart must provide the information described in § § 725.428 and 725.455, as well as information sufficient to enable EPA to evaluate the effects of all activities described in the request.

(d) *Recordkeeping.* Each person who submits a request under this subpart must comply with the recordkeeping requirements of § 725.65. In addition, the submitter should maintain records which contain information that verifies compliance with the following:

(1) The certifications made in the request.

(2) All the eligibility criteria for the Tier II exemption request including the criteria for the recipient microorganism, the introduced genetic material, the physical containment and control technologies.

§ 725.455 Information to be included in the Tier II exemption request.

The applicant must indicate clearly that the submission is an Tier II exemption request for a microorganism instead of the MCAN under subpart D of this part and must submit the following information:

(a) *Submitter identification.* (1) The name and headquarters address of the submitter.

(2) The name, address, and office telephone number (including area code) of the principal technical contact representing the submitter.

(b) *Microorganism identity information.* (1) Identification (genus, species, and strain) of the recipient microorganism. Genus, species designation should be substantiated by a letter from a culture collection or a brief summary of the results of tests conducted for taxonomic identification.

(2) Type of genetic modification and the function of the introduced genetic material.

(3) Site of insertion.

(4) Certification of compliance with the introduced genetic material criteria described in § 725.421.

(c) *Production volume.* Production volume, including total liters per year, and the maximum cell concentration achieved during the production process.

(d) *Process and containment information.* (1) A description of the process including the following:

(i) Identity and location of the manufacturing site(s).

(ii) Process flow diagram illustrating the production process, including downstream separations, and indicating the containment envelope around the appropriate equipment.

(iii) Identities and quantities of feedstocks.

(iv) Sources and quantities of potential releases to both the workplace and environment, and a description of engineering controls, inactivation procedures, and other measures which will reduce worker exposure and environmental releases.

(v) A description of procedures which will be undertaken to prevent fugitive emissions, i.e. leak detection and repair program.

(vi) A description of procedures/safeguards to prevent and mitigate accidental releases to the workplace and the environment.

(2) Certification of those elements of the containment criteria described in § 725.422 with which the manufacturer is in compliance, including stating by number the elements with which the manufacturer is in full compliance.

§ 725.470 EPA review of the Tier II exemption request.

General procedures for review of all submissions under this part are contained in § § 725.28 through 725.60. In addition, the following procedures apply to EPA review of requests submitted under this subpart:

(a) *Length of the review period.* The review period for the request will be 45 days from the date the Document Control Officer for the Office of Pollution Prevention and Toxics receives a complete request, or the date EPA determines the request is complete under § 725.33, unless the Agency extends the review period for good cause under § 725.56.

(b) *Criteria for review.* EPA will review the request to determine that the new microorganism complies with § 725.428 and that its use as described in the request will not present an unreasonable risk of injury to health or the environment.

(c) *EPA decision regarding the Tier II exemption request.* A decision concerning a request under this subpart will be made by the Administrator, or a designee.

(d) *Determination that the microorganism is ineligible for a Tier II review.* (1) EPA may determine that the manufacturer or importer is not eligible for Tier II review, because the microorganism does not meet the criteria under § 725.428 or the Administrator, or a designee, decides that there is insufficient information to determine that the conditions of use of the microorganism as described in the request will not present an unreasonable risk to health or the environment.

(2) If the Agency makes this determination, the Administrator, or a designee will notify the manufacturer by telephone, followed by a letter, that the request has been denied. The letter will explain reasons for the denial.

(3) If the request is denied, the manufacturer may submit the information necessary to constitute a MCAN under subpart D of this part.

(e) *Approval or denial of the Tier II exemption request.* (1) No later than 45 days after EPA receives a request, the Agency will either approve or deny the request.

(2) In approving a request, EPA may impose any restrictions necessary to ensure that the microorganism will not present an unreasonable risk of injury to health and the environment as a result of general commercial use.

(f) EPA may seek to enjoin the manufacture or import of a microorganism in violation of this subpart, or act to seize any microorganism manufactured or

imported in violation of this section or take other actions under the authority of sections 7 or 17 of the Act.

Subparts H–K—[Reserved]

Subpart L—Additional Procedures for Reporting on Significant New Uses of Microorganisms

§ 725.900 Scope and purpose.

(a) This subpart describes additional provisions governing submission of MCANs for microorganisms subject to significant new use rules identified in subpart M of this part.

(b) Manufacturers, importers, and processors described in § 725.105(c) must submit a MCAN under subpart D of this part for significant new uses of microorganisms described in subpart M of this part, unless they are excluded under § § 725.910 and 725.912.

(c) Section 725.920 discusses exports and imports.

(d) Additional recordkeeping requirements specific to significant new uses of microorganisms are described in § 725.950.

(e) Section 725.975 describes how EPA will approve alternative means of complying with significant new use requirements designated in subpart M of this part.

(f) Expedited procedures for promulgating significant new use requirements under subpart M of this part for microorganisms subject to section 5(e) orders are discussed in § § 725.980 and 725.984.

§ 725.910 Persons excluded from reporting on significant new uses.

(a) A person who intends to manufacture, import, or process a microorganism identified in subpart M of this part and who intends to distribute it in commerce is not required to submit a MCAN under subpart D of this part, if that person can document one or more of the following as to each recipient of the microorganism from that person:

(1) That the person has notified the recipient, in writing, of the specific section in subpart M of this part which identifies the microorganism and its designated significant new uses.

(2) That the recipient has knowledge of the specific section in subpart M of this part which identifies the microorganism and its designated significant new uses.

(3) That the recipient cannot undertake any significant new use described in the specific section in subpart M of this part.

(b) The manufacturer, importer, or processor described in paragraph (a) of this section must submit a MCAN under subpart D of this part, if such person has knowledge at the time of commercial distribution of the microorganism identified in the specific section in subpart M of this part that a recipient intends to engage in a designated significant new use of that microorganism without submitting a MCAN under this part.

(c) A person who processes a microorganism identified in a specific section in subpart M of this part for a significant new use of that microorganism is not required to submit a MCAN if that person can document each of the following:

(1) That the person does not know the specific microorganism identity of the microorganism being processed.

(2) That the person is processing the microorganism without knowledge that the microorganism is identified in subpart M of this part.

(d)(1) If at any time after commencing distribution in commerce of a microorganism identified in a specific section in subpart M of this part, a person who intends to manufacture, import, or process a microorganism described in subpart M of this part and intends to distribute it in commerce has knowledge that a recipient of the microorganism is engaging in a significant new use of that microorganism designated in that section without submitting a MCAN under this part, the person is required to cease supplying the microorganism to that recipient and to submit a MCAN for that microorganism and significant new use, unless the person is able to document each of the following:

(i) That the person has notified the recipient and EPA enforcement authorities (at the address in paragraph (d)(1)(iii) of this section), in writing within 15 working days of the time the person develops knowledge that the recipient is engaging in a significant new use, that the recipient is engaging in a significant new use without submitting a MCAN.

(ii) That, within 15 working days of notifying the recipient as described in paragraph (d)(1)(i) of this section, the person received from the recipient, in writing, a statement of assurance that the recipient is aware of the terms of the applicable section in subpart M of this part and will not engage in the significant new use.

(iii) That the person has promptly provided EPA enforcement authorities with a copy of the recipient's statement of assurance described in paragraph (d)(1)(ii) of this section. The copy must be sent to the Director, Office of Compliance Monitoring (EN–342), Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

(2) If EPA notifies the manufacturer, importer, or processor that the recipient is engaging in a significant new use after providing the statement of assurance described in paragraph (d)(1)(ii) of this section and without submitting a MCAN under this part, the manufacturer, importer, or processor shall immediately cease distribution to that recipient until the manufacturer, importer, or processor or the recipient has submitted a MCAN under this part and the MCAN review period has ended.

(3) If, after receiving a statement of assurance from a recipient under paragraph (d)(1)(ii) of this section, a manufacturer, importer, or processor has knowledge that the recipient is engaging in a significant new use without submitting a MCAN under this part, the manufacturer, importer, or processor must immediately cease distributing the microorganism to that recipient and notify EPA enforcement authorities at the address identified in paragraph (c)(1)(iii) of this section. The manufacturer, importer, or processor may not resume distribution to that recipient until any one of the following has occurred:

(i) The manufacturer, importer, or processor has submitted a MCAN under this part and the MCAN review period has ended.

(ii) The recipient has submitted a MCAN under this part and the MCAN review period has ended.

(iii) The manufacturer, importer, or processor has received notice from EPA enforcement authorities that it may resume distribution to that recipient.

§ 725.912 Exemptions.

Persons identified in § § 725.100(c) and 725.910 are not required to submit a MCAN under subpart D of this part for a microorganism identified in subpart M of this part, unless otherwise specified in a specific section in subpart M, if:

(a) The person submits a MCAN for the microorganism prior to the promulgation date of the section in subpart M of this part which identifies the microorganism, and the person receives written notification of compliance from EPA prior to the effective date of such section. The MCAN submitter must comply with any applicable requirement of section 5(b) of the Act. The MCAN must include the information and test data specified in section 5(d)(1) of the Act. For purposes of this exemption, the specific section in subpart M of this part which identifies the microorganism and § § 725.3, 725.15, 725.65, 725.70, 725.75, 725.100, and 725.900 apply; after the effective date of the section in subpart M of this

part which identifies the microorganism, §§ 725.105 and 725.910 apply and § 725.920 continues to apply. EPA will provide the MCAN submitter with written notification of compliance only if one of the following occurs:

(1) EPA is unable to make the finding that the activities described in the MCAN will or may present an unreasonable risk of injury to health or the environment under reasonably foreseeable circumstances.

(2) EPA and the person negotiate a consent order under section 5(e) of the Act, such order to take effect on the effective date of the section in subpart M of this part which identifies the microorganism.

(b) The person is operating under the terms of a consent order issued under section 5(e) of the Act applicable to that person. If a provision of such section 5(e) order is inconsistent with a specific significant new use identified in subpart M of this part, abiding by the provision of the section 5(e) order exempts the person from submitting a MCAN for that specific significant new use.

§ 725.920 Exports and imports.

(a) *Exports.* Persons who intend to export a microorganism identified in subpart M of this part, or in any proposed rule which would amend subpart M of this part, are subject to the export notification provisions of section 12(b) of the Act. The regulations that interpret section 12(b) appear at 40 CFR part 707.

(b) *Imports.* Persons who import a substance identified in a specific section in subpart M of this part are subject to the import certification requirements under section 13 of the Act, which are codified at 19 CFR §§ 12.118 through 12.127 and 12.28. The EPA policy in support of the import certification requirements appears at 40 CFR part 707.

§ 725.950 Additional recordkeeping requirements for reporting of significant new uses.

Persons submitting a MCAN for a significant new use of a microorganism must comply with the recordkeeping requirements of § 725.65. In addition, the following requirements apply:

(a) At the time EPA adds a microorganism to subpart M of this part, the Agency may specify appropriate recordkeeping requirements. Each manufacturer, importer, and processor of the microorganism shall maintain the records for 3 years from the date of their creation.

(b) The records required to be maintained under this section may include the following:

(1) Records documenting the information contained in the MCAN submitted to the Agency.

(2) Records documenting the manufacture and importation volume of the microorganism and the corresponding dates of manufacture and import.

(3) Records documenting volumes of the microorganism purchased domestically by processors of the microorganism, names and addresses of suppliers and corresponding dates of purchase.

(4) Records documenting the names and addresses (including shipment destination address, if different) of all persons outside the site of manufacture or import to whom the manufacturer, importer, or processor directly sells or transfers the microorganism, the date of each sale or transfer, and the quantity of the microorganism sold or transferred on such date.

§ 725.975 EPA approval of alternative control measures.

(a) In certain sections of subpart M of this part, significant new uses for the identified microorganisms are described as the failure to establish and implement programs providing for the use of either: specific measures to control worker exposure to or release of microorganisms which are identified in such sections, or alternative measures to control worker exposure or environmental release which EPA has determined provide substantially the same degree of protection as the specified control measures. Persons who manufacture, import, or process a microorganism identified in such sections and who intend to employ alternative measures to control worker exposure or environmental release must submit a request to EPA for a determination of equivalency before commencing manufacture, import, or processing involving the alternative control measures.

(b) A request for a determination of equivalency must be submitted in writing to the Office of Pollution Prevention and Toxics, Document Control Officer, 7407, 401 M St., SW., Washington, DC 20460: ATTN: SNUR Equivalency Determination, and must contain:

(1) The name of the submitter.

(2) The specific identity of the microorganism.

(3) The citation for the specific section in subpart M of this part which pertains to the microorganism for which the request is being submitted.

(4) A detailed description of the activities involved.

(5) The specifications of the alternative worker exposure control measures or environmental release control measures.

(6) An analysis justifying why such alternative control measures provide substantially the same degree of protection as the specific control measures identified in the specific section in subpart M of this part which pertains to the microorganism for which the request is being submitted.

(7) The data and information described in §§ 725.155 and 725.160 of this part unless such data and information have already been submitted to EPA's Office of Pollution Prevention and Toxics.

(c) Requests for determinations of equivalency will be reviewed by EPA within 45 days. Determinations under this paragraph will be made by the Director, or a designee. Notice of the results of such determinations will be mailed to the submitter.

(d) If EPA notifies the submitter under paragraph (c) of this section that EPA has determined that the alternative control measures provide substantially the same degree of protection as the specified control measures identified in the specific section of subpart M of this part which pertains to the microorganism for which the request is being submitted, the submitter may commence manufacture, import, or processing in accordance with the specifications for alternative worker exposure control measures or environmental release control measures identified in the submitter's request, and may alter any corresponding notification to workers to reflect such alternative controls. Deviations from the activities described in the EPA notification constitute a significant new use and are subject to the requirements of this part.

§ 725.980 Expedited procedures for issuing significant new use rules for microorganisms subject to section 5(e) orders.

(a) *Selection of microorganisms.* (1) In accordance with the expedited process specified in this section, EPA will issue significant new use notification requirements for each new microorganism that, after MCAN review under subpart D of this part, becomes subject to a final order issued under section 5(e) of the Act, except for an order that prohibits manufacture and import of the microorganism, unless EPA determines that significant new use notification requirements are not needed for the microorganism.

(2) If EPA determines that significant new use notifications requirements are

not needed for a microorganism that is subject to a final order issued under section 5(e) of the Act, EPA will issue a notice in the **Federal Register** explaining why the significant new use requirements are not needed.

(b) *Designation of requirements.* (1) The significant new use notification and other specific requirements will be based on and be consistent with the provisions included in the final order issued for the microorganism under section 5(e) of the Act. EPA may also designate additional activities as significant new uses which will be subject to notification.

(2) Significant new use requirements and other specific requirements designated under this section will be listed in subpart M of this part. For each microorganism, subpart M of this part will identify:

(i) The microorganism name.

(ii) The activities designated as significant new uses.

(iii) Other specific requirements applicable to the microorganism, including recordkeeping requirements or any other requirements included in the final section 5(e) order.

(c) *Procedures for issuing significant new use rules.* (1) Possible processes. EPA will issue significant new use rules under this section by one of the following three processes: direct final rulemaking, interim final rulemaking, or notice and comment rulemaking. EPA will use the direct final rulemaking process to issue significant new use rules unless it determines that, in a particular case, one of the other processes is more appropriate.

(2) Notice in the **Federal Register**. **Federal Register** documents issued to propose or establish significant new uses under this section will contain the following:

(i) The microorganism identity or, if its specific identity is claimed confidential, an appropriate generic microorganism name and an accession number assigned by EPA.

(ii) The MCAN number.

(iii) A summary of EPA's findings under section 5(e)(1)(A) of the Act for the final order issued under section 5(e).

(iv) Designation of the significant new uses subject to, or proposed to be subject to, notification and any other applicable requirements.

(v) Any modification of subpart M of this part applicable to the specific microorganism and significant new uses.

(vi) If the **Federal Register** document establishes a final rule, or notifies the public that a final rule will not be issued after public comment has been received, the document will describe comments received and EPA's response.

(3) *Direct final rulemaking.* (i) EPA will use the direct final rulemaking procedure to issue a significant new use rule, when specific requirements will be based on and be consistent with the provisions included in the final order issued for the microorganism under section 5(e) of the Act. The Agency will issue a final rule in the **Federal Register** following its decision to develop a significant new use rule under this section for a specific new microorganism.

(ii) The **Federal Register** document will state that, unless written notice is received by EPA within 30 days of publication that someone wishes to submit adverse or critical comments, the rule will be effective 60 days from the date of publication. The written notice of intent to submit adverse or critical comments should state which SNUR(s) will be the subject of the adverse or critical comments, if several SNURs are established through the direct final rule. If notice is received within 30 days that someone wishes to submit adverse or critical comments, the section(s) of the direct final rule containing the SNUR(s) for which a notice of intent to comment was received will be withdrawn by EPA issuing a document in the final rule section of the **Federal Register**, and a proposal will be published in the proposed rule section of the **Federal Register**. The proposal will establish a 30–day comment period.

(iii) If EPA, having considered any timely comments submitted in response to the proposal, decides to establish notification requirements under this section, EPA will issue a final rule adding the microorganism to subpart M of this part and designating the significant new uses subject to notification.

(4) *Interim final rulemaking.* (i) EPA will use the interim final rulemaking procedure to issue a significant new use rule, when specific requirements will be based on and be consistent with the provisions included in the final order issued for the microorganism under section 5(e) of the Act. The Agency will issue an interim final rule in the **Federal Register** following its decision to develop a significant new use rule for a specific new microorganism. The document will state EPA's reasons for using the interim final rulemaking procedure.

(A) The significant new use rule will take effect on the date of publication.

(B) Persons will be given 30 days from the date of publication to submit comments.

(ii) Interim final rules issued under this section shall cease to be in effect 180 days after publication unless, within the 180–day period, EPA issues a final rule in the **Federal Register** responding to any written comments received during the 30–day comment period specified in paragraph (c)(5)(i)(B) of this section and promulgating final significant new use notification requirements and other requirements for the microorganism.

(5) *Notice and comment rulemaking.* (i) EPA will use a notice and comment procedure to issue a significant new use rule, when EPA is designating additional activities which are not provisions included in the final order issued for the microorganism under section 5(e) of the Act as significant new uses which will be subject to notification. EPA will issue a proposal in the **Federal Register** following its decision to develop a significant new use rule under this section for a specific new microorganism. Persons will be given 30 days to comment on whether EPA should establish notification requirements for the microorganism under this part.

(ii) If EPA, having considered any timely comments, decides to establish notification requirements under this section, EPA will issue a final rule adding the microorganism to subpart M of this part and designating the significant new uses subject to notification.

(d) *Schedule for issuing significant new use rules.* (1) Unless EPA determines that a significant new use rule should not be issued under this section, EPA will issue a proposed rule, a direct final rule, or an interim final rule within 180 days of receipt of a valid notice of commencement under § 725.190 of this part.

(2) If EPA receives adverse or critical significant comments following publication of a proposed or interim final rule, EPA will either withdraw the rule or issue a final rule addressing the comments received.

§ 725.984 Modification or revocation of certain notification requirements.

(a) *Criteria for modification or revocation.* EPA may at any time modify or revoke significant new use notification requirements for a microorganism which has been added to subpart M of this part using the procedures of § 725.980. Such action may be taken under this section if EPA makes one of the following determinations, unless other information shows that the requirements should be retained:

(1) Test data or other information obtained by EPA provide a reasonable basis for concluding that activities designated as significant new uses of the microorganism will not present an unreasonable risk of injury to health or the environment.

(2) EPA has promulgated a rule under section 4 or 6 of the Act, or EPA or another agency has taken action under another law, for the microorganism that eliminates the need for significant new use notification under section 5(a)(2) of the Act.

(3) EPA has received MCANs for some or all of the activities designated as significant new uses of the microorganism and, after reviewing such MCANs, concluded that there is no need to require additional notice from persons who propose to engage in identical or similar activities.

(4) For a microorganism added to subpart M of this part under § 725.980, EPA has examined new information, or has reexamined the test data or other information supporting its finding under section 5(e)(1)(A)(ii)(I) of the Act and has concluded that a rational basis no longer exists for the findings that activities involving the microorganism may present an unreasonable risk of injury to human health or the environment required under section 5(e)(1)(A) of the Act.

(5) For a microorganism added to subpart M of this part under § 725.980, certain activities involving the microorganism have been designated as significant new uses pending the completion of testing, and adequate test data developed in accordance with applicable procedures and criteria have been submitted to EPA.

(b) Procedures for limitation or revocation. Modification or revocation of significant new use notification requirements for a microorganism that has been added to subpart M of this part using the procedures described in § 725.980 may occur either at EPA's initiative or in response to a written request.

(1) Any affected person may request modification or revocation of significant new use notification requirements for a microorganism that has been added to subpart M of this part using the procedures described in § 725.980 by writing to the Director, or a designee, and stating the basis for such request. The request must be accompanied by information sufficient to support the request. All requests should be sent to the TSCA Document Processing Center (7407), Room L–100, U.S. Environmental Protection Agency, 401 M St., SW., Washington, DC 20460, ATTN: Request to amend SNUR.

(2) The Director, or a designee, will consider the request, make a determination whether to initiate rulemaking to modify the requirements, and notify the requester of that determination by certified letter. If the request is denied, the letter will explain why EPA has concluded that the significant new use notification requirements for that microorganism should remain in effect.

(3) If EPA concludes that significant new use notification requirements for a microorganism should be limited or revoked, EPA will propose the changes in a notice in the **Federal Register**, briefly describe the grounds for the action, and provide interested parties an opportunity to comment.

Subpart M—Significant New Uses for Specific Microorganisms—[Reserved]

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