DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 409, 410, 411, 412, 413, 424, 440, 485, 488, 489, and 498

[BPD–878–FC]

RIN 0938–AH55

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 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 resulting from the Balanced Budget Act of 1997, Pub. L. 105–33, and changes arising from our continuing experience with the systems. In the addendum to this final rule with comment period, we describe changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. Generally, these changes are applicable to discharges occurring on or after October 1, 1997. We also set forth rate-of-increase limits and changes for hospitals and hospital units excluded from the prospective payment systems.

DATES: *Effective Date:* This rule is a major rule as defined in Title 5, United States Code, section 804(2). Section 4644 of Pub. L. 105–33 provides that, with respect to this final rule, the reference in Title 5, United States Code, section 801(a)(3)(A) to a 60-day delay in the effective date for major rules is deemed to be a reference to a 30-day delay. In accordance with these provisions, the provisions of this final rule with comment period are effective on October 1, 1997.

Comment Period: Comments on the provisions resulting from the Balanced Budget Act of 1997 will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on October 28, 1997. We will not consider comments concerning provisions that remain unchanged from the June 2, 1997 proposed rule or that were revised based on public comment.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–878–FC, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or Room C5–09–26, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–878–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to:

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer; and

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850

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FOR FURTHER INFORMATION CONTACT: Nancy Edwards, (410) 786–4531, Operating Prospective Payment, DRG, and Wage Index Issues. Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, and Graduate Medical Education Issues.

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 care 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.

As required by section 1886(g) of the Act, effective with cost reporting periods beginning on or after October 1, 1991, we also have implemented a prospective payment methodology for hospital inpatient capital-related costs. Under the capital-related cost methodology, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs.

B. Summary of the Provisions of the June 2, 1997 Proposed Rule

On June 2, 1997, we published a proposed rule in the **Federal Register** (62 FR 29902) setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, which would be effective for discharges occurring on or after October 1, 1997. Subsequently, on August 5, 1997, the Balanced Budget Act of 1997, Public Law 105–33, was enacted. This Act made major changes to the Medicare hospital payment systems, rates, and policies effective beginning with FY 1998. These legislative changes are summarized under section I.D. of this preamble. More specific details on individual provisions that we are implementing in this final rule with comment period are included under the various sections of this preamble.

Following is a summary of the major changes that we had proposed to make in the June 2, 1997 proposed rule:

- We proposed changes for FY 1998 DRG classifications and relative weights, as required by section 1886(d)(4)(c) of the Act.
- We proposed to update the hospital wage index for FY 1998. We also

proposed revisions to the wage index based on hospital redesignations and a revised process for wage data verification.

• We proposed to use a revised hospital market basket in developing the recommended FY 1998 update factor for the operating prospective payment rates and the excluded hospital rate-of-increase limits.

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

+ Elimination of day outlier payments.

+ Rural referral centers.

+ Indirect medical education.

+ Direct graduate medical education programs.

• We discussed several provisions of the regulations in 42 CFR parts 412, 413, and 489 and set forth certain proposed changes and clarifications concerning the following:

+ Possible adjustments to capital minimum payment levels.

+ Special exceptions application process.

• We proposed changes to the application of the criteria for ''hospitals within hospitals'' seeking exclusion from the prospective payment system. We also proposed technical clarifications concerning exclusion of rehabilitation units.

• In the addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1998 prospective payment rates for operating costs and capital-related costs. We also proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 1998 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 would have on affected entities.

• In Appendix B of the proposed rule, we set forth our technical appendix on the proposed FY 1998 capital cost model.

• In Appendix C of the proposed rule, we set forth the data sources used to determine the market basket relative weights and choice of price proxies.

• In Appendix D of the proposed rule, we included our report to Congress on our initial estimate of an update factor for FY 1998 for both hospitals included in and hospitals excluded from the prospective payment systems, as required by section 1886(e)(3)(B) of the Act.

• As required by sections 1886(e)(4) and (e)(5) of the Act, in Appendix E, we provided our recommendation of the appropriate percentage change for FY 1998 for the following:

+ Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.

+ Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

• In the proposed rule, we discussed in detail the March 1, 1997 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 patients, adjustments to the DRGs to reflect severity of illness, and changes in the methods under which hospitals are paid for capital-related costs. Under section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2) (A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We printed ProPAC's March 1, 1997 report, which included its recommendations, as Appendix F to the proposed rule. The recommendations, and the actions we proposed to take with regard to them (when an action was recommended), were discussed in detail in the appropriate sections of the preamble, the addendum, or the appendices to the proposed rule.

C. Public Comments Received in Response to the June 2 Proposed Rule

A total of 341 items of correspondence containing comments on the proposed rule were received. The main areas of concern addressed by the commenters were the changes in the DRG classifications related to coronary stents and stereotactic radiosurgery, and the request for comments on future changes for burn cases. Among other areas of concern addressed by the commenters were implementation of the FY 1999 wage index and the policy change related to hospitals and hospital units excluded from the prospective payment system (specifically, hospital-within-hospital policy).

Summaries of the public comments received and our responses to those comments appear in the individual related sections of the preamble.

D. Relevant Provisions of the Balanced Budget Act of 1997

As noted above, on August 5, 1997, after we had issued the proposed rule for the FY 1998 prospective payment system changes, the Balanced Budget Act of 1997 was enacted. This Act made major changes that affect Medicare payments for hospital inpatient services under the prospective payment systems and the cost limits applicable to excluded hospitals, as well as the direct graduate medical education payments. Because most of these changes are effective October 1, 1997, we have had to make some revisions to the June 2 proposals as well as make additional changes. The provisions of Public Law 105–33 that we are implementing in this final rule with comment period are as follows:

1. *Hospital Operating Payment Update.* The applicable percentage change in the standardized amounts is 0 percent for FY 1998, the market basket percentage increase minus 1.9 percentage points for all hospitals in all areas for FY 1999, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas for FY 2000, the market basket percentage increase minus 1.1 percentage points for hospitals for all areas for FYs 2001 and 2002, and the market basket percentage increase for hospitals in all areas for FY 2003 and subsequent fiscal years. (Section 4401(a))

Hospitals that do not receive disproportionate share (DSH) or indirect medical education (IME) payments and are (MDH) for FY 1998 or 1999 will receive a higher update for that year if—

• The hospital is in a State in which the aggregate prospective payment system operating payments to these types of hospitals is less than the aggregate prospective payment system operating costs (an overall State negative operating margin) for FY 1995 cost reporting periods; and

• The hospital itself has a negative operating prospective payment system margin in the payment year. (Section 4401(b))

2. *Hospital Capital Rate Reduction.* The Federal capital rate and the hospital-specific rate are reduced by applying the budget neutrality factor

that was in effect in FY 1995, which results in a 15.68 percent reduction in the rates. In addition, for FY 1998 through FY 2002, both rates will be reduced an additional 2.1 percent. These reductions together result in an overall reduction of 17.78 percent in the unadjusted rates for the next 5 years. (Section 4402)

3. *Disproportionate Share Payments.* The DSH payments to hospitals are reduced by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, and 5 percent in FY 2002. (Section 4403)

4. *Outlier Payments.* Beginning in FY 1998, IME and DSH payments will be made only on the base DRG payment rates and not on outlier payments. In determining outlier payments, the fixed loss cost outlier threshold will encompass payments for IME and DSH. (Section 4405)

5. *Base Payment Rate to Puerto Rico Hospitals.* The national share of the Puerto Rico payment rate is increased from 25 to 50 percent. Thus, these hospitals will be paid based on 50 percent of a national payment amount (based on a discharge-weighted average of the large urban and other urban national standardized amounts) and 50 percent of the Puerto Rico payment amount. (Section 4406)

6. *Special Reclassification.* The Secretary is given discretionary authority to deem Stanly County, North Carolina (a rural county) as a part of the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA (a large urban area) for purposes of the prospective payment system. (Section 4408)

7. *New Guidelines for Geographic Reclassification.* Public Law 105–33 includes several provisions concerning geographic reclassification under section 1886(d)(10) of the Act. For geographic reclassifications for FY 1998 and subsequent years, the Secretary must establish and publish alternative guidelines for a hospital that demonstrates that—

- Its average hourly wage is at least 108 percent of the average hourly wage of all other hospitals in its Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA));
- It pays at least 40 percent of the adjusted uninflated wages in the MSA; and
- It submitted an application and was approved for reclassification for the wage index for FYs 1992 through 1997. (Section 4409)

For reclassifications for FYs 1999, 2000, and 2001, a hospital may seek reclassification to another area for purposes of DSH payment whether or not the standardized amount is the same. (Section 4203(a))

For any hospital that has ever been classified as a rural referral center (RRC), the Medicare Geographic Classification Review Board (MGCRB) may not reject an application for reclassification for purposes of the wage index on the basis of the 108 percent rule. (Section 4202)

For any hospital that is owned by a municipality and was reclassified as an urban hospital for FY 1996, the Secretary must exclude the overhead wages and hours associated with a skilled nursing facility that is owned by the hospital and that is physically located apart from the hospital in determining the hospital's average hourly wage for purposes of qualifying for FY 1998 reclassification, if the hospital had previously applied for and been denied reclassification for FY 1998. (Section 4410(c))

8. *Floor on Area Wage Index.* Beginning with FY 1998, the wage index for an urban hospital may not be lower than the Statewide area rural wage index. (Section 4410 (a) and (b))

9. *Indirect Medical Education.* The IME formula is revised to reduce the IME adjustment factor from 7.7 percent to 7.0 percent in FY 1998, 6.5 percent in FY 1999, 6.0 percent in FY 2000, and 5.5 percent in FY 2001 and subsequent fiscal years. (Section 4621(a))

For cost reporting periods beginning on or after October 1, 1997, the total number of full-time equivalent residents in a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine is limited to the hospital's full-time equivalent count for the most recent cost reporting period ending on or before December 31, 1996. For cost reporting periods beginning on or after October 1, 1997, a hospital's indirect medical education full-time equivalent count is based on the average full-time equivalent count for the cost reporting period and the preceding two cost reporting periods. For the first cost reporting period beginning on or after October 1, 1997, the average is based on residents in that period and the preceding period. The statute provides for adjustments for short periods and a transition rule for FY 1998. Furthermore, the ratio of residents-to-beds may not exceed the ratio calculated during the prior cost reporting period (after accounting for the cap on the number of resident FTEs).

For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary must make payments to teaching hospitals for the indirect costs of graduate medical education associated with Medicare managed care discharges. Payment is equal to the per discharge amount that would have been made for that discharge if the beneficiary were not enrolled in managed care, multiplied by an applicable percentage. The applicable percentage is 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years.

10. *Rural Referral Centers.* Any hospital classified as an RRC for FY 1991 will be classified as an RRC for FY 1998 and subsequent fiscal years. (Section 4202(b))

11. *Medicare-Dependent, Small Rural Hospitals.* The special treatment of MDHs is reinstated for FYs 1998, 1999, and 2000. The payment methodology is identical to the methodology applicable in FY 1993; that is, if the hospital's hospital-specific rate based on 1982 or 1987 costs is higher than the Federal rate, the hospital receives 50 percent of the difference between the Federal rate and the hospital-specific rate. (Section 4204)

12. *Reinstatement of the Add-On for Blood Clotting Factor.* The add-on payment for blood clotting factor provided to inpatients with hemophilia is permanently reinstated beginning in FY 1998. (Section 4452)

13. *Counting Residents for Direct Graduate Medical Education.* For cost reporting periods beginning on or after October 1, 1997, the total number of unweighted full-time equivalent residents in a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine is limited to the hospital's unweighted full-time equivalent count for the most recent cost reporting period ending on or before December 31, 1996. For cost reporting periods beginning on or after October 1, 1997, a hospital's direct medical education full-time equivalent count is based on the average full-time equivalent count for the cost reporting period and the preceding two cost reporting periods. For the first cost reporting period beginning on or after October 1, 1997 the average is based on residents in that period and the preceding period. The statute provides for adjustments for short periods and a transition rule for FY 1998.

The Secretary is permitted to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE cap on an aggregate basis.

The Secretary must prescribe rules for providing exceptions to the cap for

medical residency training programs beginning on or after January 1, 1995.

The statute gives the Secretary authority to collect whatever data are necessary to implement these provisions. (Section 4623)

14. *Payments to Managed Care Plans for Graduate Medical Education.* For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary must make payments to teaching hospitals for the direct costs of graduate medical education associated with Medicare managed care discharges. Payment is equal to the product of the per resident amount, the total number of FTE residents working all areas of the hospital, the fraction of the total number of inpatient bed days that are attributable to Medicare managed care enrollees, and an applicable percentage. The applicable percentage is 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001 and 100 percent in 2002 and subsequent years. (Section 4624)

15. *Payment to Nonhospital Providers.* For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for the direct costs of medical education incurred in the operation of an approved medical residency training program. Qualified nonhospital providers include federally qualified health centers, rural health clinics, Medicare Choice organizations, and any other nonhospital providers that the Secretary determines to be appropriate. The rules established by the Secretary must specify the amounts, form, and manner in which payments will be made and the portion of the payments that will be made from each of the Medicare Trust Funds. The Secretary must reduce the aggregate amount paid to hospitals to the extent payment is made to nonhospital providers for residents included in the hospital's full-time equivalent count. (Section 4625)

16. *Payment for Combined Medical Residency Training Programs.* The initial residency period for combined programs consisting only of primary care training is the longest of the composite programs plus one additional year. A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program qualifies for this special rule if the other programs combined with the obstetrics and gynecology program are for training a resident in primary care. This provision is effective for residency training programs beginning July 1, 1997. (Section 4627)

17. *Payment Update for Excluded Hospitals and Hospital Units.* For FY 1998, the rate-of-increase limits for excluded hospitals and units will be updated by 0 percent. For FYs 1999 through 2002, the update factor is tied to the relationship between the hospital's target amount and its operating costs. For hospitals with costs exceeding the target amount by 10 percent or more, the update is the market basket percentage increase; if costs exceed the target but by less than 10 percent, the update factor equals the market basket percentage increase minus 0.25 percentage points for each percentage point by which costs are less than 10 percent over the target (but in no case less than 0); if costs are less than or equal to the target but not below ⅔ of the target amount, the update is the greater of 0 percent or the market basket percentage increase minus 2.5 percentage points; and if costs do not exceed ⅔ of the target amount, the update factor is 0 percent. (Section 4411)

18. *Reductions to Capital Payments.* Capital payment amounts for certain excluded hospitals and hospital units are reduced by 15 percent for FYs 1998 through 2002. (Section 4412)

19. *Rebasing.* A hospital that was excluded from the prospective payment system before 1991 may apply to rebase its target amount for its cost reporting period beginning in FY 1998. The rebased target amount is determined by using the five latest settled cost reporting periods as of August 5, 1997, updating for inflation, excluding the highest and the lowest cost per discharge, and calculating an average for the remaining three. Long-term care hospitals with costs exceeding 115 percent of their target amount and a 70-percent disproportionate patient percentage may elect to use the cost reporting period beginning during FY 1996 as their base year, updated for inflation. (Section 4413)

20. *Cap on Target Amounts for Excluded Hospitals and Units.* For FYs 1998 through 2002, the target amount will be capped at the 75th percentile of the target amounts for similar facilities for cost reporting periods ending during FY 1996, updated by inflation. This cap applies to psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

21. *Bonus and Relief Payments to Excluded Hospitals and Units.* Bonus payments to excluded hospitals and units are the lesser of—

- 15 percent of the amount by which the ceiling (target amount times Medicare discharges) exceeds the amount of operating costs; or
- 2 percent of the ceiling.

A continuous improvement bonus payment system is established beginning FY 1998 for hospitals with at least 3 full cost reporting periods whose operating costs for the payment period are less than the least of its target amount, its trended costs (as defined by the statute), or its expected costs (as defined by the statute). The bonus under this system equals the lesser of—

- 50 percent of the amount by which operating costs are less than expected costs; or
- 1 percent of the ceiling.

Hospitals with costs over 110 percent of their ceiling receive relief payments equal to an additional 50 percent of the amount by which costs exceed 110 percent of the ceiling, not to exceed 10 percent of the ceiling. (Section 4415)

22. *Change in Payment and Target Amount for New Providers.* Effective October 1, 1997, the new provider exemptions for excluded hospitals are eliminated except for children's hospitals. The amount of payment for a new provider will be the lesser of operating costs for the period, or 110 percent of the national median of the target amount for hospitals in the same class for cost reporting periods ending in FY 1996, wage adjusted and updated by the market basket percentage increase to the fiscal year in which the hospital first received payments. (Section 4416 and 4419)

23. *Treatment of Certain Long-Term Care Hospitals.* Long-term care hospitals located in the same building or on the same campus as another hospital and that were in existence on September 30, 1995, are grandfathered in as hospitals excluded from the prospective payment system. This amendment applies to discharges occurring on or after October 1, 1995. (Section 4417(a))

A hospital that first received payment in 1986, has an average inpatient length of stay greater than 20 days, and in its 12-month cost reporting period ending in FY 1997, has 80 percent or more of its annual Medicare discharges that reflect a finding of neoplastic disease, is excluded from the prospective payment system as a long-term care hospital.

This provision applies to cost reporting periods beginning on or after August 5, 1997. (Section 4417(b))

24. *Treatment of Certain Cancer Hospitals.* A hospital recognized as a comprehensive cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983; located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b); that applied for and was denied classification on or before December 31, 1990; is licensed for less than 50 acute

care beds; and demonstrates that at least 50 percent of its total discharge reflects a finding of neoplastic disease for the 4-year period ending December 31, 1996, is excluded from the hospital prospective payment system retroactively to 1991. The legislation includes an option to rebase payments. Retroactive payments must be made by August 5, 1998. (Section 4418)

25. *Limited-Service Rural Hospital Program*

A ''Medicare Rural Hospital Flexibility Program'' is established. This program is a national limited-service hospital program that replaces the existing Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program which operates in seven States. The program allows States to designate rural facilities as ''critical access hospitals'' if they are located a sufficient distance from other hospitals, make available 24-hour emergency care, maintain no more than 15 inpatient beds, and keep inpatients no longer than 96 hours (except where weather or emergency conditions dictate, or a Peer Review Organization waives the limit). In addition, critical access hospitals do not have to meet all of the staffing requirements that apply to hospitals under Medicare. Payment for inpatient and outpatient services under this program is on the basis of reasonable cost.

States may receive grants for program activities, and are authorized to provide for the creation of networks, which include at least one critical access hospital and at least one acute care hospital. Critical access hospitals with swing-bed agreements are allowed to have up to 25 inpatient beds and to furnish both acute (hospital-level) and SNF-level care, provided that no more than 15 of those beds are used at any one time for acute care. Existing RPCHs, otherwise eligible as CAHs, and existing medical assistance facilities (MAFs) participating under the MAF demonstration project in Montana, will be deemed as CAHs. Existing EACHs in rural areas will continue to be paid as sole community hospitals but no new EACHs will be designated. (Section 4201)

26. *Change in Publication Dates.* Beginning with the FY 1999 update, the DRG prospective payment rate methodology and the recommended hospital prospective payment updates must be published as a proposed rule by April 1 and as a final rule by August 1 of each year. (Section 4644 (a)(1) and (b)(1))

As a conforming change, the deadline for applications for geographic reclassification for years beginning with FY 2000 is moved from October 1 to September 1. Because the FY 1999 applications are due on October 1, 1997, the Secretary is directed to shorten the deadlines for MGCRB decision making, so that a final decision for all applications is made by June 15, 1998. (Section 4644(c))

Each of these provisions and the changes to the regulations necessary to implement these provisions are described in greater detail in sections III, IV, V, and VI of this preamble.

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 all 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, 1997 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 492 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 five 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, bone marrow, and lung transplant (DRGs 480, 481, and 495, 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 several changes to the DRG classification system for FY 1998. The proposed changes, the comments we received concerning them, our responses to those comments, and the final DRG changes are set forth below.

2. MDC 1 (Diseases and Disorders of the Nervous System)

a. Stereotactic Radiosurgery

Effective October 1, 1995, procedure code 92.3 (stereotactic radiosurgery) was created and classified as a non-OR procedure. However, because this procedure had previously been coded to procedure codes that are classified as operating room procedures, we assigned procedure code 92.3 to the same surgical DRGs as the predecessor codes. Therefore, in the following DRGs, stereotactic radiosurgery is considered a non-OR procedure that affects DRG assignment: in MDC 1, DRG 1 (Craniotomy Age >17 Except for Trauma), DRG 2 (Craniotomy for Trauma Age >17), and DRG 3 (Craniotomy Age 0–17) and, in MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), DRG 286 (Adrenal and Pituitary Procedures). In addition, in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms), procedure code 92.3 is considered a major OR procedure for purposes of assignment to DRG 400 (Lymphoma and Leukemia with Major OR Procedure) and DRGs 406 and 407 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major OR Procedure).[1] We stated in the June 2, 1995 proposed rule (60 FR 29207) that we would analyze the stereotactic radiosurgery cases as soon as the FY 1996 cases were available to ensure that these DRG assignments were appropriate.

In analyzing the FY 1996 MedPAR file, we found that there were stereotactic radiosurgery cases assigned to DRGs 1, 286, 400, and 407. In DRG 1, the average standardized charges for these cases are approximately $16,400 compared to approximately $27,800 for DRG 1 overall and the lengths of stay are about 3 days and 10 days, respectively. In DRG 286, the average charges for procedure code 92.3 are also much lower than all cases in that DRG, about $11,900 versus $19,400. Again the length of stay is also much lower for stereotactic radiosurgery, just over 1 day compared to almost 7 days for all DRG 286 cases.

Because the cases associated with procedure code 92.3 clearly are much less resource-intensive than the other cases in the DRGs to which it is assigned, we proposed to reassign procedure code 92.3 to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures) in MDC 1 and DRGs 292 and 293 (Other Endocrine, Nutrition and Metabolic OR Procedures) in MDC 10. We also proposed to remove procedure code 92.3 from the list of major OR procedures in MDC 17. Therefore, these cases would be assigned to DRGs 401 and 402 (Lymphoma and Non-Acute Leukemia with Other OR Procedure) and DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other OR Procedure).

We received over 130 comments regarding our proposal to move procedure code 92.3, including many from people who underwent radiosurgery. Three commenters supported the proposal. One commenter concurred that a revision of the DRG assignment and payment level for radiosurgery is appropriate, but suggested that any change be delayed until further analysis of industry data has been conducted. The remaining commenters opposed our proposal and strongly recommended that stereotactic radiosurgery cases continue to be assigned to DRG 1, or if a change must be made, these cases should be assigned to their own DRG with an appropriate relative weight. The specific comments we received are discussed below.

Comment: Many commenters stated that stereotactic radiosurgery is cost effective and is less expensive (by approximately ⅓) than open cranial surgery. The commenters were concerned that this proposal would result in a 40 percent reduction in payment for these cases.

Response: Currently, stereotactic radiosurgery is being paid at the same level as open cranial surgery, as the commenter noted. We believe these comments support our decision to move the radiosurgery cases into a DRG with cases of comparable utilization of resources, rather than group them with open surgery procedures, which involve much greater resource use. Our intent is not to discourage the utilization of this advanced technology nor to reduce payment arbitrarily, but to make appropriate payment for the procedure by assigning it to a DRG with similar resource use.

Comment: There are several different approaches being used in stereotactic radiosurgery. The two most prevalent are the gamma knife and the linear accelerator. Some commenters believe that we should be analyzing these cases separately and possibly making different DRG assignments for them. Other commenters urged us not to distinguish between approaches in radiosurgery, and one of these commenters submitted data to demonstrate that there is no difference in patient outcomes and that the different types of approach are clinically similar.

Response: Effective October 1, 1995, a new ICD–9–CM procedure code was created to capture stereotactic radiosurgery. The new code 92.3 (Stereotactic radiosurgery) encompasses both gamma knife and linear accelerator procedures. This topic was addressed at a public meeting of the ICD–9–CM Coordination and Maintenance Committee in 1994 at which representatives from the radiosurgery industry were in attendance. Comments were accepted at the meeting and attendees were also invited to submit written comments. At that time, we did not receive any negative comments regarding the inclusion of all approaches to radiosurgery in one code. Therefore, with only one code, we are unable to distinguish the radiosurgery cases based on different approaches.

We note that one difference between the approaches is the initial capital costs of the equipment. However, now that capital payments are made to hospitals under a prospective payment system, there is no way for us to specifically recognize these different costs.

Comment: Several commenters stated that because most radiosurgery patients do not have complicating conditions, which are necessary to be assigned to DRG 7, most cases will be assigned to DRG 8 and receive the lower relative weight associated with less complicated cases. In any event, the commenters believe that the payment for DRGs 7 and 8 is less than the costs of providing the treatment. One commenter stated that the average payment for radiosurgery cases assigned to DRG 1 in FY 1996 was $11,876.28, while payment for DRGs 7 and 8 in the same year averaged $9,973.13 and $4,547.64, respectively. Therefore, this proposal could reduce hospital payment for the average Medicare radiosurgery cases in DRG 1 by as much as 62 percent.

Response: We have performed an analysis of the full FY 1996 MedPAR file, updated through June 1997. Of the 1,275 cases coded with procedure 93.2, 966 cases would have been assigned to

[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 DRG 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.

DRGs 7 and 8 under our proposal. Of those 966 cases, 406 classify to DRG 7 and 560 cases classify to DRG 8. The average charges of these reassigned cases are approximately $16,300 for DRG 7 and $13,700 for DRG 8. The average standardized charges for DRG 7 and 8 overall are approximately $20,250 and $9,950, respectively. Thus, the average charges for radiosurgery cases assigned to DRG 7 (just over 40 percent of the total) are approximately $4,000 less than the overall cases assigned to that DRG and the average charges for the cases assigned to DRG 8 are approximately $4,000 more than the overall cases.

Therefore, given a similar distribution at any hospital, the payments for the DRG 7 and 8 cases should come close to balancing out; that is, DRG 7 will result in payments in excess of costs and DRG 8 will result in approximately equal numbers of cases with costs in excess of payments. This is consistent with the design of the prospective payment system, which is intended to make an average, predetermined payment for each case that encourages hospitals to provide care efficiently and economically and treat a mix of patients so that cases incurring payments in excess of costs are balanced by cases incurring costs in excess of payments.

The difference between assignment to DRG 7 and DRG 8 is the documentation of complications resulting from treatment or comorbidities that are present upon admission and may affect treatment. Examples of these secondary diagnoses that, in fact, many of the patients who commented reported having are postoperative nausea (which may prolong the patient's stay), diabetes, congestive heart failure, and emphysema. In fact, commenters stated that one of the advantages of radiosurgery over open surgery is that it can be performed on patients with comorbidities who could not otherwise tolerate surgery for their conditions.

We also note that DRGs 1 and 2 are not split on the basis of CCs; rather, they are assigned based on whether the case is or is not a trauma case. Therefore, hospitals might not have coded secondary diagnoses for radiosurgery cases. Nonetheless, over 40 percent of the reassigned cases in our analysis have CCs included on the bill. We believe this will remain true in FY 1998 and the percentage may even increase now that properly coding CCs will affect the amount of payment.

In response to the commenter concerned about the low payment for DRGs 7 and 8, we note that, based on the MedPAR file, the average payment for radiosurgery cases assigned to DRG 1 in FY 1996 was approximately $16,000. If those cases had been assigned to DRGs 7 and 8 in that year, we estimate that the average payment would have been approximately $14,000 and $8,000, respectively. Thus, on average, payment for radiosurgery cases will be reduced by approximately 30 percent. This is consistent with commenter's assertion that this procedure costs approximately one-third less than an open cranial procedure.

Comment: Commenters suggested that instead of continuing to assign radiosurgery cases to DRG 1, it would be acceptable to assign these cases to their own DRG and assign a weight of approximately 3.0.

Response: As we have stated in several previous documents, including the June 2 proposed rule (in connection with the discussion of automatic implantable cardioverter defibrillators (62 FR 29906)), we are reluctant to create device-specific DRGs where the cost of the device dominates the charges. Creating a separate DRG for radiosurgery, where the costs of the device used to perform the procedure dominates the charges, would be a similar issue. With such a procedure-specific DRG, it would be relatively easy for hospitals and manufacturers of the equipment to raise the charges for the cases until they create a relative weight that consistently pays them more than their costs. We believe that the resource consumption associated with cases in DRGs 7 and 8 is similar to that required by radiosurgery cases. However, we will continue to monitor this technology to ensure that these DRGs remain appropriate assignments.

Comment: Several commenters believe that the relatively low charges of the radiosurgery cases result, in part, from incorrect use of procedure code 92.3. These commenters requested that we either wait until these issues are resolved to make a DRG change or that we adjust the cases in the MedPAR file based on industry data.

Response: It is often the case with a new code, whether diagnosis or procedure, that there is a period of time necessary to gain experience and correctly use the code. We did notice some coding discrepancies when we reviewed the radiosurgery cases. However, these discrepancies are not in the cases that are assigned to DRGs 7 and 8, but rather the cases that remain assigned to DRG 1. We note that coders appear to be including improperly the approach to the radiosurgery procedure, such as coding thalamotomy and pallidotomy separately in addition to the stereotactic radiosurgery code. In addition, the coding of some cases has included codes that represent the result of the radiosurgery, that is, the destruction of the lesion of the brain. Again this is an improper coding practice. Both of these coding practices result in radiosurgery cases being assigned to DRG 1.

We will continue to monitor these cases to ensure that our decision to reassign radiosurgery to DRGs 7 and 8 remains appropriate. We will also work with the industry concerning the possibility of assigning separate ICD–9–CM codes to the different types of radiosurgery.

b. Sleep Apnea

In our August 30, 1996 final rule (61 FR 46168), we discussed our review of the DRG assignment of cases in which surgery is performed to correct obstructive sleep apnea (diagnosis code 780.57). When coded as the principal diagnosis, sleep apnea is assigned to DRGs 34 and 35 (Other Disorders of the Nervous System) in MDC 1.

The result of our review was to assign several surgical procedures used to correct sleep apnea to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures). These procedures involved repair of the palate or pharynx (procedure codes 27.69, 29.4, and 29.59). Previously, since none of these surgical procedures had been assigned to MDC 1, cases of sleep apnea treated with one of these procedures had been assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis) or DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis).

An associated procedure that is also used to treat sleep apnea is correction of cleft palate (procedure code 27.62). Currently, correction of cleft palate is assigned only to DRG 52 (Cleft Lip and Palate Repair) in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). Thus, when this procedure is performed for sleep apnea cases, the cases would be assigned to DRG 468. We proposed to add this surgical procedure to MDC 1. Like the palate and pharynx repair procedures that were addressed last year, these cases are not clinically similar to the other surgical DRGs in MDC 1; thus, we proposed to include them in DRGs 7 and 8.

Comment: We received three comments on this proposal. One commenter supported the change; another registered no objection but pointed out that the proposed rule stated procedure code 27.62 is currently assigned to DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) when the principal diagnosis

is sleep apnea. The commenter noted that under the current DRG groupings, such a case would actually be assigned to DRG 468. The final commenter stated that if a patient is admitted for cleft palate repair, the principal diagnosis likely would be cleft palate (diagnosis code 749.xx) even if sleep apnea is also present, presumably resulting in assignment to DRG 52. This commenter suggested that if cleft palate repair is performed infrequently in conjunction with a principal diagnosis of obstructive sleep apnea, it would be unnecessary to reassign these cases to DRGs 7 and 8.

Response: In the proposed rule, we inadvertently stated that sleep apnea cases involving the correction of cleft palate currently would be assigned to DRG 477. The commenter is correct that such cases are currently assigned to DRG 468.

Although a patient admitted for cleft palate repair would more likely have a principal diagnosis of cleft palate than of sleep apnea, cases do occur in which obstructive sleep apnea is the documented reason for the surgery. Our rationale for the proposed change is based not on the frequency of the cases but on whether or not these cases are appropriately assigned to DRG 468, which by definition should encompass only cases involving *unrelated* operating room procedures. Because we believe that cleft palate repair is related to obstructive sleep apnea, it would be inappropriate to continue to assign these cases to DRG 468; the better policy is to assign the procedure to DRGs 7 and 8 in MDC 1. Therefore, we are adopting this change in this final rule.

c. Geniculate Herpes Zoster

Geniculate herpes zoster (diagnosis code 053.11) is an acute viral disease characterized by inflammation of spinal ganglia and by a vesicular eruption along the area of distribution of a sensory nerve. In the August 30, 1996 final rule (61 FR 27447), we moved diagnosis codes 053.10 and 053.19 (herpes zoster with unspecified nervous system complication and other herpes zoster, respectively) from DRG 20 (Nervous System Infection Except Viral Meningitis) to DRGs 18 and 19 (Cranial and Peripheral Nerve Disorders). We considered moving diagnosis code 053.11 at that time, however, the higher average charges associated with geniculate herpes zoster and slightly higher length of stay led us to decide instead to leave 053.11 in DRG 20 and to reassess this decision in upcoming years.

For the proposed rule, we conducted an analysis of the cases assigned to DRG 20 using the FY 1996 MedPAR file. The average standardized charges for these cases were approximately $8,430, significantly lower than the average charges for the DRG of approximately $21,180. The average length of stay for the geniculate herpes zoster cases, approximately 6 days, was also less than the average length of stay for DRG 20 of approximately 10 days. Based on these data, we proposed to reassign diagnosis code 053.11 to DRGs 18 and 19, which have average charges of approximately $8,460 and $5,460, respectively. The average length of stay for DRGs 18 and 19 was approximately 6 days and 4 days, respectively.

We received two comments supporting this change and we are including it in the final DRG changes.

3. MDC 5 (Diseases and Disorders of the Circulatory System)

a. Heart Assist Devices

In November 1995, we amended our general noncoverage decision concerning artificial hearts and related devices. Section 65–15 of the Medicare Coverage Issues manual was revised to allow coverage of the HeartMate Implantable Pneumatic Left Ventricular Assist System (HeartMate IP LVAS) in accordance with its Food and Drug Administration (FDA)- approved use as a temporary mechanical circulation support in nonreversible left ventricular failure as a bridge to cardiac transplant. In order to receive Medicare coverage, all of the following conditions must be met:

- The patient is listed as an approved heart transplant candidate by a Medicare-approved heart transplant center.
- The implantation of the system is done in a Medicare-approved heart transplant center. Written permission from the listing center is needed if the patient has the implantation done at another Medicare-approved center.
- The patient is on inotropes.
- The patient is on an intra-aortic balloon pump (if possible).
- The patient has left atrial pressure or pulmonary capillary wedge pressure ≥ 20mm Hg with either—

—Systolic blood pressure ≤ 80 mm Hg; or

—Cardiac index of ≤ 2.0 1/min/m^2.

A procedure code for implant of an implantable, pulsatile heart assist system (37.66), which includes the HeartMate IP LVAS, was created effective October 1, 1995. At that time, the procedure code was assigned to DRGs 110 and 111 (Major Cardiovascular Procedures). In the proposed rule, we presented our analysis of a full year of cases coded with this procedure (FY 1996 MedPAR file, December update) to determine if this DRG assignment remained appropriate.

In the full (100 percent) FY 1996 MedPAR file, there were 51 cases of implant of an internal heart assist system (procedure code 37.66) in MDC 5. Of these 51 cases, 18 were assigned to DRG 110 and none to DRG 111. The other 33 cases were assigned to DRG 103 (Heart Transplant), DRG 104 (Cardiac Valve Procedures with Cardiac Cath), DRGs 106 and 107 (Coronary Bypass), and DRG 108 (Other Cardiothoracic Procedures). Of the 18 cases assigned to DRG 110, the average charge was about $96,000 and the average length of stay was 22.5 days. The average charges for all cases assigned to DRG 110 was about $36,500 and the average length of stay was 10.1 days.

Thus, the cases coded with procedure code 37.66 are much more resource-intensive than the other cases assigned to DRG 110. In reviewing the other surgical DRGs in MDC 5 for possible reassignment of this procedure, we identified two DRGs that contained cases clinically similar to implant of heart assist device cases: DRG 103 and DRG 108. For FY 1996, the average charge of cases in DRG 103 was approximately $164,000 and the length of stay was 46 days. For DRG 108, these statistics were about $54,000 and 12.1 days. Thus, the average charge for DRG 103 was approximately $68,000 higher than the average charge of the heart assist device cases and the average charge for DRG 108 was approximately $42,000 lower.

Because our general policy is to assign a procedure code to a DRG with clinically similar cases that is the best match in terms of resource use, we proposed to assign procedure code 37.66 to DRG 108.

Comment: We received two comments supporting this proposal. However, several other commenters believe that the only solution that would be appropriate is to assign procedure code 37.66 either to DRG 103 or to its own DRG. In support of this comment, they cite the very high resource utilization associated with the procedure. In addition, one commenter believed that failure to revise our proposal could limit Medicare beneficiaries' access to this procedure.

Response: As noted in the proposed rule, although reassignment of these cases to DRG 108 does not place them in a DRG with identical resource use, it is the best alternative we have at this time. As we discuss above in section II.B.2.a. of this preamble concerning radiosurgery, it has not been our

practice to create device-specific DRGs. Assignment of these cases to DRG 103 would be no more appropriate in terms of resource use than reassignment to DRG 108. In addition, we believe that only transplant cases should be assigned to that DRG. We will continue to monitor these cases in future years. We are also contemplating the feasibility of conducting a comprehensive review of the current surgical DRGs in MDC 5. We last did this effective for FY 1991. Because there have been so many changes in approach to heart surgery in the past few years as well as the development of new devices and techniques, we believe such a review could help realign these cases in terms of both clinical and resource use homogeneity.

With regard to the statement that failure to revise our proposal could result in denial of heart assist devices to Medicare beneficiaries, we note, as we have in many previous documents, that it is a violation of a hospital—s Medicare provider agreement to place restrictions on the number of Medicare beneficiaries it accepts for treatment unless it places the same restrictions on all other patients.

We also note that, effective May 5, 1997, the coverage instructions concerning heart assist devices were revised to delete the specific product names and the hemodynamic criteria (Transmittal No. 94; April 1997). As revised, section 65–15 of the Medicare Coverage Issues Manual allows coverage of a ventricular assist device used for support of blood circulation postcardiotomy if the device has received approval from the FDA for that purpose and the device is used according to FDA-approved labeling instructions or as a bridge to heart transplant if all of the following conditions are met:

- The device is used as a temporary mechanical circulatory support as a bridge to cardiac transplant.
- The patient is listed as an approved heart transplant candidate by a Medicare-approved heart transplant center.
- The implantation of the system is done in a Medicare-approved heart transplant center. If the patient is listed with another center, written permission is needed from that center.

b. Automatic Implantable Cardioverter Defibrillators (AICD)

For several years, we have received correspondence concerning the appropriate DRG assignment of procedures involving automatic implantable cardioverter defibrillators (AICDs). These cases are currently assigned to DRG 116 (Other Permanent Cardiac Pacemaker Implant or AICD Generator or Lead Procedure), and are represented by the following procedure codes:

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

As explained in detail in the September 1, 1992 final rule (57 FR 39749), the clinical composition and relative weights of the surgical DRGs in MDC 5 do not offer a perfect match with the AICD cases. However, review of those DRGs in terms of clinical coherence and similar resource consumption led to the determination that DRG 116 was the best possible fit. In that document, we stated that we would continue to monitor these cases.

We last discussed this issue in the September 1, 1995 final rule (60 FR 45780). At that time, we concluded that, although the average charge for AICD cases was much higher than the average charge for DRG 116 overall, the AICD cases were clinically similar to the DRG 116 cases and should not be moved. In addition, a slight decrease in the average charge for the cases between the FY 1993 and FY 1994 MedPAR files led us to believe further reductions might be forthcoming since there were new AICD devices entering the market that might lead to increased price competition.

For the proposed rule, we reviewed the most current AICD cases as contained in the FY 1996 MedPAR file and found that the average standardized charge for AICD cases assigned to DRG 116 was $28,777 compared to an average charge of $21,330 for all cases in DRG 116. Because the average charge for AICD cases continued to be much higher than the average charge for all other DRG 116 cases, we proposed to move them to DRG 115 (Permanent Cardiac Pacemaker Implantation with AMI, Heart Failure or Shock). We also proposed to revise the title of DRG 115 to ''Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock or AICD Lead or Generator Procedure.''

We received several comments commending us on this decision and we are adopting it as final.

c. Coronary Artery Stent

Effective October 1, 1995, procedure code 36.06 (Insertion of coronary artery stent(s)) was introduced. As dictated by our longstanding practice, we assigned this code to the same DRG category as its predecessor codes. Therefore, procedure code 36.06 was assigned to DRG 112 (Percutaneous Cardiovascular Procedures), as insertion of a stent is usually performed in conjunction with percutaneous transluminal coronary angioplasty (PTCA).

We discussed this assignment and public comments we received in both the September 1, 1995 final rule (60 FR 45785) and the August 30, 1996 final rule (61 FR 46171). We stated that we would review the stent cases as soon as the FY 1996 MedPAR file was available, as these would be the first Medicare data available for these cases.

As discussed in the proposed rule, our analysis of the FY 1996 MedPAR data on coronary stent implantation in Medicare beneficiaries revealed the following:

- The difference between the average length of stay for the stent cases and the nonstent cases was 0.19 days (4.39 days versus 4.20 days).
- Charges for patients receiving a stent were approximately $23,650, while charges for patients without stent implant were approximately $17,480, for a difference of $6,170.
- Of those beneficiaries who had a PTCA procedure in FY 1996, approximately 34 percent received a stent.

Based on the significant variation in hospital charges between stent and nonstent cases in DRG 112, we proposed to move these cases out of that DRG. Although the coronary artery stent cases are not clinically similar to the pacemaker cases in DRG 116, the resource consumption of those cases is very similar. Therefore, absent any other appropriate DRG, we proposed to add to DRG 116 those cases including procedure codes for PTCA in combination with insertion of coronary stent. Specifically, we proposed to move into DRG 116 the following procedure codes when performed in conjunction with procedure code 36.06:

35.96 Percutaneous valvuloplasty
36.01 Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy without mention of thrombolytic agent
36.02 Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy with mention of thrombolytic agent
36.05 Multiple vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent

36.09 Other removal of coronary artery obstruction
37.34 Catheter ablation of lesion or tissues of the heart

We also proposed to change the title of DRG 116 to ''Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant.''

Comment: We received many comments in support of this move. Commenters cited increased payment for use of coronary stenting in appropriate patients as a rational response to an economic dilemma. One commenter requested that consideration be given to increased payment for the cost of the stents themselves within DRG 116 for those cases in which multiple stents are implanted in the same operative episode.

Response: We appreciate the positive responses generated by this proposal. With regard to the request for modification of DRG 116 to take into account the use of more than one stent per patient, we would remind the commenter that one of the parameters of the prospective payment system is predetermined, identical payments for each discharge in a DRG. To arbitrarily begin to increase payment based on the number of stents used in a procedure would undermine the system. We will continue to monitor the stent cases and the assignment to DRG 116. If PTCA cases with stent become a higher percentage of the PTCA cases or the average charge for stent cases falls, we may reconsider this assignment.

Comment: There were several commenters who, while supporting the proposal to increase increasing stent payment, also chided us for our lack of foresight in neglecting to consider new drug therapies in conjunction with PTCA. The pharmaceutical referenced in these comments is a category of drugs called glycoprotein (GP) IIb/IIIa inhibitors, which act to reduce platelet aggregation, thereby reducing death rate, recurrent heart attack, and further surgery.

Commenters suggested that HCFA take immediate steps to establish a procedure code describing infusion of GPIIb/IIIa therapy. They further suggested that if the agency's required lead time for revising an existing ICD–9–CM code, or creating a new code for platelet inhibitor therapy, precluded a new code from being effective this October 1, then HCFA should create a temporary code that hospitals could use until a new ICD–9–CM code could become effective. It was suggested that such a temporary code would allow the reclassification of angioplasty with GPIIb/IIIa usage into DRG 116 to be effective October 1, 1997.

Response: We appreciate the suggestion that the category of GPIIb/IIIa platelet inhibitor drugs be uniquely identified in the ICD–9–CM coding system, but would also note that a write-in campaign during a proposed rule comment period does not permit us to respond to this request in a responsible manner. To quickly produce a temporary code would be the equivalent of producing a permanent code, but would not include due process in order to make it a meaningful addition to the ICD–9–CM coding system.

We would point out that, effective October 1, 1986, code 36.04 (intracoronary artery thrombolytic infusion) was added to the procedure coding system based on a proposal made by a major pharmaceutical company. As we rely heavily on information from the public to make the ICD–9–CM coding system responsive to the coding needs of the hospital industry, we anticipated that the guidance, language, and suggestions received from this pharmaceutical company were current and timely. In the interim, there has been no public protest or demand for an ICD–9–CM platelet inhibitor therapy code that would better meet the needs of the industry.

In retrospect, we regret that we integrated this code as it does not appear to have been an appropriate addition to the coding system. We will work with the drug and hospital industry representatives to provide us with more insight and better language as we bring the topic of platelet inhibitors before the ICD–9–CM Coordination and Maintenance Committee on December 4, 1997. We would anticipate, therefore, having an appropriate code describing GPIIb/IIIa drug therapy early next year. This code would be effective for discharges on or after October 1, 1998.

d. Circulatory Disorders (DRGs 121 and 122)

In response to a comment on the May 31, 1996 proposed rule, we stated in the August 30, 1996 final rule (61 FR 46172) that we would conduct a comprehensive review of cases currently assigned to DRG 121 (Circulatory Disorders with Acute Myocardial Infarction (AMI) and Cardiovascular Complications, Discharged Alive) and DRG 122 (Circulatory Disorders with AMI without Cardiovascular Complications, Discharged Alive) to determine whether changes were needed to the list of complicating conditions that can result in assignment to DRG 121. Accordingly, for the FY 1998 proposed rule, we analyzed the cases in the FY 1996 MedPAR file that were assigned to either DRG 121 or 122. Through a variety of statistical analyses of length of stay and standardized charge data, we assessed the impact on resource use of all coded secondary diagnoses.

Our analysis of these secondary diagnosis codes revealed many cases now assigned to DRG 122 in which certain secondary diagnoses are associated with resource use comparable to cases assigned to DRG 121. Although many of these cases involve secondary diagnoses that are not strictly cardiovascular in nature, such as diagnosis code category 482 (other bacterial pneumonia), we now believe that it is appropriate to expand DRG 121 to include such major complications when they are represented in significant volume among the cases in the DRG. Continuing to limit DRG 121 only to cases involving the existing list of cardiovascular complications would contribute to large variations in the charges and lengths of stay for cases in DRG 122.

Therefore, we proposed to change the title of DRG 121 to ''Circulatory Disorders with AMI and Major Complications, Discharged Alive,'' and to add the following diagnosis codes to the list of complications that would produce assignment to DRG 121 when present in conjunction with the existing list of AMI diagnoses:

398.91 Rheumatic heart failure
416.0 Primary pulmonary hypertension
430 Subarachnoid hemorrhage
431 Intracerebral hemorrhage
432.0 Nontraumatic extradural hemorrhage
432.1 Subdural hemorrhage
432.9 Unspecified intracranial hemorrhage
433.01 Occluded basilar artery with cerebral infarction
433.11 Occluded carotid artery with cerebral infarction
433.21 Occluded vertebral artery with cerebral infarction
433.31 Occluded multiple and bilateral artery with cerebral infarction
433.81 Occluded specified precerebral artery with cerebral infarction
433.91 Occluded precerebral artery NOS with cerebral infarction
434.00 Cerebral thrombosis
434.01 Cerebral thrombosis with cerebral infarction
434.10 Cerebral embolism
434.11 Cerebral embolism with cerebral infarction
434.90 Cerebral artery occlusion
434.91 Cerebral artery occlusion with cerebral infarction
436 Acute, but ill-defined, cerebrovascular disease

481 Pneumococcal pneumonia
482.xx Other bacterial pneumonia (all 4th and 5th digits)
483.x Pneumonia due to other specified organism (all 4th digits)
484.x Pneumonia in infectious diseases classified elsewhere (all 4th digits)
485 Bronchopneumonia, organism unspecified
486 Pneumonia, organism unspecified
487.0 Influenza with pneumonia
507.x Pneumonitis due to solids and liquids (all 4th digits)
518.0 Pulmonary collapse
518.5 Pulmonary insufficiency following trauma and surgery
518.81 Respiratory failure
707.0 Decubitus ulcer
996.62 Infection and inflammatory reaction due to other vascular device, implant, and graft
996.72 Other complications due to other cardiac device, implant, and graft

We note that, in conjunction with the proposed changes, we also proposed to revise the title of DRG 122 to read ''Circulatory Disorders with AMI without Major Complications, Discharged Alive.''

We received four comments fully supporting these proposed changes and are including them in the final DRG changes.

4. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Introduction

As discussed in detail below, we proposed to create several new DRGs in MDC 8 effective for discharges on or after October 1, 1997. Specifically, we proposed to replace current DRGs 214 and 215 (Back and Neck Procedures) with the following new DRGs:

DRG 496 Combined Anterior/Posterior Spinal Fusion
DRG 497 Spinal Fusion with CC
DRG 498 Spinal Fusion without CC
DRG 499 Back and Neck Procedures Except Spinal Fusion with CC
DRG 500 Back and Neck Procedures Except Spinal Fusion without CC

In addition, we proposed to replace existing DRGs 221 and 222 (Knee Procedures) with new DRGs 501 and 502 (Knee Procedures with Principal Diagnosis of Infection) and DRG 503 (Knee Procedures without Principal Diagnosis of Infection).

b. Back and Neck Procedures

Currently, hospital inpatient cases involving back and neck procedures generally are assigned to DRGs 214 and 215 (assuming a principal diagnosis that groups the case to MDC 8). We have received correspondence indicating that within these DRGs, cases involving spinal fusion procedures represent a distinctly more complex and resource-intensive subset, and that payment under DRGs 214 and 215 is inadequate to cover the costs of treating patients that require spinal fusion. Therefore, for the proposed rule we conducted an analysis of the cases assigned to DRGs 214 and 215 using the FY 1996 MedPAR file.

Within our sample, cases involving fusion procedures (procedure codes 81.00–81.09) constituted approximately 35 percent of cases in DRG 214 (Back and Neck Procedures with CC) and 23 percent of those in DRG 215 (Back and Neck Procedures without CC). In DRG 214, the average standardized charges for the fusion cases were nearly double the charges of the nonfusion cases (approximately $25,300 versus $12,900). There were also significant differences in charges in DRG 215—$14,400 for fusion cases and $8,500 for nonfusion cases. Lengths of stay for fusion cases were also longer, although not dramatically so—7.1 days for fusion cases versus 5.4 days for other cases in DRG 214, and 3.8 days versus 3.1 days in DRG 215. In view of the volume of cases involved and the clear differences in resource use, we concluded that it would be appropriate to create additional DRGs to separate spinal fusion cases from the other back and neck procedures.

Next, we expanded our analysis to determine whether it would be appropriate to subdivide the spinal fusion cases according to whether both anterior and posterior spinal fusion were performed. This combination of procedures, which involves fusing both the front and rear of the vertebrae, typically is performed on patients who have had previous fusions that have not bonded effectively or who have several vertebrae that need extensive fusion on both sides of the spine. As the table below illustrates, the average charges and lengths of stay for the cases involving both anterior and posterior spinal fusion were markedly greater than for the other spinal fusion cases in either DRG 214 or 215.

Type of case	Avg. charges	Average length of stay (in days)
Anterior and posterior spinal fusion	$51,200	12.3
DRG 214—Other spinal fusion	24,300	6.9
DRG 215—Other spinal fusion	14,300	3.8

Even though the cases in which both anterior and posterior spinal fusions were performed represented only about 3 percent of all spinal fusion cases in our sample, we concluded that the magnitude of the differences in both average charges and lengths of stay warranted a further subdivision of the spinal fusion cases.

Based on this analysis, we proposed to replace the two existing DRGs for back and neck procedures with five new DRGs. For ease of reference and classification, current DRGs 214 and 215 would be made invalid and we would establish new DRGs 496 through 500 to contain all the cases that are currently grouped in DRGs 214 and 215. We believe that the division of these cases into the new DRGs would improve clinical coherence and provide for more appropriate payment for both spinal fusion cases and cases involving other back and neck procedures.

Discharges would be assigned to each of the five proposed DRGs as follows:

DRG 496 Combined Anterior/Posterior Spinal Fusion

DRG 496 would include any combination of procedure codes as follows:

One or more of the following procedure codes—
81.02 Other cervical fusion anterior
81.04 Dorsal/dorsulum fusion anterior
81.06 Lumbar/lumbosac fusion anterior
and
One or more of the following procedure codes—
81.03 Other cervical fusion posterior
81.05 Dorsal/dorsulum fusion posterior
81.08 Lumbar/lumbosac fusion posterior

DRGs 497 and 498 Spinal Fusion with and without CC

DRGs 497 and 498 would include any of the following procedure codes, as long as any combination of procedure codes would not otherwise result in assignment to proposed DRG 496—
81.00 Spinal fusion NOS
81.01 Atlas-axis fusion
81.02 Other cervical fusion anterior
81.03 Other cervical fusion posterior
81.04 Dorsal/dorsulum fusion anterior
81.05 Dorsal/dorsulum fusion posterior
81.06 Lumbar/lumbosac fusion anterior

81.07 Lumbar/lumbosac fusion lateral
81.08 Lumbar/lumbosac fusion posterior
81.09 Refusion of spine
DRGs 499 and 500 Back and Neck Procedures Except Spinal Fusion with and without CC.

All procedure codes in current DRGs 214 and 215 other than procedure codes 81.00 through 81.09 would be assigned to DRGs 499 and 500.

We received five comments in support of this proposal. We are adopting the proposed changes as final.

c. Knee Procedures

On several occasions, most recently in our September 1, 1993 final rule (58 FR 46286), we have examined cases in DRG 209 (Major Joint and Limb Reattachment of the Lower Extremity) to see whether hip replacement cases that involve infections or other complications should be classified separately from the less complicated cases in DRG 209. We have found that the average charges and lengths of stay for cases with principal diagnoses of infection or complications were only slightly higher than for all cases in DRG 209. When we limited our analysis to cases with a principal diagnosis of infection, we found that the cases had significantly higher charges than for DRG 209 overall, but in view of the small volume of cases (less than 0.5 percent of the total DRG 209 cases), we decided that changes in the classification of cases in DRG 209 were not warranted.

In the proposed rule, at the request of several correspondents, we revisited the issue of whether DRG refinements are needed to address differences in resource use associated with orthopedic procedures where deep infections are present. To evaluate this issue, we analyzed various classifications of cases in MDC 8. We began by identifying all cases with a principal diagnosis indicating deep orthopedic infection of the lower extremities or spine. The diagnosis codes used were as follows:

711.05 Pyogenic arthritis pelvic region and thigh
711.06 Pyogenic arthritis lower leg
711.07 Pyogenic arthritis ankle and foot
711.08 Pyogenic arthritis other specified sites
730.05 Acute osteomyelitis pelvic region and thigh
730.06 Acute osteomyelitis lower leg
730.07 Acute osteomyelitis ankle and foot
730.08 Acute osteomyelitis other specified sites
730.15 Chronic osteomyelitis pelvic region and thigh
730.16 Chronic osteomyelitis lower leg
730.17 Chronic osteomyelitis ankle and foot
730.18 Chronic osteomyelitis other specified sites
730.25 Unspecified osteomyelitis pelvic region and thigh
730.26 Unspecified osteomyelitis lower leg
730.27 Unspecified osteomyelitis ankle and foot
730.28 Unspecified osteomyelitis other specified sites
996.66 Infection and inflammatory reaction due to internal joint prosthesis
996.67 Infection and inflammatory reaction due to other internal orthopedic device

For each of the DRGs into which these cases are grouped, we then compared the average standardized charges and average length of stay for cases with any of the infection diagnoses listed above with other cases in the DRGs. Unlike in the past, we did not limit our analysis to DRG 209 but examined all DRGs within MDC 8 that focus on surgical procedures of the lower extremities or spine, including DRGs 209; 210, 211, and 212 (Hip and Femur Procedures Except Major Joint); 214 and 215 (Back and Neck Procedures); and 221 and 222 (Knee Procedures).

For the most part, we again found that these cases represented only a very small proportion of the total cases in the DRGs in question. In DRG 209, for example, cases with one of the above diagnosis codes as the principal diagnosis continued to constitute less than 1 percent of all cases in the DRG. Moreover, although the average standardized charges for the deep infection cases ($24,834) were approximately 21 percent higher than the charges for the remaining cases in the DRG ($19,297), the differences are well within one standard deviation of the average charge. Given the small volume of cases, we again conclude that changes in DRG 209 are not justified.

The only DRGs that we examined in which cases with a principal diagnosis of deep infection represented more than 1 percent of total cases in our sample were DRGs 221 and 222. As illustrated in the chart below, there are significant differences in both average charges and average length of stay between infection cases in these DRGs and other cases in the DRGs.

Type of case	Number of cases [1]	Average charges (in dollars)	Average length of stay (in days)
DRG 221 (all cases)	451	16,529	7.2
DRG 221 with infection	152	23,174	11.4
DRG 221 w/out infection	299	13,151	5.1
DRG 222 (all cases)	340	9,149	3.9
DRG 222 with infection	37	14,452	7.0
DRG 222 w/out infection	303	8,502	3.5

[1] Based on the 10-percent random sample of the FY 1996 MedPAR file.

Thus, more than one-third of cases in DRG 221 had a principal diagnosis of deep infection, the average length of stay for these cases was more than twice as long as for the remaining cases, and average charges were approximately 76 percent higher. Similarly, for the 12 percent of total DRG 222 cases with infection as the principal diagnosis, the average length of stay was double that for other cases, with average charges approximately 70 percent higher. Given the proportional volume of cases involved, and the significant differences in both average charges and length of stay for infection cases in these DRGs, we concluded that DRG refinements are appropriate.

Based on this analysis, we proposed to replace the two existing DRGs for knee procedures with three new DRGs. Again, for ease of reference and classification, current DRGs 221 and 222 would be made invalid and we would establish new DRGs 501 through 503 to contain all the cases that are currently grouped in DRGs 221 and 222. Discharges would be assigned to each of the three proposed DRGs as follows:

DRG 501 Knee Procedures with Principal Diagnosis of Infection with CC

DRG 502 Knee Procedures with Principal Diagnosis of Infection without CC

DRG 501 and 502 would include any of the operating room procedures now assigned to DRGs 221 and 222, when the principal diagnosis is any of the following:

711.06 Pyogenic arthritis lower leg
730.06 Acute osteomyelitis lower leg
730.16 Chronic osteomyelitis lower leg
730.26 Unspecified osteomyelitis lower leg
996.66 Infection and inflammatory reaction due to internal joint prosthesis
996.67 Infection and inflammatory reaction due to other internal orthopedic device

DRG 503 Knee Procedures without Principal Diagnosis of Infection

DRG 503 would include any of the operating room procedures now assigned to DRGs 221 and 222 when the principal diagnosis is not listed above under DRGs 501 and 502.

Comment: We received four comments in support of this proposed change. One of the commenters suggested that we also consider splitting proposed DRG 503 into two DRGs to distinguish between cases with and without CCs.

Response: As shown in the table above, based on the FY 1996 MedPAR 10 percent sample, the average charges associated with cases in new DRG 503 are $13,151 for cases with CC and $8,502 for cases without CC. The average lengths of stay for DRG 503 cases with and without CC are 5.1 and 3.5 days, respectively. We note that the mean standardized charges for this DRG are approximately $10,100. Given the similar lengths of stay for these two sets of cases and the relatively small magnitude of difference in average charges (much less than one standard deviation), we do not believe that further division of the new DRG is warranted. Thus, we are adopting the new proposed DRGs for Knee Procedures as final.

5. MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract)

Among the ICD–9–CM coding changes that took effect October 1, 1995 was the addition of new procedure code 59.72 (injection of implant into urethra or bladder neck). Although this procedure is not routinely performed in an operating room, the code was previously included within codes classified as operating room procedures. Thus, as is our practice, we assigned this procedure code to the surgical DRGs to which the procedure had formerly been assigned as a non-OR procedure that affects DRG assignment. Therefore, procedure code 59.72 was assigned to DRGs 308 and 309 (Minor Bladder Procedures) and DRG 356 (Female Reproductive System Reconstructive Procedures).

In the June 2, 1995 proposed rule (60 FR 29209), we stated that we would reevaluate the DRG classification of this code when data on its use became available for analysis in 2 years, that is, in preparation for the FY 1998 rulemaking process. We indicated that possible changes would include moving the procedure code to a different surgical DRG or classifying the code as a non-OR procedure that did not affect DRG assignment.

In the FY 1996 MedPAR file, there were several cases with procedure code 59.72 assigned to DRGs 308 and 309. The chart below compares average charges and length of stay for cases in these DRGs with and without the injection procedure.

Type of case	Number of cases	Average charge (in dollars)	Average length of stay (in days)
DRG 308 with procedure 59.72	5	6,978	4.2
DRG 308 w/out procedure 59.72	910	13,254	6.5
DRG 309 with procedure 59.72	7	5,879	1.4
DRG 309 w/out procedure 59.72	311	7,888	2.7

As the table illustrates, cases in which injection of implant into the urethra or bladder neck is the only relevant procedure for DRG assignment purposes constitute a very small minority of the cases in DRGs 308 and 309. However, these cases have lower average charges and length of stay than other cases in the DRGs. Thus, we proposed to reclassify the procedure code as a non-OR procedure that does not affect DRG assignment.

Under this proposal, cases currently assigned to DRGs 308 and 309 because of the performance of an implant injection would be reassigned to medical DRGs in MDC 11, primarily either DRGs 320, 321, and 322 (Kidney and Urinary Tract Infections) or DRGs 331 and 332 (Other Kidney and Urinary Tract Diagnoses). Both of these sets of DRGs have average charges closely in line with the charges for cases in which procedure 59.72 now determines DRG assignment.

This change would also affect DRG 356 in MDC 13 (Diseases and Disorders of the Female Reproductive System). Within the 10 percent sample used for this analysis, only 2 of the 2,689 cases in DRG 356 were assigned based on the presence of procedure code 59.72, and as in DRGS 308 and 309, both the average charges and length of stay were lower than for other cases.

We received two comments in support of this proposal and are including it in the final DRG changes.

6. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. It is, therefore, necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

A surgical class can be composed of one or more DRGs. For example, in MDC 5, the surgical class ''heart transplant'' consists of a single DRG (DRG 103) and the class ''coronary bypass'' consists of two DRGs (DRGs 106 and 107). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class, therefore, involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5, and that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we 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, 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 we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of the proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of revised GROUPER software at the time this proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule.

We proposed to revise the surgical hierarchy for the Pre-MDC DRGs, MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), and MDC 12 (Diseases and Disorders of the Male Reproductive System) as follows:

- In the Pre-MDC DRGs, we would reorder Bone Marrow Transplant (DRG 481) above Liver Transplant (DRG 480).
- In MDC 9, we would reorder Perianal and Pilonidal Procedures (DRG 267) above Breast Procedures (DRGs 257–262).
- In MDC 10, we would reorder OR Procedures for Obesity (DRG 288) above Skin Graft and Wound Debridement (DRG 287).
- In MDC 12, we would reorder Circumcision (DRGs 342 and 343) above Transurethral Prostatectomy (DRGs 336 and 337).

Based on a test of the proposed changes using the most recent MedPAR file and the revised GROUPER software, we found that the proposed change to the Pre-MDC DRGs, Bone Marrow Transplant (DRG 481) above Liver Transplant (DRG 480) is not supported and this change will not be incorporated in this final rule. The Pre-MDC DRGs hierarchy will remain the same as in FY 1997.

We received one comment in support of our surgical hierarchy proposals. We also received one comment that disagreed, as discussed below.

Comment: One commenter was opposed to reordering Circumcision (DRGs 342 and 343) above Transurethral Prostatectomy (DRGs 336 and 337). The commenter stated that circumcision (procedure code 64.0) is the only procedure in DRGs 342 and 343, and the commenter believes that this procedure is not as resource intensive or complex as the procedures assigned to DRGs 336 and 337. The commenter suggested the more appropriate assignment for a case involving both a transurethral prostatectomy and a circumcision would be DRGs 336 and 337.

Response: Based on the Medicare cases, the average standardized charges for cases assigned to DRGs 342 and 343 is almost $7,000, which is higher than the average standardized charges of cases assigned to DRGs 336 and 337, approximately $6,500. Thus, if a case involves both a circumcision and a prostatectomy, we believe it should be assigned to the higher-weighted DRG category. Although circumcision can be a relatively simple surgery for infants, when it is performed for Medicare beneficiaries, it appears to be a more complicated procedure and might involve the use of significant resources.

The other proposed changes to the surgical hierarchy are still supported by the data and no additional changes are indicated. Therefore, we are incorporating these changes in this final rule.

7. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications or comorbidities (CCs). 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 previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the 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. (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 FY 1990 revision (54 FR 36552); the September 4, 1990 final rule for the FY 1991 revision (55 FR 36126); the August 30, 1991 final rule for the FY 1992 revision (56 FR 43209); the September 1, 1992 final rule for the FY 1993 revision (57 FR 39753); the September 1, 1993 final rule for the FY 1994 revisions (58 FR 46278); the September 1, 1994 final rule for the FY 1995 revisions (59 FR 45334); the September 1, 1995 final rule for the FY 1996 revisions (60 FR 45782); and the August 30, 1996 final rule for the FY 1997 revisions (61 FR 46171)).

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, 1997, as well as the proposed CC changes described above. (See section II.B.9, below, for a discussion of ICD–9–CM changes.) These changes were proposed in accordance with the principles established when we created the CC Exclusions List in 1987. We received one comment, which supported our changes to the CC lists.

The changes discussed above have been added to Table 6E, Additions to the CC Exclusions List, in section V of the Addendum to this final rule.

Tables 6E and 6F in section V of the Addendum to this final rule contain the revisions to the CC Exclusions List that will be effective for discharges occurring on or after October 1, 1997. Each table shows the principal diagnoses with final 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 6E—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1997, 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 6F—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1997 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 $92.00 plus $6.00 shipping and handling and on microfiche for $20.50, plus $4.00 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, 1994, 1995, 1996, and 1997) and those in Tables 6E and 6F 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, 1997.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 14.0, is available for $195.00, which includes $15.00 for shipping and handling. Version 15.0 of this manual, which will include the final FY 1998 DRG changes, will be available in October 1997 for $195.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road; Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

8. 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 it would be appropriate to change the procedures 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
60.21 Transurethral prostatectomy
60.29 Other 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 prostatic 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, September 1, 1993, September 1, 1994, September 1, 1995, and August 30, 1996, we moved several other procedures from DRG 468 to 477. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, 59 FR 45336, 60 FR 45783, and 61 FR 46173, 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. Based on this year's review, we proposed to move procedure code 54.92 (Removal of foreign body from peritoneal cavity) to MDC 11 and assign it to DRG 315 (Other Kidney and Urinary Tract OR Procedures). We note that, under the current DRGs, when procedure code 54.92 is coded in addition to a principal diagnosis code of 868.14 (injury with open wound into retroperitoneum), the case is assigned to DRG 468.

Comment: We received two comments on this proposed change. One commenter fully supported the proposal. The other commenter noted that moving procedure code 54.92 from DRG 468 to DRG 315 in MDC 11 would result in a 43 percent reduction in the DRG relative weight associated with the case. Although the change makes sense clinically, the commenter questioned the financial impact involved.

Response: The purpose of DRG 468 is to accommodate cases in which an OR procedure that is unrelated to the principal diagnosis is performed. As the commenter acknowledges, the clinical relationship between procedure code 54.92 (Removal of foreign body from peritoneal cavity) and a principal diagnosis code of 868.14 (injury with open wound into retroperitoneum) is clear. We note that this change would have resulted in the reassignment of only one case in FY 1996; therefore, the financial impact involved is minimal. We are adopting this change as proposed.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

We also reviewed the list of procedures that produce assignments to DRGs 468, 476, and 477 to ascertain if any of those procedures should be moved from one of these DRGs to another 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.

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 two procedures—other surgical occlusion of abdominal arteries (procedure code 38.86) and other arthrotomy of knee (procedure code 80.16)—that are significantly less resource intensive than the other procedures assigned to DRG 468. Therefore, we proposed to move procedure codes 38.86 and 80.16 to the list of procedures that result in assignment to DRG 477.

In reviewing the list of procedures assigned to DRG 477, we did not identify any procedures that should be assigned to either DRG 468 or 476.

Comment: We received two comments on this proposal. Both commenters supported moving procedure code 80.16, but one of the commenters believes that procedure code 38.86 represents cases that are very complicated and require a high level of resources.

Response: Our review of the average resource use associated with DRG 468 cases with procedure code 38.86 support this change. The average charge associated with this case is approximately $13,150. The average charges for cases in DRG 468 and 477 are approximately $30,000 and $14,300, respectively. Thus, moving procedure code 38.86 to DRG 477 appears appropriate in terms of resource use. We will review the cases in the FY 1997 MedPAR file when it becomes available to ensure that this remains true for those cases.

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

As discussed above in section II.B.1 of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee charged with the mission of maintaining and updating the ICD–9–CM. 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 June 6 and December 5 and 6, 1996, and finalized the coding changes after consideration of comments received at the meetings and in writing within 60 days following the December 1996 meeting. The initial meeting for consideration of coding issues for implementation in FY 1999 was held on June 6, 1997. The minutes of the meeting can be obtained from the HCFA Home Page @ http://www.hcfa.gov.pubaffr.htm. Paper copies of these minutes will no longer be available and the mailing list will be discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@nch11a.em.cdc.gov.

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 Hospital Policy; Division of Prospective Payment System; C5–06–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 1997. 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 V of the Addendum to this final rule. As we stated above, the code

numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 1997. The corresponding new or expanded diagnosis codes are included in Table 6A. Revisions to diagnosis code titles are in Table 6D (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. For FY 1998, there are no procedure codes that have been replaced or deleted nor are there any revisions to procedure code titles. We received three comments concerning our assignment of new ICD–9–CM codes.

Comment: One commenter wrote in support of the creation of a new diagnosis code for pyoderma gangrenosum (code 686.01) in order to distinguish this condition from infectious pyoderma. The commenter stated that pyoderma gangrenosum is not infectious, but instead is a manifestation of other disease such as ulcerative colitis or Crohn's disease. Pyoderma gangrenosum is characterized by ulcers with extensive necrosis around the edges and are generally found on the lower extremities. Therefore, the commenter believes that this code should be assigned to DRG 271 (Skin Ulcers) rather than DRGs 277, 278, and 279 (Cellulitis).

Response: When a new code is introduced, our longstanding practice is to assign it to the same DRG category as its predecessor code or codes. Therefore, we proposed to assign diagnosis code 686.01 to DRGs 277, 278, and 279, the DRGs to which its predecessor code, 686.0 (pyoderma), had been assigned. The resource use and other data associated with this diagnosis code will be available in the FY 1998 MedPAR file, which will be used for analysis as part of the FY 2000 DRG changes. We will evaluate the DRG assignment of code 686.01 at that time.

Comment: In the proposed rule, we announced a new diagnosis code (031.2) for disease due to disseminated mycobacterium avium-intracellulare complex (DMAC). We proposed that this code be classified to DRG 423 (Other Infectious and Parasitic Disease Diagnoses) in MDC 18 (Infectious and Parasitic Diseases, Systemic or Unspecified Sites) as well as be designated as an HIV major related condition in DRG 489 (HIV with Major Related Condition). A commenter disagreed with our decision to classify this code as a non-CC; that is, diagnosis code 031.2 would not be included on the CC list. The commenter believes that when DMAC is present as a secondary diagnosis, it would be considered a substantial complication or comorbidity.

Response: DMAC is the most common disseminated bacterial infection in patients with advanced acquired immunodeficiency syndrome (AIDS). As such, cases coded with 031.2 will also be coded with a principal or secondary diagnosis of 042, Human immunodeficiency virus (HIV) disease and will be assigned to DRG 489. DRG 489 is not divided based on the presence or absence of CCs. We believe that the vast majority of patients with DMAC, if not all, will be assigned to this DRG, thus negating the need to add this disease to the CC list. As noted above, it is our practice to assign new codes to the same category as their predecessor code was assigned. We note that cases coded 031.2 would have been coded to 031.8 (other specified mycobacterial diseases), which is not a CC. We will review the assignment of cases in which DMAC is coded as a secondary condition when the FY 1998 MedPAR file becomes available and re-evaluate our decision.

Comment: Commenters noted what they believed to be a typographical error concerning new code V42.83 (organ or tissue replaced by transplant, pancreas). In Table 6A, New Diagnosis Codes, this code was recorded as being assigned to MDC 7, DRG 467 (Other Factors Influencing Health Status). Since DRG 467 is assigned to MDC 23, the commenters assumed this was a typographical error.

Response: The commenters are correct; diagnosis code V42.83 is assigned to DRG 204 (Disorders of Pancreas Except Malignancy) in MDC 7.

10. Other Issues

a. MDC 22 (Burns)

Under the current DRG system, burn cases generally are assigned to one of six DRGs in MDC 22 (Burns). These DRGs—DRGs 456 through 460 and 472—have been in place without change since 1986. Recently, we have received several letters from representatives of facilities that specialize in treating burn cases asserting that the existing DRGs do not adequately capture the variation in resource use associated with different types of burn cases. In the proposed rule (62 FR 29912), we discussed the concerns of these correspondents and solicited public comments on whether changes in these DRGs can increase their ability to explain the variation in resource use among burn cases.

We received approximately 15 public comments on this issue, all of which supported our efforts to identify DRG groupings that would reflect more homogeneous resource use. These comments included a proposal for restructuring the DRG classifications in MDC 22 that has been endorsed by the American Burn Association. Several commenters also suggested the need for a special facility category to make possible payment differences for designated burn care facilities. As noted in the proposed rule, however, any suggestions involving payment adjustments for hospitals designated as burn centers would require legislative action. We intend to conduct a full review of the comments and proposals we have received as part of the FY 1999 DRG analysis agenda. We will discuss our findings and, if appropriate, propose modifications to MDC 22 in the FY 1999 proposed rule.

b. Marfan Syndrome (DRG 390)

We are making a minor DRG classification change for FY 1998 that we inadvertently did not include in the June 2 proposed rule. Based on correspondence we have received, we reviewed the assignment of diagnosis code 759.82 (Marfan syndrome) to DRG 390 (Neonate with Other Significant Problems) in MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). While Marfan syndrome is a congenital disorder, cardiovascular abnormalities associated with the disorder are most likely to manifest in adults. Because the current classification system often results in adult patients being classified to the MDC for newborns, we agree that, from a clinical coherence standpoint, it is appropriate that these cases be reclassified. Therefore, we are reassigning code 759.82 from DRG 390 into MDC 5, DRGs 135, 136, and 137 (Cardiac Congenital & Valvular Disorders). There were no cases with a principal diagnosis code of 759.82 in the FY 1996 MedPAR file.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 1998 recalibration as we did for FY 1997. (See the August 30, 1996 final rule (61 FR 46176).) That is, we would recalibrate the weights based on charge data for

Medicare discharges. However, we would use the most current charge information available, the FY 1996 MedPAR file, rather than the FY 1995 MedPAR file. The MedPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from FY 1996 MedPAR data, based on bills received by HCFA through June 1997, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1996 MedPAR file includes data for approximately 11.2 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1996 MedPAR file is as follows:

- All the claims were regrouped using the DRG classification revisions discussed above in section II.B of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as was used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- 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. A transfer case is counted as a fraction of a case based on the ratio of its length of stay to the geometric mean length of stay of the cases assigned to the DRG. That is, a 5-day length of stay transfer case assigned to a DRG with a geometric mean length of stay of 10 days is counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) 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, heart-lung, liver, and lung transplant centers that have cases in the FY 1995 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant for heart and heart-lung transplants); 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 1998. For this final rule, using the FY 1996 MedPAR data set, there are 34 DRGs that contain fewer than 10 cases. We computed the weights for the 34 low-volume DRGs by adjusting the FY 1997 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The weights developed according to the methodology described above, using the proposed DRG classification changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.a of the Addendum to this final rule, we are making a budget neutrality adjustment to assure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Although we received no comments on the recalibration of the DRG weights, we did receive one comment that relates to that process.

Comment: One commenter was concerned about the reduction in the proposed FY 1998 relative weight for DRG 480 (Liver Transplant), compared to the FY 1997 weight. The commenter noted that Table 5 of the proposed rule (62 FR 29990) indicated approximately an 8-day reduction in length of stay from FY 1995 to FY 1996 and asked that we review the MedPAR data for this DRG to verify the accuracy of the data and the consequent change in the relative weight.

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 under each DRG to establish the relative weights. As the commenter requested, we have re-examined the FY 1996 MedPAR data that are used in establishing the DRG relative weights for FY 1998. We have not identified any problems or anomalies related to the cases in DRG 480 and are confident that the relative weight and length of stay data set forth in Table 5 of this final rule are accurate. We note that the final FY 1996 MedPAR data result in a slightly higher relative weight and average length of stay for DRG 480 than shown in the proposed rule, although the data still indicate close to a 7-day reduction in average length of stay for these cases. (Data for the final rule are taken from the June 1997 update of the FY 1996 MedPAR data, rather than the December 1996 file used for the proposed rule.)

Both the relative weight and the length of stay for liver transplant cases have exhibited continuing declines since the early 1990's. Although the decline between FY 1995 and FY 1996 was more pronounced than in some other years, this change is not unusual for a relatively low volume DRG (fewer than 400 cases) with a large range of reported charges and lengths of stay. A few very low or very high charge cases can make a dramatic difference in the DRG weight.

III. Changes to the Hospital Wage Index and Medicare Geographic Reclassification Guidelines

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must 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 under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprised of two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA.

In the proposed rule, we noted that, effective April 1, 1990, the term Metropolitan Area (MA) replaced the term Metropolitan Statistical Area (MSA) (which had been used since June 30, 1983) to describe the set of metropolitan areas comprised of MSAs, PMSAs, and CMSAs. The terminology was changed by OMB in the March 30, 1990 **Federal Register** to distinguish between the individual metropolitan areas known as MSAs and the set of all metropolitan areas (MSAs, PMSAs, and CMSAs) (55 FR 12154). For purposes of the prospective payment system, we will continue to refer to these areas as MSAs.

Section 1886(d)(3)(E) of the Act also requires that the wage index be updated annually beginning October 1, 1993. Furthermore, this section 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 the wages and wage-related costs incurred in furnishing skilled nursing services. We also adjust the wage index, as discussed below in section III.B.3, to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

B. FY 1998 Wage Index Update

The final FY 1998 wage index in section V. of the Addendum (effective for hospital discharges occurring on or after October 1, 1997 and before October 1, 1998) is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1994 (the FY 1997 wage index was based on FY 1993 wage data). We used the same categories of data that were used in the FY 1997 wage index. Therefore, the FY 1998 wage index reflects the following:

- Total salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Fringe benefits associated with hospital and home office salaries.
- Direct patient care contract labor costs and hours.
- The exclusion of salaries and hours for nonhospital type services such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

We proposed to calculate a separate Puerto Rico-specific wage index to be applied to the Puerto Rico standardized amount. We stated that this wage index would be calculated in the same manner as the national wage index described below, but will be based solely on Puerto Rico's data. We received several comments supporting the new Puerto Rico-specific wage index. We are implementing that change and revising § 412.210(e) accordingly.

We did not propose any changes in the reporting of hospital wage index data, but we received numerous comments regarding the FY 1995 wage data, which will not be used until we develop the FY 1999 wage index. The Medicare cost report for reporting periods beginning during FY 1995 included several changes to the Worksheet S–3 that will allow us to analyze further refinements to the wage index. Among those changes are the separate reporting of all salary costs for physicians (including teaching physicians), residents, and certified registered nurse anesthetists (CRNAs). In addition, we collected overhead cost data by cost center in order to analyze the possibility of excluding overhead costs attributable to skilled nursing facilities and other excluded areas from the wage index. These comments are discussed in detail below.

Comment: Two commenters stated that we should exclude physician salaries (as recommended by the Medicare Technical Advisory Group); one suggested that we should immediately exclude these costs using information from the Worksheet A–8–2 of the Medicare cost report. Alternatively, a few commenters suggested that we should include contracted Part A physician salaries for those States in which hospitals are prohibited from employing physicians. Several commenters are concerned that the removal of teaching physician and resident salaries would redistribute revenues from large metropolitan areas with large teaching programs to areas that support medical education to a lesser extent. The commenters noted that recent legislation revising the payments for disproportionate share and the indirect medical education adjustments (sections 4403 and 4621 of Public Law 105–33) will further reduce payment for hospitals in major metropolitan areas.

Other commenters suggested that we analyze the impact of excluding the data before making a final decision. Some commenters specifically recommended that we determine whether hospitals that are prohibited from employing physicians are disadvantaged by our current policy, and, if so, that we develop a policy that minimizes the redistribution of revenue and the concentration of losses in particular geographic areas.

Response: These comments relate to the FY 1995 wage data, which we are not using in developing the FY 1998 wage index. We will consider these comments in developing the FY 1999 wage index. Although the deadline for fiscal intermediaries to submit all of the reviewed FY 1995 wage data to HCFA is mid-November 1997, we intend to begin our analysis of these data prior to that time, based on the data that have already been submitted to the Health Care Provider Cost Report Information System (HCRIS). We note that our fundamental objective in administering the wage index is to ensure that it is accurate and fair, and we will evaluate the use of the FY 1995 wage data with that objective in mind.

Regarding the suggestion that we use Worksheet A–8–2 to exclude Part A physician salaries, we noted in the proposed rule (62 FR 29914) that, because the intermediaries had already begun reviewing the FY 1994 cost report and finalizing the Worksheet S–3 data, we did not believe it would be appropriate to revise their instructions and require them to make a change to their procedure. Therefore, we will review and evaluate for the FY 1995 data, which provides for the separate

reporting of physician salaries when considering appropriate changes in the FY 1999 wage index.

Comment: One hospital association commented that it had analyzed unedited preliminary FY 1995 HCRIS data and concluded that revising our policy to include contracted Part A physician salaries would redistribute current payments by only half of what would result if we changed our policy to exclude all Part A physician and resident salaries. (Currently, we exclude contracted Part A physician salaries, but include similar salaries if the physician is employed by the hospital.) Other commenters noted other data issues that arise using the preliminary FY 1995 HCRIS wage data.

Response: In response to these comments, we would emphasize that the cost report data analyzed by these commenters are very preliminary, and in many cases, have not yet been reviewed by the intermediaries. The data were extracted from the HCRIS Minimum Data Set, which is updated quarterly and becomes more accurate and complete after the deadline for completion of the wage data desk reviews by the intermediaries. We are aware of the need to carefully review these data due to the changes discussed above, and we will work with those in the hospital industry that have taken the initiative to begin to examine the data in order to draw upon their findings while proceeding with our analysis.

Comment: Two commenters stated that wages and wage-related costs for physicians, residents, and CRNAs are not reported separately for FY 1995, but are reported separately for FY 1996. They requested that HCFA postpone its evaluation of the exclusion of these data until the FY 1996 data are available, and that HCFA announce this 1-year delay in the FY 1998 final rule.

Response: We are aware that for the FY 1995 cost reports some hospitals may have reported teaching physicians' salaries with residents' wages, and also did not separately report wage-related costs for physicians, residents, and CRNAs. To address this situation we revised the FY 1996 cost reporting instructions. We will consider the impact of this problem in our FY 1995 data analysis.

Comment: Four commenters disputed the rationale that Part A physician and resident salaries should be excluded from the wage index because these costs are largely paid through Medicare direct graduate medical education payments. They stated that other costs, such as outpatient and general service costs that are allocated to excluded cost centers, are similarly paid outside the prospective payment system, but are included in the wage index calculation.

Response: The FY 1995 revised Worksheet S–3 allows for the separate reporting of direct salaries and hours by general service cost centers as well as physician salaries. We plan to analyze these data to determine the feasibility of allocating general service costs and removing those costs that are associated with excluded areas. Regarding outpatient costs, hospital staff frequently provide services in both the outpatient and inpatient departments, and we believe that the inclusion of outpatient salaries causes little or no distortion to the wage index.

1. Verification of Wage Data From the Medicare Cost Report

The data for the FY 1998 wage index were obtained from Worksheet S–3, Part II of the Medicare cost report. The data file used to construct the final wage index includes FY 1994 data submitted to HCRIS. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

In the proposed rule, we discussed in detail our review of the wage data as well as the process that hospitals could use to verify their wage data and submit requests for corrections if necessary (62 FR 29914). To be reflected in the final wage index, wage data corrections had to be reviewed, verified, and transmitted to HCFA through HCRIS by June 16, 1997. (Any changes after this date are limited to errors related to handling the data, as described below in section III.C of this preamble.) All data elements that failed edits have been resolved and are reflected in the final wage index.

2. Computation of the Wage Index

The method used to compute the final wage index is as follows:

Step 1—As noted above, we based the FY 1998 wage index on wage data reported on the FY 1994 Medicare cost reports. 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 period beginning on or after October 1, 1993 and before October 1, 1994. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1993 and reported a cost reporting period exceeding 52 weeks. These 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 these wage data as FY 1994 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 subprovider components not subject to the prospective payment system) from gross hospital salaries to determine net hospital salaries. To determine total salaries plus fringe benefits, we added direct patient care contract labor costs, hospital fringe benefits, and any home office salaries and fringe benefits reported by the hospital, to the net hospital salaries.

Step 3—For each hospital, we adjusted 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 estimated for each 30-day increment from October 14, 1993 through April 15, 1995, for hospital industry workers from Standard Industry Classification 806, Bureau of Labor Statistics Employment and Earnings Bulletin. The annual inflation rates used were 3.6 percent for FY 1993, 2.7 percent for FY 1994, and 3.3 percent for FY 1995. 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
10/14/93	11/15/93	1.038679
11/14/93	12/15/93	1.036376
12/14/93	01/15/94	1.034077
01/14/94	02/15/94	1.031784
02/14/94	03/15/94	1.029496
03/14/94	04/15/94	1.027213
04/14/94	05/15/94	1.024935
05/14/94	06/15/94	1.022662
06/14/94	07/15/94	1.020394
07/14/94	08/15/94	1.018131
08/14/94	09/15/94	1.015873
09/14/94	10/15/94	1.013620
10/14/94	11/15/94	1.010881
11/14/94	12/15/94	1.008150
12/14/94	01/15/95	1.005426
01/14/95	02/15/95	1.002709
02/14/95	03/15/95	1.000000
03/14/95	04/15/95	0.997298

For example, the midpoint of a cost reporting period beginning January 1, 1994 and ending December 31, 1994 is June 30, 1994. An inflation adjustment factor of 1.020394 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 1994 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 direct patient care contract labor hours and home office hours to determine total hours.

Step 5—As part of our editing process, we deleted data for 18 hospitals for which we lacked sufficient documentation to verify data that failed edits because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. We retained the data for other hospitals that are no longer participating in the Medicare program because these hospitals reflected the relative wage levels in their labor market areas during their FY 1994 cost reporting period.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area prior to any reclassifications under sections 1886(d)(8)(B) or 1886(d)(10) of the Act. 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 $20.0950.

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.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. We added the total adjusted salaries plus fringe benefits (as calculated in Step 3) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.1364 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the hospital wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410(a) Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in the State in which the hospital is located. For FY 1998, this change affects 128 hospitals in 32 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate prospective payment system payments are not greater or less than those which would have been made in the year if this section did not apply. We note that the Secretary has exercised the authority granted to her by section 4408 of Public Law 105- 33 to include Stanly County in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA. This change is reflected in the final wage index.

3. 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 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, as provided in 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 would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area 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 that combined wage index value.
- If including the wage data for the redesignated hospitals increases the wage index value for the area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value.
- The wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred.
- Rural areas whose wage index values increase as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index values calculated exclusive of the wage data 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 value for an urban area below the statewide rural wage index value.

We note that, except for those rural areas where redesignation would reduce the rural wage index value, the wage index value for each area is computed exclusive of the wage data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, several urban areas listed in Table 4a have no hospitals remaining in the area. This is because all the hospitals originally in these urban areas have been reclassified to another area by the MGCRB. These areas with no remaining hospitals receive the prereclassified wage index value. The prereclassified wage index value will apply as long as the area remains empty.

The final wage index values for FY 1998 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Subject to the provisions of Public

Law 105–33, the FY 1998 wage index values incorporate all hospital redesignations for FY 1998, withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process. For FY 1998, 357 hospitals are redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act). Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a rural hospital is redesignated is lower than the wage index value for the rural areas of the State in which the rural hospital is located, the redesignated rural hospital receives the higher wage index value, that is, the wage index value for the rural areas of the State in which it is located, rather 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, prior to the redesignation of hospitals, based on the FY 1994 wage data. In addition, Table 3C in the Addendum to this final rule includes the adjusted (inflated) average hourly wage for each hospital based on the FY 1994 data. The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(s)(2). In such cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index.

C. Changes to the Medicare Geographic Classification Review Board (MGCRB) Guidelines and Timeframes

Various provisions of Public Law 105–33 address the guidelines the MGCRB uses to reclassify hospitals to other geographic areas as well as the timetable under which hospitals must submit applications for reclassification and the MGCRB and the Secretary must make decisions on those applications.

1. Revised Application and MGCRB Timeframes

Currently, a hospital must submit an application to the MGCRB for geographic reclassification for a fiscal year by the first day of the preceding fiscal year (that is, October 1, 1997 for reclassification effective in FY 1999). The MGCRB has 180 days to make a decision on that application (no later than March 31 of the fiscal year), the hospital has 15 days to request a review of that decision by the Administrator of HCFA (by April 15), and the Administrator has up to 90 days to issue a final decision (July 15). Under our current publication schedule, the July 15 deadline allows the final geographic reclassification decisions to be incorporated in the wage index and payment rates that are published in the final rule on or about September 1.

Sections 4644 (a)(1) and (b)(1) of Public Law 105–33 amend section 1886 (d)(6) and (e) of the Act to provide that the final rule setting the payment rates for years beginning with FY 1999 must be published by August 1. Because this change in publication dates would conflict with the timetable for geographic reclassification decisions, section 4644(c) of Public Law 105–33 amended section 1886(d)(10)(C)(ii) of the Act to require a hospital to submit an application for reclassification no later than the first day of the month preceding the beginning of the Federal fiscal year (that is, by September 1) beginning with applications filed for reclassification for FY 2000. Under this timetable, the amount of time the MGCRB and the Administrator have to make decisions will not change from the current schedule.

In addition, because applications filed for reclassification effective in FY 1999 are not due until October 1, 1997, section 4644(c)(2) requires us to shorten the deadlines under section 1886(d)(10)(C) of the Act so that all final decisions on MGCRB applications will be completed by June 15, 1998. We have consulted with the staff of the MGCRB and the reclassification decisions will be made by the MGCRB by February 28, 1998. This will allow final decisions of the Secretary to be completed by June 15, 1998.

We are revising §§ 412.256 and 412.274 to implement the change in the application deadline.

2. Alternative Wage Index Reclassification Guidelines for Individual Hospitals

a. In the September 1, 1992 final rule, we revised the wage index guidelines at § 412.230(e) to add the requirement that a hospital cannot be reclassified unless its average hourly wage is at least 108 percent of the average hourly wage of the area in which it is located. For FY 1998 reclassification, section 4409 of Public Law 105–33 requires the Secretary to establish alternative wage index guidelines for geographic reclassification. As provided in the statute, a hospital may reclassify for wage index purposes if it demonstrates that:

- Its average hourly wage is at least 108 percent of the average hourly wage of all *other* hospitals in its MSA, that is, not including its own wage data.
- It pays at least 40 percent of the adjusted uninflated wages in the MSA.
- It reclassified for the wage index for each of the fiscal years 1992 through 1997.

The hospital must also meet all other applicable guidelines (for example, proximity).

As noted above, this provision is effective for FY 1998 reclassifications. Because the application and decision making process for FY 1998 reclassification is already completed, we must provide special guidelines for hospitals to apply for reclassification under this provision for FY 1998.

A hospital seeking reclassification for FY 1998 under this provision must submit its application to the MGCRB by September 15, 1997. In addition, the hospital must submit 7 copies of a completed application to the MGCRB. The MGCRB will dismiss a hospital's request for reclassification if the completed application is not received by September 15, 1997. If the MGCRB renders a favorable decision on a hospital's application, the hospital will be reclassified for purposes of the wage index for FY 1998 as if that decision had been made under the usual guidelines and timetable.

Ordinarily, a hospital seeking MGCRB reclassification for a fiscal year must submit its application by October 1 of the preceding fiscal year, and all reclassification decisions with respect to a fiscal year must be finalized before the beginning of the fiscal year (this includes decisions of the MGCRB as well as decisions of the HCFA Administrator when the Administrator undertakes review). However, sections 4409 and 4410 of Public Law 105–33, enacted on August 5, 1997, set forth special reclassification provisions under which certain hospitals may be reclassified for FY 1998 (beginning on October 1, 1997). The MGCRB will make decisions on applications for reclassification based on these provisions before the beginning of the fiscal year, but it will not be feasible to complete the process for appeals or other review before October 1. Nevertheless, we believe it is appropriate to permit appeals of decisions on requests for reclassification under sections 4409 and 4410. Therefore, for such appeals, we are incorporating the current appeals and

review process (including the timetables for a hospital to request review and for the Administrator to complete review) even though that process will not be finalized until after the beginning of the fiscal year. Our general position has been, and continues to be, that changes to the prospective payment rates should be made prospectively only. Nevertheless, given the extraordinary circumstances presented by the recent enactment of the legislation, if a decision on a request for reclassification under section 4409 or section 4410 becomes final under this process after the beginning of the fiscal year, the decision will be effective as of the beginning of the fiscal year. We are revising the regulations at § 412.230(e) to implement this provision.

b. In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital for FY 1996, in calculating the hospital's average hourly wage for the purposes of geographic reclassification for FY 1998 only, section 4410(c) of Public Law 105–33 requires the exclusion of general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital seeking reclassification under this provision must submit 7 copies of a completed application to the MGCRB by September 15, 1997. The MGCRB will dismiss a hospital's request for reclassification if the completed application is not received by September 15, 1997. If the MGCRB renders a favorable decision on a hospital's application, the hospital will be reclassified for purposes of the wage index for FY 1998 as if that decision had been made under the usual guidelines and timetable. The special appeals procedures discussed earlier apply to this context as well.

3. Alternative Guidelines for Rural Referral Centers

Currently, under section 1886(d)(10)(D) of the Act, rural referral centers (RRCs) are allowed to apply to the MGCRB to be reclassified for purposes of the wage index adjustment. To be reclassified, RRCs must meet the following criteria:

- The hospital's average hourly wage must be at least 108 percent of the Statewide rural hourly wage.
- The hospital's average hourly wage must be at least 84 percent of the average hourly wage of the target urban area to which the RRC is applying.

As provided in section 4202 of Public Law 105–33, the MGCRB is prohibited from rejecting a hospital's request for reclassification on the basis of any comparison between the average hourly wage and the average hourly wage of hospitals in the area in which the hospital is located if the hospital was ever classified as an RRC. However, RRCs will continue to be required to have an average hourly wage that is at least 84 percent of the average hourly wage of the target urban area to which the RRC is applying. In addition, while RRCs do not have to meet the proximity requirements for reclassification, they continue to be required to seek reclassification to the nearest urban area. We are revising § 412.230(a)(3) to implement this provision.

4. Reclassification for the Disproportionate Share Adjustment

Section 4203 of Public Law 105–33 provides that for a limited time a rural hospital may apply and qualify for reclassification to another area for purposes of disproportionate share adjustment payments whether or not the standardized amount is the same for both areas. For 30 months after the date of enactment of Public Law 105–33, the MGCRB will consider the application under section 1886(d)(10)(C)(i) of a hospital requesting a change in the hospital's geographic classification for purposes of determining for a fiscal year eligibility for and additional payment amounts under section 1886(d)(5)(F) of the Act. Under Public Law 105–33, the MGCRB will apply the guidelines for standardized amount reclassification (§ 412.230(d)) until the Secretary establishes separate guidelines. Therefore, hospitals seeking such reclassification for FY 1998 must submit a reclassification application to the MGCRB by October 1, 1997. Decisions based on these applications will be effective for FY 1999 (beginning on October 1, 1998). Section 4203 of Public Law 105–33 is effective for the 30 month period beginning on the date of enactment. Accordingly, hospitals may seek reclassification for purposes of DSH for FY 2000 and FY 2001. We are revising § 412.230(a)(5)(ii) of the regulations to implement this provision.

5. Occupational Mix Adjustment

Section 412.230(e) describes the criteria for hospital reclassification for purposes of the wage index. One of the criteria relates to the relationship between the hospital's wages and those of the area to which it seeks reclassification. Specifically, § 412.230(e)(1)(iv) provides that the hospital must demonstrate that its wages are at least 84 percent of the average hourly wage of hospitals in the area to which it seeks reclassification, or that the hospital's average hourly wage weighted for occupational mix is at least 90 percent of the average hourly wage of hospitals in the area to which it seeks reclassification. Under §§ 412.232(c) and 412.234(b), a group of hospitals seeking to reclassify must demonstrate that its aggregate average hourly wage is at least 85 percent of the average hourly wage of the hospitals in the area to which it seeks reclassification. These sections also provide that the threshold for the occupational-mix adjusted hourly wage for hospital groups is the same as that for a single hospital, that is, 90 percent.

In the August 30, 1996 final rule, we stated that, because the American Hospital Association (AHA) was terminating its collection of information on the Hospital Personnel by Occupation Category as of 1994, there would be no suitable source of occupational mix data for hospitals to use for geographic reclassification under §§ 412.230(e)(1)(iv), 412.232(c) and 412.234(b) beginning with reclassifications effective for FY 1999 (61 FR 46185). In that rule, we stated that we would not make a final decision on this issue until the next year in case another suitable source of occupational mix data were found. Although we did not include any alternative data source in the proposed rule, we received some comments suggesting another way to obtain occupational mix data.

Comment: One commenter proposed a methodology for collecting occupational mix data for those hospitals that seek to be reclassified through the MGCRB process using occupational mix data as part of their wage index calculations. The commenter proposed the following process:

- Any hospital that wants to use the 90 percent occupational mix adjustment criteria should be allowed to use the 1993 AHA data for FY 1999 reclassifications, which must be filed by October 1, 1997.
- For any hospital that successfully reclassifies for FY 1999 using the 1993 AHA data, HCFA would contact the State or local hospital associations in the State in which the reclassified hospital is located to obtain more current occupational mix data for the affected MSAs that could be used by the individual hospital for future years' occupational mix data. In some cases, there may be costs incurred in collecting these data. The commenter suggested that the individual reclassified hospitals would bear any costs of data collection incurred by the State or local hospital

associations or, alternatively, the costs could be distributed by the associations to the individual hospitals in the MSA asked to provide these data.

- The applicable hospital associations would provide the data to HCFA for any data review deemed necessary by HCFA. The individual hospitals would obtain the occupational mix data directly from HCFA after HCFA had completed any data edits or performed any other procedures that HCFA believes necessary to determine the validity and usability of the data. The data would be collected in a single survey for FY 1995, FY 1996, and FY 1997 to correspond with the next 3 years of wage survey data. Thus, current data would be available for the next 3 years for the individual MSA to which a hospital was successfully reclassified using the 90 percent occupational mix data.
- For future years, individual hospitals seeking to qualify using the occupational mix criterion for a wage index reclassification to an MSA where the data are not already being collected could use the 1993 AHA data for the first year. This would then trigger a data accumulation request for that area. It is the opinion of the commenter that this would allow all prospective payment hospitals to use the 90 percent criterion if needed.

Three State hospital associations also wrote to indicate support for this proposal. The AHA supports the use of its 1993 occupational mix data on an interim basis. In addition, although the AHA does not wish to be the future vehicle of data collection, it supports the concept of hospitals designing a method to collect occupational mix data for use in future years.

Response: As we stated in the June 4, 1991 final rule with comment period (56 FR 25458), the reclassification process requires the use of occupational mix data that are comparable across areas and that can be consistently applied. We are unaware of any sources other than the AHA data that meet these criteria. (Originally, these data were also available from the Department of Labor Statistics, which has since discontinued its hospital wage survey.) We responded to comments on this issue in the August 30, 1996 final rule (61 FR 46186). In that document, we reiterated that we were interested only in occupational mix data that are available on a national basis. We also noted that we were not interested in collecting the data ourselves.

The commenter's proposal fails to meet the ''national basis'' criterion that we set. The commenter proposes that only hospitals in certain areas would have to report occupational mix data. This does not provide a national database for those other hospitals that might want to use the data at some future time, nor does it allow verification of the data through edit checks performed on a national basis, such as those that we perform on the wage data. The commenter also proposes that HCFA ensure that the data are collected and that HCFA edit and validate the data and provide them to those who request the data. We do not want to be either the requestor or the repository of these data, nor do we have the resources to edit or validate these data.

In addition, this proposal contemplates the use of the 1993 AHA data for several years. For example, if a hospital first attempts to qualify using occupational mix data for FY 2002 in an area not already collecting these data, it would have to use the 1993 AHA occupational mix categories to adjust 1997 wage data. We believe that this would not be an accurate measure of the hospital's weighted average hourly wage for purposes of reclassification.

Finally, the commenter suggests that those hospitals that benefit from the use of occupational mix data should fund the data collection effort. This could lead to some inconsistency in availability of the data. If some hospitals that could benefit are unable to fund the collection effort, they would be at a disadvantage. Moreover, we are uncomfortable with the concept of allowing hospitals that will benefit from certain data to pay others for those data. We are unsure about how the payment incentive might influence the data.

Since we have discovered no other suitable source of occupational mix data during the past year, we have no updated occupational mix data to correspond with the FY 1994 wage data that will be used for FY 1999 reclassifications. Therefore, this option will no longer be available to hospitals. We have amended the regulations at §§ 412.230(e), 412.232(c), and 412.234(b) to reflect this decision. We remain interested in any occupational mix data proposals that meet our criteria.

D. Requests for Wage Data Corrections

In the proposed rule, we stated that, as in past years, we would make a data file available in mid-August containing the wage data used to construct the wage index values in the final rule. (Please note that this data file is also available through the Internet at HCFA's home page (http://www.hcfa.gov).) As with the file made available in March 1997, HCFA makes the August wage data file available to hospital associations and the public. This August file is being made available only for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that result from the process described above, not for the initiation of new wage data correction requests.

If, after reviewing the August data file or the information in this final rule, a hospital believes that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and HCFA. The letters should outline why the hospital believes an error exists and provide all supporting information, including dates. These requests must be *received* by HCFA and the intermediaries no later than September 15, 1997. Requests mailed to HCFA should be sent to: Health Care Financing Administration; Center for Health Plans and Providers; Attention: Stephen Phillips, Technical Advisor; Division of Acute Care; C5–06–27; 7500 Security Boulevard; Baltimore, MD 21244–1850. Each request also must be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact HCFA immediately to discuss its findings.

As noted in the proposed rule, after mid-August, we will make changes to the hospital wage data only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the August wage data file. Specifically, after that point, neither the intermediary nor HCFA will accept the following types of requests in conjunction with this process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCRIS on or before June 16, 1997.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the March 1997 data.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by September 15, 1997) will be effective October 1, 1997.

We believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals had access to the wage data in mid-August, they will have

had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the implementation of the FY 1998 wage index on October 1, 1997. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be free of such errors. Nevertheless, in the unlikely event that such errors should occur, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(s)(2), we may make midyear corrections to the wage index only in those limited circumstances where a hospital can show: (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 1998 (that is, by the September 15, 1997 deadline). As indicated earlier, since a hospital will have had the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

E. Modification of the Process and Timetable for Updating the Wage Index

Although the wage data correction process described above has proven successful for ensuring that the wage data used each year to calculate the wage indexes are generally reliable and accurate, we expressed concern in the proposed rule that there have been an excessive number of revisions being requested after the release of the wage data in mid-March. Last year, in developing the FY 1997 wage index, the wage data were revised between the proposed and the final rules for more than 13 percent of the hospitals (approximately 700 of 5,200). The number of revisions this year was similar. Since hospitals are expected to submit complete and accurate data, and the data are reviewed and edited by the intermediaries and HCFA, we believe that we should be making few revisions after the release of the March wage data file. According to information received from the intermediaries, these late revisions are partly due to the lack of responsiveness of hospitals in providing sufficient information to the intermediaries during the desk reviews (that is, during the intermediary's review of the hospital's cost report).

Our analysis of last year's wage data also showed that, although the volume of revisions was high, the effect of the changes on the wage index was minimal. Of the 370 labor market areas, only 4 (1.1 percent) experienced a change of 5 percent or more in their wage index value and only 39 (10.6 percent) experienced a change of 1 percent or more. Thus, the intensity of work that must be performed in order to incorporate these revisions in the 1 month available between the mid-June date for revision requests and the mid-July date by which we must begin calculation of the final wage index is not warranted in light of the minimal changes to the actual wage index values.

Another feature of the current process is that it results in corrections to the final wage index after the September 1 final rule publication and before the October 1 effective date of the wage index. Immediately following the development of the final wage index, a second wage data file is made available in mid-August so that hospitals may again verify the accuracy of their wage data. If a hospital detects an error made by the intermediary or HCFA in the handling (entry or transmission) of the wage data, the hospital may request a correction (this year, by September 15). The corrections are published in the **Federal Register** after the October 1 implementation date in a correction notice to the final rule. We would prefer to minimize the need to republish certain wage index values after the final rule is in effect.

Finally, hospitals base their geographic reclassification decisions (whether or not to withdraw their applications) on the wage index published in the proposed rule. Although the FY 1997 proposed and final wage indexes were quite similar, we cannot ensure this will happen each year if increasing numbers of hospitals delay the submittal to their intermediaries of wage data supporting documentation until the May 15 deadline. We believe that hospitals could make more informed decisions regarding reclassification if the proposed wage index more closely resembles the final wage index. Therefore, in the proposed rule, we discussed possible revisions to the wage data verification process.

1. Process and Timetable

The major change we proposed to the current process was the requirement that wage data revisions be requested (and resolved) earlier, before publication of the proposed rule. Subsequent corrections would be allowed only for errors in handling the data (our current timetable allows for such corrections after the final rule is published). For example, the FY 1999 wage index will use FY 1995 cost report data (that is, cost reports beginning in FY 1995) and become effective October 1, 1998. Under the proposed timetable, hospitals would be required to submit all requests for wage data revisions to their intermediary by mid-December 1997. We indicated this would provide ample opportunity for hospitals to evaluate the results of intermediaries' desk reviews and prepare any requests for corrections. We noted that the desk reviews are to be performed on an ongoing basis as cost reports are received from hospitals and, for the FY 1995 wage data, must be completed prior to the mid-November 1997 deadline for submitting all FY 1995 wage data to HCRIS.

As under the current process, after reviewing requests for wage data revisions submitted by hospitals, fiscal intermediaries would transmit any revised cost report to HCRIS and forward a copy of the revised wage index Worksheet S–3 to the hospital. If requested revisions are not accepted, the fiscal intermediaries would notify the hospital in writing of reasons why the changes were not accepted. We believe that fiscal intermediaries are generally 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, if a hospital disagrees with the intermediary's policy interpretation, the hospital may contact HCFA in an effort to resolve the dispute. All policy issues would be resolved by mid-January.

The proposed timetable for developing the annual update to the wage index was as follows (an asterisk indicates no change from prior years):

Mid-November* All desk reviews for hospital wage data are completed and revised data transmitted by intermediaries to HCRIS.

Mid-December Deadline for hospitals to request wage data revisions and provide adequate documentation to support the request.

Mid-January Deadline for intermediaries to submit to HCRIS all revisions resulting from hospitals' requests for adjustments (as of mid-December) (and verification of data submitted to HCRIS (as of mid-November)).

Early April Edited wage data are available for release to the public.

May 1* Proposed rule published with 60-day comment period and 45-day withdrawal deadline for geographic reclassification.

Early May (2 weeks after publication of proposed rule) Deadline for hospitals to notify HCFA and intermediary that wage data are incorrect due to mishandling of data (that is, error in data entry or transmission) by intermediary or HCFA.

Late May (2 weeks after previous deadline) Deadline for intermediaries to transmit all revisions to HCRIS.

September 1* Publication of the final rule.

October 1* Effective date of updated wage index.

The most significant change reflected in the proposed timetable is that we would no longer make available a preliminary wage data file prior to hospitals' final opportunity to request corrections.

As noted in section V of this preamble, section 4644(b) of Public Law 105–33 requires that, beginning with FY 1999, we publish a proposed rule on changes to the prospective payment system by April 1 prior to the fiscal year when such changes are to become effective, and a final rule by August 1. In light of this and for other reasons discussed below, we are revising this proposed timetable for preparing the FY 1999 wage index to allow for release of a public use file containing the edited preliminary FY 1995 wage data.

2. Cost Reporting Timetable

In the proposed rule, we stated that the proposed timetable would not significantly alter the time hospitals have to ensure the accuracy of their data. In developing the wage index for a given fiscal year, we use the most recent, reviewed wage data, that is, wage data from cost reports that began in the fiscal year 4 years earlier. For example, for the FY 1999 wage index, we will use data from cost reporting periods beginning in FY 1995. Hospitals must submit cost reports to their intermediaries within 150 days of the end of their cost reporting periods. Once the cost report is received, the intermediary has 12 months to review and settle it.

As part of the settlement process, we require intermediaries to conduct a desk review of the wage data. The desk review program for hospital wage data targets potentially aberrant data and checks the completeness and accuracy of the data, including verifying that reported costs are in conformance with our policy, before they are used in calculating the wage index. The intermediary checks the wage data and supporting documentation submitted by the hospital and contacts the hospital if additional information is needed to verify the accuracy of the data. When it is necessary for the intermediary to adjust a hospital's wage data, the intermediary notifies the hospital in writing of the change to the cost report and hospitals then have the opportunity to request adjustments. This would continue to be the case.

Since intermediaries must settle cost reports within 12 months of their receipt, most of the cost reports are settled by the time we compile the data to calculate the wage index. We note, however, that the annual update of the wage index is not tied directly to the cost report settlement process since extensions or reopenings of settled cost reports may be granted.

The following is an illustration of the process for settling a typical cost report beginning in FY 1995. Of course, hospitals' cost reporting periods may begin at any time during the year.

January 1, 1995 Cost reporting period begins.

December 31, 1995 Cost reporting period ends.

May 31, 1996 Cost report must be submitted by the hospital to the intermediary.

July 31, 1996 Cost report must be transmitted by the intermediary to HCRIS.

May 31, 1997 Cost report must be settled by the intermediary. (Desk review of hospital wage data is performed on an ongoing basis by the intermediary before the cost report is settled.)

July 31, 1997 Settled cost report must be transmitted by the intermediary to HCRIS.

Comment: One association representing fiscal intermediaries objected to our statement that the intermediaries must settle cost reports within 12 months of their receipt. The commenter stated that this is not consistent with our current audit and reimbursement performance standards.

Response: The regulations at § 405.1835(c) provide that the intermediary has up to 12 months from receipt of a cost report in which to settle it. For purposes of the contractor performance evaluation program (CPEP) for FY 1997, the standard is that the intermediary has at least 21 months from receipt of a hospital's cost report in which to settle it. While we are not changing the CPEP instructions or standards for FY 1997, the instructions are subject to change from year to year. Therefore, in the discussion of the wage index timetable, we used the cost report settlement information from the regulations, which are relatively constant, not the performance evaluation standard, which is subject to change from year to year. Since we are required by statute to update the wage index on an annual basis, the wage index update is not tied directly to the cost report settlement process as the settlement may be delayed for several reasons, including allowances by the CPEP, extensions, and reopenings.

Comment: The same commenter was also concerned that the proposed modification to the timetable for developing the FY 1999 wage index would require intermediaries to complete desk reviews for two cost reporting periods within the same budget year and that this substantial increase in work would require additional funding.

Response: Regarding the commenter's concern that additional funding would be needed to handle the increased desk review workload (which would result from revising the timetable as proposed), in the instructions for the wage index desk review the intermediaries are instructed to perform the desk reviews as the cost reports are received. We do not agree with the commenter's assertion that shortening the timeframe for developing the wage index will result in a substantial increase in the intermediaries' workload. In fact, as we pointed out in the preamble to the proposed rule, under the current process, intermediaries are required to verify the inclusion and accuracy of all hospitals' wage data twice during the wage index development. Our proposed timetable would have eliminated the need for the second verification by the intermediaries.

Comment: One hospital association suggested that the number of late revisions could be reduced if intermediaries completed the wage data desk reviews within 60 days from receipt of hospitals' cost reports and if HCFA and the intermediaries would use the same edits. Others commented that HCFA's edits are unrealistic and that improved edits would reduce the need for a preliminary wage data file.

Response: We agree with the commenter's suggestion that the number of late revisions could be reduced if intermediaries completed the wage data desk reviews soon after receipt of the hospitals' cost reports. There is a desk review being developed to perform an automated review of the entire cost report, including the hospital wage index information, as the cost reports are received by the intermediary. The expectation is that desk review would integrate the editing of the wage data and the other cost report data, as well

as eliminate the need for a separate desk review of the wage data by the intermediary and editing of the wage data by HCFA. Until that desk review is in place, the wage data desk review is a necessary part of the annual update to the wage index.

Regarding the edits, the same types of edits are used by HCFA and the intermediaries. The initial edits, performed by the intermediary in the desk review, are broad in order to identify problem areas. We then perform a more focused review, using the same types of edits as in the desk review, once the data are received and aggregated. Also, additional edits on the aggregated data are performed. We update the wage data edits each year and will reevaluate and revise the types and thresholds of the edits to better identify incomplete or inaccurate data.

3. The Final Revised Timetable for Finalizing Wage Data

We received approximately 40 comments regarding our proposal to reduce the amount of time for developing the wage index.

Comment: Most of the commenters were opposed to our proposal, stating that it would reduce the number of days that the hospital industry has for reviewing the wage data. Another commenter believes that the fact that the preliminary wage data file is released only 2 months prior to the mid-May deadline for revisions is the main cause of late submissions. One hospital added that the expedited timeframe would be disadvantageous for rural hospitals, especially in an environment in which their wage index values are decreasing while the urban values are increasing.

Response: We continue to believe that expediting the resolution of all wage data issues earlier in the process will improve the accuracy of the wage index. Hospitals are ultimately responsible for the accuracy of their cost report information. Because intermediaries are required to notify hospitals of changes to their cost reports, including those affecting the wage data, we do not agree that the timing of the release of the preliminary data file is the cause for the volume of last minute revisions. Hospitals should know what is included in their wage data well before the release of this file. In fact, our intent in releasing the preliminary data file is primarily to allow hospitals to verify that the data on file at HCFA matches their latest wage data information. We remain concerned that the release of the preliminary file itself and the final opportunity for revisions it provides actually encourages hospitals to wait to request revisions until after its release.

With regard to the comment that the proposed timetable would adversely impact rural hospitals, it is not clear to us from the comment how this proposal would have that effect. By placing greater emphasis on individual hospitals to ensure the accuracy of their data earlier in the process, we believe the result would be a more accurate wage index overall.

Comment: Two commenters stated that they agreed that the schedule for developing the wage data should be shortened, but that HCFA should continue to make available the preliminary wage data file. A few commenters suggested that the preliminary file could be released to the public earlier, for example, in mid-December (about 30 days after the deadline for the intermediaries to transmit the data to HCRIS) to reduce the amount of late changes.

Response: Due to the requirement that the changes to the inpatient prospective payment system be published one month earlier (beginning with FY 1999), we have no choice but to expedite this process. Although commenters suggested that a preliminary file could be released in mid-December, that date would not provide sufficient time for the fiscal intermediaries to verify hospitals' data that are included on the file. We believe it would be counterproductive to ask the industry to review the data file prior to the fiscal intermediaries' verification. However, in light of the concerns about eliminating the preliminary file, we plan to make available an edited, preliminary FY 1995 wage data file in February 1998.

Comment: Several commenters stated that since the wage data requirements in the FY 1995 cost report have changed significantly from previous years, it would be inappropriate to implement an expedited process for the FY 1999 wage index. Two hospital associations commented that they evaluated preliminary FY 1995 wage data from the HCRIS Minimum Data Set and concluded that the data showed serious reporting problems.

Many of the commenters stated that the hospital industry uses the preliminary file to evaluate the quality of the wage data and to ensure that Medicare payment is properly allocated among hospitals. Some of the commenters said that the wage data would likely be less accurate without the industry's review of the preliminary wage data file. One association added that, without the edited preliminary file, those evaluating hospital wage data would have to rely on the HCRIS file, which is less accurate and less complete.

Response: Effective with cost reporting periods beginning on or after October 1, 1994, we revised the Medicare cost report to provide for the separate reporting of all salary costs for physicians (including teaching physicians), residents, and CRNAs. In addition, in order to analyze the feasibility of excluding overhead costs attributable to skilled nursing facilities and other excluded areas, overhead cost data is collected by cost center. After evaluating these data, we will consider appropriate changes in developing the FY 1999 and future wage index updates.

Thus, we have decided to release a preliminary wage data file for the FY 1999 wage index prior to hospitals' final opportunity to request corrections. The combination of the changes to the FY 1995 wage data, the earlier publication schedule, and the comments we received regarding the timing of intermediaries' audits caused us to reverse our intention to eliminate the preliminary data file during the processing of the FY 1999 wage index and to make other adjustments. Therefore, we are making several changes to the current timetable as well as the timetable we proposed. The most significant of these changes is that the preliminary public use file will now be made available in February (we will contact the hospital industry regarding the precise release date), and that hospitals will then have 30 days (rather than the current 60 days) to request revisions to their data. This shortened review period is necessitated by the earlier publication date and our intent to eliminate the need for an annual correction notice reflecting changes due to data handling errors.

We believe that this will enable us to utilize the hospital industry's analyses to help ensure the accuracy of the data. However, due to the earlier publication schedule, hospitals will have only 30 days to review their data and request adjustments. We believe the trade-off between making preliminary data available earlier and shortening the time for review is fair. Intermediaries will have 30 days to review the requests, make their determinations, and transmit the revised data to HCRIS.

We plan to release a final wage data file in May for the limited purpose of allowing hospitals the opportunity to identify errors made by HCFA or the intermediary in the transmission of the final wage data. We anticipate that this revised timetable will meet our objective of enabling us to correct any data errors contained in the final wage data file prior to publication of the final rule on August 1.

Thus, the final revised timetable is as follows:

Mid-November—All desk reviews for hospital wage data are completed and revised data transmitted by fiscal intermediaries to HCRIS.

Early February—Edited wage data are available for release to the public.

Early March—Deadline for hospitals to request wage data revisions and provide adequate documentation to support the request.

Early April—Deadline for intermediaries to transmit appropriate revised wage data to HCRIS.

April 1—Proposed rule published with 60-day comment period and 45-day withdrawal deadline for geographic reclassification.

Early May—Final wage data are available for release to the public.

Early June—Deadline for hospitals to notify HCFA and their fiscal intermediary that wage data are incorrect due to mishandling of data (that is, an error in data entry or transmission) by intermediary or HCFA.

August 1—Publication of the final rule.

October 1—Effective date of updated wage index.

We believe this timetable, like the timetable reflected in the proposed rule, is a logical step in the evolution of the process for compiling the wage data used to calculate the hospital wage index. For a number of years, the hospital wage index was based on a wage survey that was not updated every year. Applicable policies permitted hospitals to request and receive midyear corrections to the data on the wage survey. Beginning with FY 1994 (beginning on October 1, 1993), we used wage data submitted by hospitals on Worksheet S–3, Part II of the hospital cost report, and we update the wage data every year. We revised our wage data process accordingly—we stopped making midyear corrections to the wage data (except under very limited circumstances, as noted below), and instead attempted to finalize the wage data by the final rule.

The new timetable would shorten the time for revisions somewhat further. Because we have used cost report data for 5 years now, hospitals should be well aware of the importance of submitting accurate wage data on the Worksheet S–3, Part II. Also, as intermediaries and hospitals have become increasingly familiar with the data collection and verification process, handling the data has become more routine and streamlined. For example, over the past year, we have greatly improved the overall efficiency of our communications with the intermediaries through greater reliance on electronic transmission of wage data. In short, then, there should be less need for revising wage data after desk reviews, and we believe it is reasonable and appropriate to revise the timetable for requesting and resolving wage data revisions.

We would continue to make midyear corrections to the wage index in accordance with § 412.63(s)(2), in those limited circumstances where a hospital can show: (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of the fiscal year. Although we do not anticipate that such situations would arise, this regulation would remain unchanged.

F. Wage Index Workgroup

As stated in the proposed rule, we are concerned that the rapid and dramatic changes occurring in hospitals' operating environments, combined with the current time lag in the data used to construct the wage index, is leading to a situation where the wage index may be becoming less representative of hospitals' current labor costs. Hospitals' increasing reliance on contract labor for a broadening array of functions, hospital mergers and the development of integrated delivery systems, and the expansion of the prospective payment system to other sites of care are factors that indicate a need for a concerted effort to ensure that the data required for calculating the wage index are available and reliable. Furthermore, despite the improvements that resulted from the work of the special Medicare Technical Advisory Group (MTAG) several years ago, technical questions about the treatment of certain types of labor costs continue to arise.

For these reasons, we believe there is a need for an ongoing workgroup to address wage index related issues periodically. We solicited input from representatives of the hospital industry (and other provider types interested in the collection of wage data) regarding the need for such a workgroup and their willingness to participate. We also sought public input regarding the structure and scope of such a workgroup.

Comment: The response to the proposed wage index workgroup was favorable. Some commenters believe the group should be formally established and meet on a regular basis to ensure the attention and resources needed to accomplish its objectives. Several commenters recommended that the wage index workgroup be formed under the auspices of the MTAG. Another commenter suggested that a workgroup formed on an ad hoc basis, with one or more specific issues to address, might be the best way to structure the group. Several commenters stated that the group's agenda should be broadly defined to encompass input price adjustment issues related to hospitals, skilled nursing facilities, home health agencies, rehabilitation facilities, and managed care plans. Some commenters expressed interest in participating in such a workgroup.

Response: We will proceed with the development of the wage index workgroup. We will be in contact with interested parties to arrange a meeting to discuss issues related to its structure and focus. We appreciate the enthusiastic responses, and believe that utilization of a workgroup will expedite many procedural improvements in the wage index process.

IV. Revising the Hospital Operating Market Baskets

A. General Discussion

We used a hospital input price index (that is, the hospital ''market basket'') to develop the inflation component update factors for operating costs. Although ''market basket'' technically describes the mix of goods and services used to produce hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket'' as used in this document refers to the hospital input price index.

The terms rebasing and revising, although often used interchangeably, actually denote different activities. Rebasing moves the base year for the structure of costs of an input price index (for example, moving the base year cost structure from FY 1987 to FY 1992). Revising means changing data sources, cost categories, or price proxies used in the input price index for a given base year. In the August 30, 1996 final rule, effective for FY 1997, we both rebased and revised the hospital operating market baskets (61 FR 46186).

B. Revising the Hospital Market Basket

We used a revised hospital market basket for the FY 1998 update framework for the operating prospective payment rates. In the August 30, 1996 final rule, we discussed the possibility of revising the market basket when additional data became available (61 FR 46187). Consistent with that discussion, we used a revised market basket that still has a base year of FY 1992, but

incorporates additional data, specifically the Asset and Expenditure Survey, 1992 Census of Service Industries, by the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce, which did not become available until after the FY 1997 final rule was published. (For further discussion of the differences between the revised market basket for FY 1998 and the current market basket, see Appendix C of this final rule with comment period.)

In the current market basket, data for four major expense categories (wages and salaries, employee benefits, pharmaceuticals, and a residual category) are from Medicare hospital cost reports for periods beginning in FY 1992 (that is, periods beginning on or after October 1, 1991 and before October 1, 1992). These cost reports, which we refer to as PPS–9 cost reports (the 9th year of the prospective payment system), are reported in the Health Care Provider Cost Report Information System (HCRIS). In the revised hospital market basket, we still use the cost report data, and categories and weights are unchanged from the current market basket. Within the residual category, the categories and weights for nonmedical professional fees and professional liability insurance are also unchanged. (For a detailed discussion of the determination of weights, see the August 30, 1996 final rule (61 FR 46187)).

Table 1 shows a comparison of the current and the revised operating market basket cost categories, weights, and price proxies. For the revised market basket, weights for the ''Utilities'' and ''All Other'' cost categories, as well as most subcategories, were derived using the Asset and Expenditure Survey, published by the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce, in conjunction with the latest available (1987) Input-Output Table, produced by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce. The 1987 input-output cost shares, aged to 1992 using historical price changes between 1987 and 1992 for each category, were allocated to be consistent with the newly available 1992 asset and expenditure data.

The resulting combined data were allocated to be consistent with the 1992 hospital cost report data. Revised relative weights for the base year were then calculated for various expenditure categories. This work resulted in the identification of 22 separate cost categories in the revised market basket. Four categories previously separate were combined with existing categories. Specifically, Business Services, and Computer and Data Processing Services were combined with All Other Labor-Intensive Services. Transportation Services was combined with All Other Nonlabor-Intensive Services, and the Fuel, Oil, Coal etc. category was split between Fuels (nonhighway) and Miscellaneous Products. We combined these categories so that the market basket would conform more closely with the 1992 Asset and Expenditure Survey. Detailed descriptions of each of the four categories and their respective price proxies can be found in the August 30, 1996 final rule (61 FR 46323). Changing the structure of the market basket using the 1992 Asset and Expenditure Survey allows for a more accurate reflection of the cost structures faced by hospitals. When the Bureau of the Census or the BEA improves methodologies for the collection and categorization of data, it is likely the weights will also change.

TABLE 1.—COMPARISON OF CURRENT 1992–BASED PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET WITH REVISED 1992–BASED PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET

Expense categories	Price proxy	Current 1992-based PPS market basket [1]	Revised 1992-based PPS market basket
1. Compensation:		61.390	61.390
A. Wages and salaries	HCFA occupational wage index	50.244	50.244
B. Employee benefits	HCFA occupational benefits index	11.146	11.146
2. Nonmedical professional fees	ECI-compensation for professional, specialty, and technical	2.127	2.127
3. Utilities:		2.470	1.542
A. Electricity	PPI commercial electric power	1.349	0.927
B. Fuels (nonhighway)	PPI commercial natural gas	1.015	0.369
C. Water and sewerage	CPI–U water and sewerage maintenance	0.106	0.246
4. Professional liability insurance	HCFA professional liability insurance premium index	1.189	1.189
5. All other expenses:		32.825	33.752
A. All other products:		24.033	24.825
(1) Pharmaceuticals	PPI ethical (prescription) drugs	4.162	4.162
(2) Food		3.459	3.386
(a) Direct purchase	PPI processed foods and feeds	2.363	2.314
(b) Contract service	CPI food away from home	1.096	1.072
(3) Chemicals	PPI industrial chemicals	3.795	3.666
(4) Medical instruments	PPI medical instruments and equipment	3.128	3.080
(5) Photographic supplies	PPI photographic supplies	0.399	0.391
(6) Rubber and plastics	PPI rubber and plastic products	4.868	4.750
(7) Paper products	PPI converted paper and paperboard products	2.062	2.078
(8) Apparel	PPI apparel	0.875	0.869
(9) Machinery and equipment	PPI machinery and equipment	0.211	0.207
(10) Miscellaneous products	PPI finished goods	1.074	2.236
B. All other services:		8.792	8.927
(1) Postage	CPI–U postage	0.272	0.272
(2) Telephone services	CPI–U telephone services	0.531	0.581
(3) All other: labor intensive	ECI compensation for private service occupations	7.457	7.277
(4) All other: nonlabor intensive	CPI–U all items	0.532	0.796

TABLE 1.—COMPARISON OF CURRENT 1992–BASED PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET WITH REVISED 1992–BASED PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET—Continued

Expense categories	Price proxy	Current 1992-based PPS market basket [1]	Revised 1992-based PPS market basket
Total		100.000	100.000

Note: Due to rounding, weights may not sum to total.
[1] Expense categories based on revised 1992-based hospital market basket for comparison purposes.

In calculating payments to hospitals, the labor-related portion of the standardized amounts is adjusted by the hospital wage index. As discussed in the August 30, 1996 final rule (61 FR 46189), for purposes of determining the labor-related portion of the standardized amounts, we sum the percentages of the labor-related items (that is, wages and salaries, employee benefits, professional fees, business services, computer and data processing services, postage, and all other labor-intensive services) in the operating hospital market basket. Effective for FY 1997, this summation resulted in a labor-related portion of the hospital market basket of 71.246 percent, and a nonlabor-related portion of 28.754 percent. Thus, since October 1, 1996, we have considered 71.2 percent of operating costs to be labor-related for purposes of the prospective payment system (we rounded to the nearest tenth).

In connection with the revisions to the hospital market basket, we have reestimated the labor-related share of the standardized amounts. Based on the relative weights described in Table 2, the labor-related portion (wages and salaries, employee benefits, professional fees, postage, and all other labor-intensive services) is 71.066 percent, and the nonlabor-related portion is 28.934 percent. Accordingly, effective with discharges occurring on or after October 1, 1997, we are revising the labor-related and nonlabor-related shares of the large urban and other areas' standardized amounts used to establish the prospective payment rates to 71.1 and 28.9, respectively. The amounts in Table 2 reflect the revised labor-related and nonlabor-related portions. We note that the labor-related portions of the rates published in Table 2 have remained approximately the same. The labor-related portion has decreased from 71.2 percent to 71.1 percent.

TABLE 2.—LABOR-RELATED SHARE OF REVISED 1992-BASED PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET

Cost category	Weight
Wages and salaries	50.244
Employee benefits	11.146
Professional fees	2.127
Postal services	0.272
All other labor intensive	7.277
Total labor-related	71.066
Total nonlabor-related	28.934

Comment: We received comments encouraging us to revisit the market basket framework annually to adjust for changes such as additional administrative costs for hospitals that revise their Medicare billing procedures to screen claims in response to current policies such as the 3-day payment window and pending legislation such as the change in definition of a transfer.

Response: When slight adjustments are made to individual weights within the hospital market baskets, there is typically little or no change in the historical or forecasted market baskets. A shift in weights from one cost category to another results in a zero sum. Cost categories rising in relative importance are offset by cost categories falling in relative importance. The total weight is 100 before and after the shift. There is an impact on the weighted average of price changes only when the price changes (not levels) of the cost categories shifted are substantially different. This is not typically the case.

Regarding administrative costs, we note that rebasing the market basket is done at 5-year intervals. In the interim, additional costs for administration are appropriately handled in the update framework, which includes factors such as hospital productivity and intensity of services.

Comment: We received a comment requesting that the market baskets be revised again when more recent Input-Output Tables become available from the Bureau of Economic Analysis. The commenter also questioned changes to the market baskets that (1) reduce weights within the utilities cost category by moving some of the weight to the miscellaneous products category and (2) combine business and computer services into all other labor-intensive services.

Response: The changes in weights in the revised market baskets are the result of using data from the Asset and Expenditure Survey. We did a sensitivity analysis in which we developed a test index identical to the revised prospective payments market basket except that the weights and proxies for the current version of ''All Other Services'' were substituted for those in the revised market basket's ''All Other Services'' category. For the historical and forecast period of 1992–2002, half of the years showed no difference and half showed a 0.1 percentage point difference in the percent change upon which updates are based. We feel that the revised market baskets represent an improvement in cost categories and price proxies, and therefore are better measures of composite price changes. When the Input-Output Tables for 1992 become available we will review these data carefully. Revised Input-Output data are automatically included in rebasing on a regular schedule (approximately every 5 years).

C. Selection of Price Proxies

Only four categories that are part of the current hospital market basket do not appear in the revised hospital market basket. Of the 22 categories that are part of both the current and the revised market baskets, only the weights might differ. The wage and price proxies selected for these cost categories are the same as those selected last year. A description and discussion of each price proxy are set forth in the August 30, 1996 final rule (61 FR 46324). The price proxies are shown in Table 1, above. The makeup of the HCFA Blended Occupational Wage Index and the HCFA Blended Occupational Benefits Index used as proxies for Wages and Salaries

and Employee Benefits, respectively, remain the same as last year. (See 61 FR 27463.)

To examine the impact of the changes to the weights and the reduction of the number of cost categories, we developed a comparison for the period FY 1994 through FY 1999. Using historical data for FY 1994 through FY 1996, and forecasts for FY 1997 through FY 1999 for the prospective payment market basket, we compared the percentage changes for the current and the revised market baskets.

TABLE 3.—COMPARISON OF THE CURRENT PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET AND THE REVISED PROSPECTIVE PAYMENT HOSPITAL MARKET BASKET PERCENT CHANGE, FY 1994–1999

Federal fiscal year	Current hospital market basket	Revised hospital market basket	Difference
Historical:			
1994	2.6	2.6	0.0
1995	3.2	3.2	0.0
1996	2.5	2.4	−0.1
Forecasted:			
1997	2.3	2.1	−0.2
1998	2.7	2.7	0.0
1999	3.0	2.9	−0.1
Historical average: 1994–1996	2.8	2.7	−0.1
Forecasted average: 1997–1999	2.7	2.6	−0.1

Note that the historical average rate of growth for 1994 through 1996 for the improved revised prospective payment hospital market basket is almost equal to that of the current market basket. The 0.1 percentage point difference is less than the +/− 0.25 percent threshold for corrections for forecast error. The forecasted average rate of growth for 1997 through 1999 for the revised market basket is 0.1 percentage points less than that of the current market basket.

D. Separate Market Basket for Hospitals and Hospital Units Excluded From the Prospective Payment System

As in the prospective payment hospital market basket, weights for the six main cost categories contained in the excluded hospital market basket (that is, weights for wages and salaries, employee benefits, professional fees, malpractice insurance, pharmaceuticals, and the residual category) remain the same. Only the weights for ''Utilities'' and the categories within ''All Other'' have been revised. Table 4 below shows weights for the current and revised 1992-based excluded hospital market basket.

TABLE 4.—COMPARISON OF CURRENT 1992-BASED EXCLUDED HOSPITAL MARKET BASKET WITH REVISED 1992-BASED EXCLUDED HOSPITAL MARKET BASKET

Expense categories	Price proxy	Current 1992-based excluded market basket [1]	Revised 1992-based excluded market basket
1. Compensation:		63.721	63.721
A. Wages and salaries	HCFA occupational wage index	52.152	52.152
B. Employee benefits	HCFA occupational benefits index	11.569	11.569
2. Nonmedical professional fees	ECI-compensation for professional, specialty, and technical	2.098	2.098
3. Utilities		2.557	1.675
A. Electricity	WPI commercial electric power	1.396	1.007
B. Fuels (nonhighway)	WPI commercial natural gas	1.051	0.401
C. Water and sewerage	CPI–U water and sewerage maintenance	0.110	0.267
4. Professional liability insurance	HCFA professional liability insurance premium index	1.081	1.081
5. All other expenses		30.541	31.425
A. All other products		23.640	24.227
(1) Pharmaceuticals	PPI ethical (prescription) drugs	3.070	3.070
(2) Food		3.581	3.468
(a) Direct purchase	PPI processed foods and feeds	2.446	2.370
(b) Contract service	CPI food away from home	1.135	1.098
(3) Chemicals	PPI industrial chemicals	3.929	3.754
(4) Medical instruments	PPI medical instruments and equipment	3.238	3.154
(5) Photographic supplies	PPI photographic supplies	0.413	0.400
(6) Rubber and plastics	PPI rubber and plastic products	5.039	4.865
(7) Paper products	PPI converted paper and paperboard products	2.134	2.182
(8) Apparel	PPI apparel	0.906	0.890
(9) Machinery and equipment	PPI machinery and equipment	0.218	0.212
(10) Miscellaneous products	PPI finished goods	1.112	2.232
B. All other services		6.901	7.198
(1) Postage	CPI–U postage	0.282	0.295
(2) Telephone services	CPI–U telephone services	0.549	0.631

TABLE 4.—COMPARISON OF CURRENT 1992-BASED EXCLUDED HOSPITAL MARKET BASKET WITH REVISED 1992-BASED EXCLUDED HOSPITAL MARKET BASKET—Continued

Expense categories	Price proxy	Current 1992-based excluded market basket [1]	Revised 1992-based excluded market basket
(3) All other: labor intensive	ECI compensation for private service occupations	5.519	5.439
(4) All other: nonlabor intensive	CPI–U all items	0.551	0.833
Total		100.000	100.000

Note: Due to rounding, weights may not sum to total.
[1] Expense categories based on revised 1992-based hospital market basket for comparison purposes.

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

A. Outlier Payments (§§ 412.80, 412.82, 412.84, and 412.86)

1. Elimination of Day Outlier Payments

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, that is, cases involving extraordinarily high costs (cost outliers) or long lengths of stay (day outliers). That section also provides that, beginning with FY 1995, payments for day outliers will be phased out over 3 years. We have discussed this phase out and its implementation in detail in the September 1, 1994, September 1, 1995, and August 30, 1996 final rules (59 FR 45366, 60 FR 45854, and 61 FR 46228, respectively). Since payment for day outliers will be eliminated effective with discharges occurring in FY 1998, we proposed conforming revisions to the regulations at §§ 412.80, 412.82, 412.84, and 412.86. At the same time, we proposed to make a technical change to the provision concerning outlier payments for transfer cases to conform the regulations to policies that we have stated in previous prospective payment system rules but did not codify. See the final rules published September 1, 1995 (60 FR 45804) and September 1, 1993 (58 FR 46306–07).

We received no comments on these conforming changes and are incorporating them in this final rule with comment period as proposed.

2. Changes to Outlier Payments in Pub. L. 105–33

Section 4405 of Public Law 105–33 amended sections 1886 (d)(5)(B)(i)(I) and (d)(5)(F)(ii)(I) of the Act to provide that, in determining the additional payment for indirect medical education (IME) and/or disproportionate share hospitals (DSH), the IME and DSH adjustment factors are applied only to the base DRG payment, not the sum of the base DRG payment and any cost outlier payments, effective with discharges occurring on or after October 1, 1997. The same section of Pub. L. 105–33 also amended section 1886(d)(5)(A)(ii) of the Act to require that the fixed loss cost outlier threshold is based on the sum of DRG payments and IME and DSH payments for purposes of comparing costs to payments. Therefore, we are revising our regulations at § 412.84(g) to remove the provision that costs be reduced by the IME and DSH adjustment factors for purposes of comparing costs to payments to determine if costs exceed the fixed loss cost outlier threshold, as well as deleting current § 412.80(c). Conforming changes are made at current § 412.105(a) (IME) and § 412.106(a)(2) (DSH). We are also making a corresponding change to the capital cost outlier methodology. We received two public comments urging us to implement this provision in the final rule.

As indicated above, one change resulting from Pub. L. 105–33 is that, in determining whether a case meets the cost outlier threshold, we will not standardize the costs of the case to account for IME and DSH payments. The following examples show the effect on two hospitals of this change in methodology. In the example, we use DRG 286, which has a relative weight of 2.2671. Each hospital has a wage index of 1. The labor-related national large urban standardized amount is $2,776.21; the nonlabor-related large urban standardized amount is $1,128.44.

Before the Change

Standard Cost = (Billed Charges × Cost to Charge Ratio) ÷ (1 + IME + DSH)

Outlier Payments = (80 percent of (Standard Cost—Threshold)) * (1 + IME + DSH)

Total Payments = Outlier Payments + (Federal Rate × (1 + IME + DSH))

	IME and DSH hospital	Non-IME, Non-DSH hospital
Billed charges	$100,000	$100,000
IME adjustment factor	0.0744	0.0
DSH adjustment factor	0.1413	0.0
Cost to charge ratio	0.72	0.72
Standard cost	$59,225.14	$72,000
Outlier threshold	$17,806.30	$17,806.30
Outlier payments	$40,282.30	$43,354.96
Total payments	$51,043.96	$52,207.19

Even with high IME and DSH adjustments, the IME and DSH hospital receives a lower payment for an identical outlier case. This case uses the fixed loss outlier threshold of $7,600 from the proposed rule.

In the following example, the IME and DSH hospital's costs are not adjusted for IME and DSH. The outlier threshold amount includes IME and DSH payments. There are no IME and DSH payments for outliers. The outlier threshold increases under this method for all hospitals.

After the Change

Standard Cost = (Billed Charges × Cost to Charge Ratio)

Outlier Payments = 80 percent of (Standard Cost—Threshold)

Total Payments = Outlier Payments + (Federal Rate × (1 + IME + DSH))

	ME and DSH hospital	Non-IME, non-DSH hospital
Billed charges	$100,000	$100,000
IME adjustment factor	0.0744	0.0
DSH adjustment factor	0.1413	0.0
Cost to charge ratio	0.72	0.72
Standard cost	$72,000	$72,000
Outlier threshold	$20,961.91	$19,052.49
Outlier payments	$40,830.47	$42,358.01
Total payments	$51,592.13	$51,210.24

This case uses the final fixed loss threshold of $11,050 for FY 1998. The fixed loss threshold increase from the proposed rule is due to the higher standard costs of IME and DSH hospitals.

B. Rural Referral Centers (§ 412.96)

Under section 1886(d) of the Act, hospitals generally are paid by the Medicare program for inpatient hospital services covered by Medicare in accordance with the prospective payment system. Certain hospitals, however, receive special treatment under that system. Section 1886(d)(5)(C)(i) of the Act specifically provides for exceptions and adjustments to prospective payment amounts, as the Secretary deems appropriate, to take into account the special needs of rural referral centers.

Section 412.96(d) of the regulations provides that, for discharges occurring before October 1, 1994, rural referral centers received the benefit of payment for inpatient operating costs per discharge based on the other urban payment amount rather than the rural standardized amount. As of October 1, 1994, the other urban and rural standardized amounts are the same. However, rural referral centers continue to receive special treatment under both the disproportionate share hospital payment adjustment and the criteria for geographic reclassification. One of the ways that a rural hospital may qualify as a rural referral center is to meet two mandatory criteria (specifying a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or volume of referrals). These criteria are described in detail in § 412.96(c).

1. Case-Mix Index Criteria

Section 412.96(c)(1) sets forth the case-mix index criteria and provides that, for cost reporting periods beginning on or after October 1, 1986, a hospital's case-mix index for discharges ''during the Federal fiscal year that ended 1 year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status'' must be at least equal to the national case-mix index value as established by HCFA or the median case-mix value for urban hospitals in the region in which the hospital is located (excluding hospitals receiving indirect medical education payments), whichever is lower. As discussed in the proposed rule, we feel that the language in § 412.96(c)(1) does not clearly address situations in which the Federal fiscal year does not end exactly 1 year prior to the beginning of the cost reporting period for which the hospitals are seeking referral center status. Therefore, we clarified which case-mix index values are used to determine referral center status. We emphasized that this clarification represents no substantive change in policy.

Our policy, which we have applied consistently since 1986, is that the case-mix index used for an individual hospital in the determination of whether it meets the case-mix index criterion is the case-mix index for discharges during the *most recent* Federal fiscal year that ended *at least* 1 year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status.

We received no comments on our proposal to revise § 412.96(c)(1) to clarify the time period used to calculate the case-mix index, and we are adopting it as proposed.

2. Updated Case-Mix and Discharge Criteria

As noted above, a rural hospital can qualify as a rural referral center if the hospital meets two mandatory criteria (case-mix index and number of discharges) 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 may be 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.)

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

These values are based on discharges occurring during FY 1996 (October 1, 1995 through September 30, 1996) and include bills posted to HCFA's records through December 1996. Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status, a hospital's case-mix index value for FY 1996 would have to be at least—

- 1.3525; 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 the table set forth in the June 2, 1997 proposed rule at 62 FR 29923).

Based on the latest data available (FY 1996 bills received through June 1997), the final national case-mix value is 1.3529 and the median case-mix values by region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2322
2. Middle Atlantic (PA, NJ, NY)	1.2455
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3701
4. East North Central (IL, IN, MI, OH, WI)	1.2610
5. East South Central (AL, KY, MS, TN)	1.3023
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2088
7. West South Central (AR, LA, OK, TX)	1.3265
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3476
9. Pacific (AK, CA, HI, OR, WA)	1.3450

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 1996 case-mix index value in Table 3C in section IV of the Addendum to this final rule with comment period. 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.

b. 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 are based on discharges for urban hospitals' cost reporting periods that began during FY 1995 (that is, October 1, 1994 through September 30, 1995). 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 or to meet the triennial review standards for cost reporting periods beginning on or after October 1, 1997, the number of discharges a hospital must have for its cost reporting period that began during FY 1996 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 the table set forth in the June 2, 1997 proposed rule at 62 FR 29924.)

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

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6658
2. Middle Atlantic (PA, NJ, NY)	8367
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7515
4. East North Central (IL, IN, MI, OH, WI)	7290
5. East South Central (AL, KY, MS, TN)	6650
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5189
7. West South Central (AR, LA, OK, TX)	5133
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7982
9. Pacific (AK, CA, HI, OR, WA)	5919

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1997, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1996 would have to be at least 3,000.

We received no comments on the rural referral center criteria.

3. Retention of Referral Center Status

Section 1886(d)(5)(C)(i) of the Act states that ''the Secretary shall provide for such exceptions and adjustments to the payment amounts * * * as the Secretary deems appropriate to take into account the special needs of regional and national referral centers * * *'' The Conference Committee Report accompanying Public Law 98–21 (the original legislation implementing the prospective payment system) contained little additional language concerning the definition of ''regional and national referral centers.'' The Report did indicate, however, that they should include very large acute care hospitals located in rural areas. Thus, we established qualifying criteria for referral center status to identify those rural hospitals that, because of bed size, a large number of complicated cases, a high number of discharges, or a large number of referrals from other hospitals or from physicians outside the hospital's service area, were likely to have operating costs more similar to urban hospitals than to the average smaller community hospitals. The regulations implementing the referral center provision are codified at § 412.96.

In 1984, after a year's experience with the referral center criteria, we determined that once approved for the referral center adjustment, a hospital would retain its status for a 3-year period. At the end of the 3-year period, we would review the hospital's performance to determine whether it should be requalified for an additional 3-year period. The requirement for triennial review was added to the regulations in 1984 (§ 412.96(f)) 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, since then, three statutory moratoria on the performance of the triennial reviews were enacted by Congress. When the third of these moratoria expired at the end of cost reporting periods that began during FY 1994, we implemented the triennial review requirements and some hospitals lost their referral center status. (See the September 1, 1993 final rule (58 FR 46310) for a detailed explanation of the moratoria and the implementation of the triennial reviews.)

Hospitals could lose rural referral center status in other ways. With the creation of the Medicare Geographic Classification Review Board (MGCRB) and a hospital's ability, beginning in FY 1992, to request that it be reclassified from one geographic location to another, we stated that if a referral center was reclassified to an urban area for purposes of the standardized amount, it would, in most instances, be voluntarily terminating its referral center status. (See the June 4, 1991 final rule with comment period (56 FR 25482).) This was true because, in most instances, a hospital's ability to qualify as a ''rural referral center'' was contingent upon (among other criteria) its status as a rural hospital.

In addition, rural referral centers located in areas that were redesignated as urban by the Office of Management and Budget lost their referral center status. These hospitals had qualified for referral center status under criteria applicable only to hospitals located in rural areas. OMB's designation of the areas to urban status meant that such hospitals were urban for *all* purposes and thus could no longer qualify as *rural* referral centers.

Section 4202(b)(1) of Public Law 105–33 states that, ''Any hospital classified as a rural referral center by the Secretary * * * for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.'' Thus, many of the hospitals that lost their referral center status for the reasons listed above must be reinstated. For the purpose of implementing this provision, we consider that a hospital that was classified as a referral center for any day during FY 1991 (October 1, 1990 through September 30, 1991) meets the reinstatement criterion.

We have identified 136 hospitals that were classified as rural referral centers in 1991 and are no longer classified as referral centers at this time. Of these, approximately 70 lost their referral center status for failure to meet the triennial review requirements; approximately 40 lost their status due to MGCRB reclassification; approximately 20 were in areas redesignated as urban by OMB, and 6 hospitals voluntarily requested withdrawal of their referral center status.

We are reinstating rural referral center status for all hospitals that lost the status due to triennial review or MGCRB reclassification. The HCFA regional offices will notify each hospital (and the hospital's fiscal intermediary) of their reinstatement as referral centers effective October 1, 1997. If a hospital believes it should be reinstated but does not receive notification, it should contact the appropriate regional office.

We are not reinstating rural referral center status to hospitals in areas redesignated as urban by OMB or hospitals that requested withdrawal of such status. The language of section 4202(b)(1) states that any hospital classified as a rural referral center for FY 1991, ''* * * shall be classified as such a *rural* referral center for fiscal year 1998 and each subsequent fiscal year.'' (Emphasis added.) Hospitals located in

areas redesignated as urban by OMB, since FY 1991, are no longer physically located in a rural area and they can no longer be classified as ''rural'' referral centers. We also do not believe the law intended that referral center classification be forced on hospitals that do not want it and we are, therefore, not reinstating the status of the six hospitals that requested withdrawal. If, however, any of these hospitals wish to be requalified as a referral center, they should contact their HCFA regional office.

We note that section 4202(b)(1) provides reinstatement to only those hospitals that were classified as rural referral centers during FY 1991. That is, any hospital approved as a referral center after FY 1991 would not be protected by this provision. We do not believe that it is equitable or administratively practical to maintain two lists of referral centers, that is, a list of those hospitals approved for referral center status in 1991 and thus protected by the reinstatement provision and a list of those hospitals approved after FY 1991 and not protected by the provision. Therefore, we are terminating the requirement for triennial reviews of referral center status and reinstating all hospitals that lost referral center status due to those reviews. Thus, §§ 412.96 (f) and (g) (1) and (2) are deleted. If we later discover some hospital or class of hospitals that we believe should not be allowed to retain referral center status because they fail to meet some basic requirement we believe is essential to receiving this special designation, we will consider reinstating some type of annual or periodic qualifying criteria.

In addition, we recognize that there are hospitals that qualified for referral center status after 1991 and that may have lost that status in a subsequent year due to reclassification by the MGCRB. Again, we do not believe it is equitable or administratively practical to treat such hospitals differently than those protected by the provision of Public Law 105–33. Thus, we believe that any hospital that lost its referral center status due to reclassification by the MGCRB, regardless of whether it was classified as a referral center during FY 1991, should be reinstated effective October 1, 1997. The regional offices will make every effort to identify and notify all affected hospitals. However, hospitals that believe they meet the criteria for reinstatement but do not receive notification from the regional office or their fiscal intermediary, should contact the appropriate regional office.

We are also eliminating the policy that a hospital loses RRC status if it is reclassified as urban by the MGCRB. We note that for reclassified hospitals, RRC status would have no payment effect.

Every effort will be made to process all reinstatements as quickly as possible.

C. Payment for Medicare-Dependent, Small Rural Hospitals (§ 412.108)

Section 4204 of Public Law 105–33 amended section 1886(d)(5)(G) of the Act to reinstate the classification of Medicare-dependent, small rural hospitals (MDHs) for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2001. This category of hospitals was originally created by section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), enacted on December 19, 1989, which added a new section 1886(d)(5)(G) of the Act. As provided by that law, the special payment for MDHs was to be available for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to sole community hospitals; that is, based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The national Federal rate applicable to the hospital.
- The updated hospital-specific rate using FY 1982 cost per discharge.
- The updated hospital-specific rate using FY 1987 cost per discharge.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66), enacted on August 10, 1993, extended the MDH provision through discharges occurring before October 1, 1994. Under this revised provision, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which that hospital-specific rate exceeded the Federal rate.

In reinstating the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, section 4204 of Public Law 105–33 did not revise either the qualifying criteria for these hospitals nor the most recent payment methodology. Therefore, the criteria a hospital must meet in order to be classified as an MDH are the same as before. Section 1886(d)(5)(G)(iv) of the Act defines an MDH as any hospital that meets all of the following criteria:

- The hospital is located in a rural area.
- The hospital has 100 or fewer beds.
- The hospital is not classified as an SCH (as defined at § 412.92) at the same time that it is receiving payment under this provision.
- In the hospital's cost reporting period that began during FY 1987, not less than 60 percent of its inpatient days or discharges were attributable to inpatients entitled to Medicare Part A benefits.

For the purpose of implementing section 4204 of Pub. L. 105–33, we consider that a hospital that meets the criteria above and that was classified as an MDH on September 30, 1994 is reinstated as an MDH. We have identified 414 hospitals that were classified as MDHs on September 30, 1994. Of these, 20 hospitals no longer participate in the Medicare program, 15 hospitals are now classified as SCHs, 6 hospitals are now located in urban areas, and 5 have more than 100 beds. We will provide fiscal intermediaries with a list of the hospitals we have identified; therefore, hospitals that meet the criteria for classification as an MDH and that were classified as an MDH on September 30, 1994 do not need to take any action in order to be reinstated as an MDH. At the time the year-end settlement is made, the fiscal intermediary will determine for each cost reporting period which hospitals meet the criteria to qualify as MDHs. In addition, the intermediary will determine for each cost reporting period which of the payment options yields the highest rate of payment to a hospital that qualifies as an MDH.

We note that classification as an MDH is not optional. Therefore, hospitals that meet the criteria in § 412.108(a) are not eligible for the temporary special payment provided for in section 4401(b) of Public Law 105–33 (discussed below in section IV–D). However, if a hospital that receives notification that it is being reinstated as an MDH believes it no longer meets the criteria because, for example, it has had an increase in its bed size to more than 100 beds, it should contact its fiscal intermediary.

For purposes of determining a hospital's bed size, we will continue to use the same definition (which is defined for indirect medical education purposes at § 412.105(b)). That is, the number of beds in a hospital is determined by counting the number of available bed days during the hospital's cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care, and excluded distinct part units, and dividing that number by the number of days in the cost reporting period.

We are revising §§ 412.90 and 412.108 to reflect the reinstatement of the MDH special payment.

Section 4204(a)(3) of Public Law 105–33 permits those hospitals that applied and were approved for reclassification to a large urban area for purposes of receiving the large urban rates through the MGCRB to decline that reclassification for FY 1998. Normally, hospitals approved for reclassification have only 45 days from the date of the proposed rule to withdraw their request for reclassification. However, the statute provides that, in this situation, hospitals may withdraw their request for FY 1998 reclassification to a large urban area for purposes of the standardized amount. Any hospital that does not requalify for MDH reinstatement for FY 1998 because of a reclassification to an urban area by the MGCRB for FY 1998 will be notified and given the opportunity to decline that reclassification.

D. Special Payment for Certain Nonteaching, Nondisproportionate Share Hospitals That Do Not Qualify as Medicare-Dependent, Small Rural Hospitals (§ 412.107)

Section 4401(b) of Public Law 105–33 provides a temporary special payment for FYs 1998 and 1999 for certain hospitals that do not receive any additional payment through the IME or DSH adjustment and do not meet the criteria to be classified as a Medicare-dependent, small rural hospital (MDH). As set forth in section 4401(b)(2), in order to qualify for the special payment, a hospital must be located in a State in which the aggregate operating prospective payment for hospitals that meet the special payment criteria (that is, non-IME, non-DSH, non-MDH hospitals) is less than the aggregate allowable operating costs of inpatient hospital services (referred to hereafter as a negative operating prospective payment margin) for those hospitals for their cost reporting periods that began during FY 1995. In addition, a hospital must have a negative operating prospective payment margin during the cost reporting period at issue (beginning in FY 1998 or 1999).

Under the provisions of section 4401(b)(1), for these hospitals, the percentage increase otherwise applicable to the standardized amount for FY 1998 will be increased by 0.5 percentage points and, for FY 1999, the applicable percentage increase will be increased by 0.3 percentage points. Based on the current law, this means that these hospitals will receive an update of 0.5 percent for FY 1998 (the update for all other hospitals is 0) and, for FY 1999, an update of the market basket increase minus 1.6 percentage points (1.9 for all other hospitals). Under section 4401(b)(1), in applying these updates, the increase provided in FY 1998 will not apply in computing the update for FY 1999 and neither update will affect the updates provided for discharges in fiscal years after FY 1999.

Under section 4401(b)(2) of Public Law 105–33, in determining whether a hospital qualifies for the special payment for a given cost reporting period, we must look first at statewide aggregate data for non-IME, non-DSH, non-MDH hospitals for cost reporting periods beginning during FY 1995, and second at hospital-specific characteristics for the cost reporting period at issue. With respect to the first criterion, we used the best data currently available. We used the latest update to the provider-specific file to identify those hospitals that do not receive IME or DSH payments. We also identified those hospitals that meet the criteria to be designated as an MDH. Using the latest update to the Health Care Provider Cost Report Information System (HCRIS), we examined the FY 1995 cost report data for the non-IME, non-DSH, and non-MDH hospitals identified above and found that the following States meet the criteria set forth in section 4401(b)(2)(B):

Alaska, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Missouri, New Hampshire, New Jersey, Ohio, Puerto Rico, Rhode Island, Vermont, Wisconsin,

For purposes of determining qualification for special payment under section 4401(b), this is the final list of qualifying States. We recognize that cost reports for cost reporting periods beginning during FY 1995 might be subject to further adjustments, and we considered the option of waiting until all FY 1995 cost reports are finally settled before determining the qualifying States. We rejected this approach because under the prospective payment system, we believe that, to the extent possible, we must set the payment parameters that will be applied to hospitals before the start of the fiscal year. If we waited several years for all FY 1995 cost reports to be settled before making this additional payment to the qualifying hospitals, hospitals would have less certainty about the amount of payments they would receive. Moreover, the intent of Congress to provide relief to hospitals in FYs 1998 and 1999 would be compromised. In addition, for purposes of computing the FY 1998 and 1999 standardized amounts and performing the necessary related calculations (for example, the budget neutrality adjustments), we need to make a prospective determination about which hospitals are likely to be affected. In short, then, for purposes of determining the qualifying States under section 4401(b)(2)(B), we have decided to use the best data available now.

With respect to hospital-specific characteristics, however, the statute requires that we look at data for the cost reporting period at issue (beginning in FY 1998 or 1999). That is, we must look at the cost reporting period at issue and determine whether the hospital has a negative operating prospective payment margin for that period, and whether the hospital received IME or DSH payments or qualified as an MDH for that period. Thus, the final determination as to whether a hospital is eligible for the add-on cannot be made until cost report settlement. We intend to make interim payment to these hospitals beginning with discharges occurring on or after October 1, 1997, based on the latest information available to the fiscal intermediaries. That is, if a hospital is in one of the 17 designated States, is not receiving IME or DSH payments in FY 1998 or 1999, is not an MDH, and, based on the latest cost report information available to the intermediary, has a negative operating prospective payment margin, the intermediary will pay the hospital based on the higher standardized amount *during* the fiscal year. As noted above, the final decision as to a hospital's qualification for the additional payment will be made at cost report settlement.

We have added a new § 412.107 to the regulations and revised § 412.90 to implement this provision. We note that in the Addendum and Appendix A to this final rule with comment period, we refer to the hospitals that qualify for the higher standardized amount as ''temporary relief'' hospitals.

E. Payments to Disproportionate Share Hospitals (§ 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients receive additional payments through the DSH adjustment. Section 4403(a) of Public Law 105–33 reduces the payment a hospital would otherwise receive under the current disproportionate share formula by 1 percent for FY 1998, 2 percent for FY 1999, 3 percent for FY 2000, 4 percent for FY 2001, 5 percent for FY 2002, and 0 percent for FY 2003 and each subsequent fiscal year. Therefore, the actual payment a hospital receives under DSH will be reduced by 1 percent for FY 1998. We are adding a new

paragraph (e) to § 412.106 to implement this provision.

In addition, section 4403(b) of Public Law 105–33 requires the Secretary to submit to Congress, no later than 1 year after enactment (that is, by August 5, 1998), a report that contains a formula for determining the amount of additional payments to disproportionate share hospitals. In determining the formula, the Secretary is required to establish a single threshold for costs incurred by hospitals in serving low-income patients, and consider the following costs:

(1) the costs incurred for furnishing hospital services to individuals entitled to Medicare Part A and SSI; and

(2) the costs incurred for furnishing services to individuals receiving Medicaid who are not entitled to benefits under Part A of Medicare, including individuals enrolled in a managed care organization or any other managed care plan under Medicaid and individuals who receive medical assistance in a State with an 1115 waiver under Medicaid. In developing the formula, the Secretary is given the authority to require hospitals receiving DSH payments to submit any information the Secretary finds necessary in order to develop the formula.

F. Payment for Blood Clotting Factor for Hemophilia Inpatients (§§ 412.2 and 412.115)

Hemophilia is a blood disorder characterized by prolonged coagulation time, caused by an inherited deficiency of a factor in plasma necessary for blood to clot. For purposes of this final rule with comment period, hemophilia is considered to encompass the following three conditions: Factor VIII deficiency (classical hemophilia); Factor IX deficiency (plasma thromboplastin component); and Von Willebrand's disease.

Section 6011 of Public Law 101–239 amended section 1886(a)(4) of the Act to provide that prospective payment hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) specified that the payment is to be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factor furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of Public Law 103–66 amended section 6011(d) of Public Law 101–239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Most recently, section 4452 of Public Law 105–33 amended section 6011(d) of Public Law 101–239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1997.

We are calculating the add-on payment for FY 1998 using the same methodology we used in the past. That is, we are establishing a price per unit of clotting factor based on the current price listing available from the 1997 Drug Topics Red Book, the publication of pharmaceutical average wholesale prices (AWP). We are setting separate add-on amounts, for the following clotting factors, as described by HCFA's Common Procedure Coding System (HCPCS). The add-on payment amount for each HCPCS code is based on the median AWP of the several products available in that category of factor, discounted by 15 percent.

Based on this methodology, the prices per unit of factor are as follows:

	Per unit
J7190 Factor VIII (antihemophilic factor-human)	$0.76
J7192 Factor VIII (antihemophilic factor-recombinant)	1.00
J7194 Factor IX (complex)	0.32
J7196 Other hemophilia clotting factors (e.g., anti-inhibitors)	1.10

These prices will be effective for add-on payment for blood clotting factors administered to inpatients who have hemophilia for discharges beginning on or after October 1, 1997 through September 30, 1998.

As noted above, we are following the same methodology as we have in previous years in calculating the FY 1998 add-on payment for the cost of administering blood clotting factors to hospital inpatients with hemophilia. In view of the brief period of time between the enactment of Public Law 105–33 and the need to reinstitute the add-on payment for blood clotting factors, we believe that using this methodology is the only viable alternative. However, we understand that hospitals may be able to obtain blood clotting factors at prices substantially below the median AWP. Thus, we believe it is possible that the methodology for determining add-on payment amounts could be revised to better reflect the actual costs of administering the blood clotting factors. We intend to examine our methodology before establishing the add-on payment amount for FY 1999 and are soliciting comments on the appropriateness of the add-on payment amount and suggestions for the best methodology to calculate this amount.

We have revised §§ 412.2(f)(8) and 412.115(b) to indicate that for discharges occurring on or after October 1, 1997, we will make an add-on payment for the costs of administering blood clotting factor to Medicare hospital inpatients who have hemophilia. We will reissue instructions to Medicare hospitals and fiscal intermediaries concerning the codes to use for clotting factor and how to use them. We note that payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia and the appropriate HCPCS code included on the bill.

G. Payments to Hospitals in Puerto Rico (§ 412.204)

Currently, the Puerto Rico payment rate for operating costs is based on 75 percent of the Puerto Rico-specific standardized amount and 25 percent of a national standardized amount. Section 4406 of Public Law 105–33 amended section 1886(d)(9)(A) of the Act to revise the Puerto Rico and national shares of the Puerto Rico payment rate. Beginning with discharges occurring on or after October 1, 1997, the Puerto Rico payment rate will be a blend of 50 percent of the Puerto Rico standardized amount and 50 percent of a national standardized amount. We are revising § 412.204 of the regulations to conform with this amendment.

H. Changes to the Indirect Medical Education Adjustment (§ 412.105)

1. Changes in the June 2, 1997 Proposed Rule

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 IME adjustment, are at § 412.105. The additional payment is based in part on 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.

The criteria governing whether a program is considered approved are currently at § 412.105(g)(1)(i). These criteria are the same as those used to identify approved programs for the direct graduate medical education

payment under § 413.86(b). In the August 30, 1991 final rule (56 FR 43237), we added a criterion to § 413.86(b), but inadvertently did not add it to § 412.105(g)(1)(i). This criterion added the Annual Report and Reference Handbook of the American Board of Medical Specialties (ABMS) as another publication to be used to identify approved programs.

Historically, we have used the same criteria to determine whether a residency training program is approved for payments under both the indirect and the direct graduate medical education payments. This has in fact been our policy with regard to whether programs listed in the ABMS' Annual Report and Reference Handbook are considered approved for IME adjustment payments, even though § 412.105(g)(1)(i) was not changed. To avoid any future confusion, we proposed to revise this section to parallel the changes made at § 413.86(b). We received no public comments on this proposal and are adopting this change in the final rule with comment period.

In addition, we proposed to delete current § 412.105(g)(1)(iv), which excludes from the IME resident count any anesthesiology residents employed to replace anesthetists. This exclusion was originally intended to prevent hospitals from hiring residents in lieu of nonphysician anesthetists. Given that certain rural hospitals continue to receive pass-through cost-based payment for their anesthetist costs, we no longer believe this provision is warranted. Nor are we aware of any specific instances where it has been applied. We received one public comment in support of this proposed revision and no opposing comments. Therefore, we are implementing this change in the final rule with comment period.

2. Changes to IME in Public Law 105–33

In addition to making the changes set forth above, we are revising the regulations to incorporate the provisions of section 4621 of Public Law 105–33, which revised section 1886(d)(5)(B) of the Act in several ways. First, it gradually reduces the current level of IME adjustment (approximately a 7.7 percent increase for every 10 percent increase in the resident-to-bed ratio) over the next several years. The schedule for the IME adjustment is as follows: 7.0 percent for discharges during FY 1998; 6.5 percent during FY 1999; 6.0 percent during FY 2000; and 5.5 percent during FY 2001 and thereafter.

Second, section 4621 established certain limits both on the full-time equivalent (FTE) number of residents counted by each hospital and on the resident-to-bed ratio. Effective for discharges on or after October 1, 1997, section 4621(b)(1) added a new section 1886(d)(5)(B)(v) to the Act to provide that a hospital's total number of resident FTEs in the fields of allopathic and osteopathic medicine may not exceed the total number of such resident FTEs in the hospital during its most recent cost reporting period ending on or before December 31, 1996. Furthermore, section 1886(d)(5)(B)(vi)(I), as added by section 4621(b)(1) of Public Law 105–33, provides that the ratio of residents-to-beds may not exceed the ratio of residents-to-beds during the prior cost reporting period (after accounting for the cap on the number of resident FTEs).

Third, for cost reporting periods beginning on or after October 1, 1997, and subject to the new limit on counting residents described above (as well as the expansion of allowable settings to off-site services, as described below), new section 1886(d)(5)(B)(vi)(II) provides that residents will be counted based on a 3-year rolling average. This policy will decrease the financial impact of downsizing residency programs. Resident counts for cost reporting periods beginning during FY 1998 will be based on an average of the number of residents from the past 2 years, and for subsequent periods, resident counts will be based on an average of the past 3 years.

With respect to medical residency training programs established on or after January 1, 1995, section 1886(d)(5)(B)(viii) provides that the Secretary must develop rules to apply these limits to new programs, giving special consideration to ''facilities that meet the needs of underserved areas,'' and to facilitate the application of aggregate limits in the case of affiliated groups (as defined by the Secretary). The Secretary may require any entity that operates a medical residency training program to submit additional information necessary to carry out the limits. We have revised the regulations at § 413.86(g)(6) to comply with these directions. For a more detailed explanation of this provision, see section V.I of the preamble concerning the direct graduate medical education payments.

Finally, section 4621(b)(2) amended section 1886(d)(5)(B)(iv) to allow all the time spent by a resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting to be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in the nonhospital setting. Therefore, we are revising current § 412.105(g)(1)(ii)(C), which allowed hospitals to include the time residents spent in certain community health centers, to also include nonhospital settings where residents' time may be counted for purposes of IME. The eligibility criteria for this new provision is similar to a provision regarding direct graduate medical education payments at section 1886(h)(4)(E) of the Act, and implemented at § 413.86(f)(iii). We will rely upon the same criteria for direct graduate medical education to identify eligible situations under this new IME provision.

In addition to the regulatory changes, we intend to issue instructions to fiscal intermediaries to implement these changes effective October 1, 1997.

We are also revising § 412.105(d) to reinsert instructions for determining the education adjustment factors that were incorrectly deleted in a correction notice published on January 29, 1996 (61 FR 2725), and deleting current paragraph (f), which describes the determination of full-time resident counts for cost reporting periods beginning prior to July 1, 1991.

Section 4622 of Public Law 105–33 added a new section 1886(d)(11) to the Act to provide for IME payments to teaching hospitals for discharges associated with Medicare managed care beneficiaries for portions of cost reporting periods occurring on or after January 1, 1998. The additional payment is equal to an ''applicable percentage'' of the estimated average per discharge amount that would have been made for that discharge if the beneficiary were not enrolled in managed care. The applicable percentage is set forth in section 1886(h)(3)(D)(ii) of the Act and is equal to 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years. We are adding a new paragraph (g) to § 412.105 to implement this provision.

I. Direct Graduate Medical Education (GME)

1. Newly Participating Hospitals (§ 413.86(e))

Under section 1886(h) of the Act and implementing regulations, Medicare pays hospitals for the direct costs of graduate medical education on the basis of per resident costs in a 1984 base year. Under existing regulations at

§ 413.86(e)(4), if a hospital did not have residents in the 1984 base period but later participates in teaching activities, the fiscal intermediaries calculate a per resident amount based on a weighted average of all the hospitals in the same geographic wage area. There must be at least three hospitals for this calculation. If there are fewer than three hospitals, the regulations require the fiscal intermediary to contact the HCFA Central Office for a determination of the appropriate amount to use.

We proposed to revise the regulations for determining base year per resident amounts for hospitals that participated in residency training after the 1984 base period. Under the proposed changes to § 413.86(e)(4)(i)(B), we sequentially follow the criteria listed below until we would base the weighted average calculation on a minimum of 3 per resident amounts:

- If there are fewer than three hospitals in the hospital's geographic wage area, we would determine a weighted average based on the per resident amounts for all hospitals in the hospital's own wage area, plus hospitals in geographically contiguous wage areas.
- If there are still fewer than three hospitals in the hospital's own wage area, plus hospitals in contiguous wage areas, the weighted average would be based on the per resident amounts for all hospitals in the State.
- If there are fewer than three hospitals in the entire State, the weighted average would be based on the per resident amounts for all hospitals in that State plus hospitals in contiguous States.
- If there are fewer than three hospitals in that State and contiguous States, the weighted average per resident amount would be based on the national average per resident amount.

Comment: One commenter stated that our proposed policy appears reasonable but we have not indicated how the policy would affect the per resident amounts for hospitals that previously had their payment amounts determined by HCFA Central Office.

Response: The proposed policy simply reflects the methodology in effect prior to this final rule with comment period. As discussed below, we are revising the methodology in this final rule with comment period. However hospitals that previously had a per resident amount determined by HCFA Central Office will be unaffected since policy changes can only be effective prospectively.

Comment: Two commenters suggested that the proposed methodology may negatively affect the expansion of training sites, particularly in rural areas where there might not be three hospitals with established per resident amounts. One of these commenters suggested that the hospital with the new training program be given the option of establishing a per resident amount based on its ''cost, not to exceed the higher of the contiguous area average, or the national average cost per resident, perhaps adjusted by the appropriate wage index.'' The other commenter suggested that if there are fewer than three hospitals, that we use the lower of the new hospital's cost per resident or the national average cost per resident adjusted by the hospital wage index. The commenter suggested that this approach would be consistent with HCFA initiatives to move from historical local or regional cost based payments to national averages. Another benefit of this approach according to this commenter is that it is simple and would overwhelmingly benefit rural hospitals.

Response: The per resident amounts vary widely among hospitals nationwide. Given this wide variation, we believe it is difficult to know whether a hospital establishing a new program in any given geographic area will receive a high or low per resident amount using our proposed methodology. Although the first commenter's suggested alternative is similar to the proposed policy, it guarantees a per resident amount for the new hospital that is either equal to or higher than the per resident amount under the proposed methodology if the hospital's own costs exceed the contiguous area average or the national average per resident amount. We find merit in the latter commenter's *suggested* alternative of using the lower of the hospital's own costs or a national average per resident amount. It has the advantage of being simple and equally as likely to produce an equitable rate as our proposed methodology. We support using the commenter's proposed methodology with a modification.

Thus, effective October 1, 1997 the per resident amount for new teaching hospitals is based on the lower of the hospital's actual per resident costs or:

- The weighted average of the per resident amounts for hospitals located in the same geographic area as that term is used in the prospective payment system under 42 CFR part 412.
- Where there are fewer than three hospitals in a geographic wage area, we will use regional weighted average per resident amounts determined for each of the nine census regions established by the Bureau of Census for statistical and reporting purposes.

2. New Legislative Changes to Direct Graduate Medical Education (Direct GME)

a. Limit on the Count of Residents (§ 413.86(g))

Section 4623 of Public Law 105–33 adds section 1886(h)(4)(F) of the Act to establish a limit on the number of allopathic and osteopathic residents that a hospital can include in its full time equivalent (FTE) count for Direct GME payment. Residents in dentistry and podiatry are exempt from the cap. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted direct medical education FTE count may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996.

Currently, hospitals report their weighted but not their unweighted FTE count on their Medicare cost report. New section 1886(h)(4)(H)(iii) of the Act gives the Secretary authority to collect whatever data are necessary to implement this provision. Hospitals have been required to report resident-specific information to their fiscal intermediaries under longstanding requirements of § 413.86, and we believe it is possible to implement section 1886(h)(4)(F) without mandating significant additional reporting. Since the unweighted direct GME FTE count will be used in calculating direct GME payments, we expect to amend the Medicare cost report to require hospitals to report the unweighted FTE direct GME count for future cost reporting periods. A separate data collection effort will be required to obtain the information for the most recent cost reporting periods ending on or before December 31, 1996.

We believe the hospital's unweighted FTE limit for its most recent cost reporting period ending on or before December 31, 1996 should be based on a 12 month cost reporting period. If the hospital's most recent cost reporting period ending on or before December 31, 1996, is a short period report, the fiscal intermediaries shall make adjustments so that the hospital's unweighted FTE limit corresponds to the equivalent of a 12 month cost reporting period. We are revising § 413.86(g)(4) accordingly.

(1) Counting Residents Based on a 3–Year Average (§ 413.86(g)(5))

Section 1886(h)(4)(G)(iii) of the Act, as added by section 4623 of Public Law 105–33, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for payment

purposes equals the average of the weighted FTE count for that cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, section 1886(h)(4)(G) of the Act requires that hospitals' direct medical education weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and the preceding 2 cost reporting periods. This provision provides incentives for hospitals to reduce the number of residents in training by phasing in the associated reduction in payment over a 3-year period. We are revising § 413.86(g)(5) accordingly.

For cost reporting periods beginning on or after October 1, 1997, we will determine the hospital's direct GME payment as follows:

Step one. Determine the average of the weighted FTE counts for the payment year cost reporting period and the prior two immediately preceding cost reporting periods (with exception of the hospital's first cost reporting period beginning on or after October 1, 1997, which will be based on the average of the weighted average for that cost reporting period and the immediately preceding cost reporting period).

Step two. Determine the hospital's allowable direct GME costs without regard to the FTE cap (before determining Medicare's share). That is, take the sum of (a) the product of the primary care per resident amount and the primary care weighted FTE count, and (b) the product of the non-primary care per resident amount and the non-primary care weighted FTE count.

Step three. Divide the hospital's allowable direct GME costs by the total number of FTE residents (including the effect of weighting factors) for the cost reporting period to determine the average per resident payment amount (this amount reflects the FTE weighted average of the primary and non-primary care per resident amounts) for the cost reporting period.

Step four. Multiply the average per resident payment amount for the cost reporting period by the 3 year average weighted count to determine the hospital's allowable direct GME costs. This product is then multiplied by the hospital's Medicare patient load for the cost reporting period to determine Medicare's direct GME payment to the hospital.

The following example illustrates determination of direct GME payment under the rolling average methodology:

Assume a hospital with a cost reporting period ending December 31, 1996 (beginning January 1, 1996) had 100 unweighted FTE residents and 90 weighted FTE residents. The hospital's FTE cap is 100 unweighted residents.

Step one. In its cost reporting period beginning January 1, 1997, it had 100 unweighted residents and 90 weighted residents.

- The hospital had 90 unweighted residents and 85 weighted residents for its cost reporting period beginning January 1, 1998.
- In its cost reporting period beginning on January 1, 1999, the hospital had 80 unweighted residents and 80 weighted residents.
- The 3 year weighted average for the hospital's cost reporting period beginning January 1, 1999 is 85 (90+85+80)/3).

Step two. Payment for the cost reporting period is determined by multiplying hypothetical per resident amounts for primary care and non-primary care residents as follows:

- Primary Care—$50,000×70 weighted FTEs=$3,500,000
- Other—$47,000×10 weighted FTEs=$470,000
- Total direct GME payments before using the 3-year average FTE counts and applying the Medicare patient load would be $3,970,000 ($3,500,000 + $470,000).

Step three. Divide $3,970,000 by 80 total FTEs (70+10) to determine an average per resident FTE payment of $49,625.

Step four. Multiply this figure by 85 FTEs (from step 1 above) to determine a total payment $4,218,125. Apply the hospital's Medicare patient load to determine Medicare's direct GME payment.

To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.

- Determine the ratio of the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, to the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
- Multiply the ratio determined above by the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. The hospital's unweighted count of interns and residents for a cost reporting period beginning before October 1, 1997 will not be subject to the FTE limit.

For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) * 100, or 90.9 FTE residents.

If a hospital's unweighted count of residents in specialties other than dentistry and podiatry does not exceed the limit, the weighted FTE count equals the actual weighted FTE count for the cost reporting period. The weighted FTE count in either instance will be used to determine a hospital's payment under the 3 year rolling average payment rules. We believe this proportional reduction in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.

Section 1886(h)(4)(G)(ii) of the Act provides that the Secretary makes appropriate modifications to ensure that the average FTE resident counts are based on the equivalent of full 12 month cost reporting periods. We are revising § 413.86(g)(5) to allow the fiscal intermediaries to make the appropriate adjustments to ensure that 3 year and 2 year average FTE counts are based on the equivalent of 12 month periods.

(2) Exceptions to the Direct GME FTE Limit (§ 413.86(g)(6))

Under new section 1886(h)(4)(H)(i) of the Act, the Secretary is required, consistent with the principles of establishing a limitation on the number of residents paid for by Medicare and the 3-year rolling average, to establish rules with respect to the counting of residents medical residency training programs established on or after January 1, 1995. Such rules must give special consideration to facilities that meet the needs of underserved rural areas. Language in the Conference Report indicates concern that there be proper flexibility to respond to changing needs given the sizeable number of hospitals

that elect to initiate new (or terminate existing) training programs.

Pursuant to the statute, we are establishing the following rules for applying the FTE limit and determining the FTE count for hospitals that established new medical residency training programs on or after January 1, 1995. For purposes of this provision, a ''program'' will be considered newly established if it is accredited for the first time, including provisional accreditation on or after January 1, 1995, by the appropriate accrediting body. Although the Secretary has broad authority to prescribe rules for counting residents in new programs, the Conference Report for Public Law 105–33 indicates concern that aggregate number of FTE residents should not increase over current levels. Accordingly, we will continue to monitor growth in the aggregate number of residency positions and may consider changes to the policies described below if there continues to be growth in the number of residency positions. We are providing for adjustments in the following situations:

(i) Hospitals with no Residents prior to January 1, 1995.

If a hospital had no residents before January 1, 1995 and it establishes one or more new medical residency training programs on or after that date, the hospital's FTE cap will be based on the number of first year residents participating in its accredited graduate medical education training programs in the third year of receiving payments for direct GME. The hospital's unweighted FTE resident cap will equal the product of the number of first year residents in that year and the number of years in which residents are expected to complete that program based on the minimum accredited length for the type of program as published in the *Graduate Medical Education Directory*.

For example, assume a hospital that did not receive any direct GME payment in its cost reporting period ending December 31, 1994 (the hospital's most recent cost reporting period ending before January 1, 1995) established an internal medicine program and receives direct GME payment for residents beginning a training program on July 1, 1998. The hospital's cap would be adjusted to reflect the resident cap for residents in the internal medicine program for its cost reporting periods ending in 1998 and 1999. In the hospital's cost reporting period ending December 31, 2000 (the third cost reporting period in which the hospital has residents), there are five first-year FTE residents participating in the hospital's internal medicine program. Since the minimum length listed for internal medicine programs in the *Graduate Medical Education Directory* is 3 years, this hospital's unweighted FTE cap can subsequently be adjusted by up to 15 FTEs.

(ii) Hospitals with Residents prior to January 1, 1995, not Located in Rural Areas

If a hospital is not located in a rural area and had residents in its most recent cost reporting period ending before January 1, 1995, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 but before August 5, 1997. An adjustment under this policy allows programs which began between January 1, 1995 and enactment of the statute to grow to full capacity. No adjustments to the FTE cap will be allowed for new medical residency training programs established on or after August 5, 1997.

An adjustment in the hospital's FTE limit for a new program will be based on the product of the number of first year residents in the third year of the newly established program and the minimum accredited length for the type of program published in the *Graduate Medical Education Directory*. The hospital's revised unweighted FTE limit reflects the number of residents in its most recent cost reporting period ending on or before December 31, 1996 adjusted for the incremental increase in its FTE count for newly established programs.

We are providing the following example to illustrate how to make adjustments to the FTE cap for newly established medical residency training programs in hospitals that received direct GME payments prior to January 1, 1995. Assume a hospital had an unweighted direct GME count of 100 FTE residents for its cost reporting period ending June 30, 1996 and the hospital, although it had 6 first year positions, began an internal medicine program on July 1, 1995 with only 4 first year residents. On July 1, 1996, the program expands to 10 residents (six first-year residents and four second-year residents). On July 1, 1997, the program has 16 residents (six first-year residents, six second-year residents and four third-year residents). Since the minimum accredited length for allopathic internal medicine programs listed in the *Graduate Medical Education Directory* is 3 years, the hospital's unweighted FTE cap can subsequently be adjusted to reflect 18 residents in the internal medicine program (six first-year residents × 3 years). In the hospital's cost reporting period ending June 30, 1996 (the initial cap year), the hospital had a total of 100 FTE residents including 4 in internal medicine. Thus, the hospital's adjusted cap equals 100 residents plus 14 (18–4) or 114 residents.

(iii) Hospitals Located in Rural Areas that had Residents before January 1, 1995 and Other Rural Hospitals that Added Residents Under (i) of this Section.

We would treat these rural hospitals the same as all other hospitals which had residents before January 1, 1995 with the exception that the unweighted FTE limit for these hospitals could be adjusted to reflect residents in new medical residency training programs established on or after August 5, 1997. That is, if these hospitals added new programs on or after August 5, 1997 the cap would be adjusted but not without limit. A hospital's unweighted limit would be adjusted for each new program based on the methodology described above based on the product of the number of first year residents in the third year of the newly established program and the minimum number of years of the accredited program. For these hospitals, the limit will only be adjusted for additional new programs but not for expansions of existing or previously existing programs.

A hospital seeking an adjustment to the unweighted direct GME FTE resident count limit under this exception policy must provide documentation to its fiscal intermediary justifying the adjustment.

(3) Aggregate Direct GME FTE Limit for Affiliated Institutions (§ 413.86(g)(4))

Section 1886(h)(4)(H)(ii) of the Act permits but does not require the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision would permit hospitals flexibility in structuring rotations within a combined cap when they share residents.

Pursuant to the broad authority conferred by the statute, we are establishing the following criteria to define ''affiliated group''.

- Hospitals in the same geographic wage area. For purposes of this provision, ''affiliated group'' includes two or more hospitals located in the same geographic wage area (as that term is used for purposes of the inpatient operating prospective payment system), if the hospital rotate residents to the other hospitals of the group during the course of the approved program.
- Hospitals that are not located in the same geographic wage area. If the hospitals are not located in the same

geographic wage area, we will consider them part of the same affiliated group if the hospitals are jointly listed in common as a major participating institution (as that term is used in the *Graduate Medical Education Directory*, 1997–1998) for one or more programs.

We are defining an affiliated group on an institution-wide basis. Hospitals may participate in many different specialty programs and may share residents for one specialty program with one hospital but share residents for a different program with another hospital. We recognize that hospitals may affiliate for the purpose of specific specialty programs, but for purposes of applying an aggregate cap, it is not administratively feasible to apply the cap on a program by program basis.

We are implementing all of the above provisions of section 1886(h)(4) of the Act effective with cost reporting periods beginning on or after October 1, 1997. The statute does not provide a specific effective date for the rules related to affiliated groups aggregating resident FTE counts. Because each of the special rules is operative in conjunction with FTE limit, we believe it is appropriate to implement these provisions on October 1, 1997. We welcome public comments on implementation of the provisions of Public Law 105–33 relating to direct GME payments.

b. Payments to Hospitals for Direct Costs of Graduate Medical Education of Medicare Managed Care Beneficiaries (§ 413.86(d)(2))

Section 4624 of Public Law 105–33 amended section 1886(h)(3) of the Act to provide a 5-year phase-in of payments to teaching hospitals for graduate medical education associated with services to Medicare managed care discharges for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment is equal to the product of the per resident amount, the total weighted number of FTE residents working all areas of the hospital (and nonhospital setting in certain circumstances) subject to the limit on number of FTE residents under section 1886(h)(4)(F) and the averaging rules under section 1886(h)(4)(G) of the Act described above, the ratio of the total number of inpatient bed days that are attributable to Medicare managed care enrollees to total inpatient days and the applicable percentage. The applicable percentages are 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years.

We are revising § 413.86(d)(2) to establish a 5-year phase-in payment methodology to hospitals for direct GME payments based on Medicare managed care enrollees for portions of cost reporting periods beginning on or after January 1, 1998. We will modify the Medicare cost report to determine direct GME payments associated with services to Medicare managed care enrollees.

Section 4001 of Public Law 105–33 adds section 1853(a)(3)(C) of the Act. New section 1853(a)(3)(C) requires the Secretary to implement a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors in Medicare payments to managed care organizations by no later than January 1, 2000. Public Law 105–33 also adds section 1853(a)(3)(B) of the Act to require the Secretary to collect data necessary from managed care organizations to implement this provision. We are currently considering the data requirements necessary to implement both the direct and indirect medical education and risk adjustment provisions. We plan to consult with organizations representing hospitals and managed care plans to develop an administrative mechanism for implementing both of these provisions.

c. Permitting Payment to Nonhospital Providers

Under section 4625 of Public Law 105–33, for cost reporting periods beginning on or after October 1, 1997, the Secretary is authorized but not required to establish rules for payment to ''qualified nonhospital providers'' for the direct costs of medical education incurred in the operation of an approved medical residency training program. Under the statute, qualified nonhospital providers include Federally Qualified Health Centers, Rural Health Clinics, Medicare + Choice organizations and such other nonhospital providers the Secretary determines to be appropriate. We expect to establish rules that specify the amounts, form, and manner in which payments will be made and the portion of such payments that will be made from each of the Medicare trust funds. The Secretary must reduce the aggregate amount paid to nonhospital providers to the extent payment is made for residents included in the hospital's FTE count. Since we have not previously made payments for direct graduate medical education to nonhospital providers, we are interested in receiving comment on how to implement this provision. We are particularly concerned that any methodology assure that Medicare does not pay two entities for the same training time.

In particular, we are interested in receiving public comments on how to determine appropriate payment for ambulatory sites. Under 42 CFR part 405 subpart E, federally qualified health centers and rural health clinics are paid on the basis of an all inclusive rate for each beneficiary visit for the covered services. We are interested in receiving public comments on whether we should pay these entities for GME on a cost basis, a per resident amount, or some other basis and how to determine Medicare's share of their costs. Similarly, since we have not previously made explicit payments to managed care plans for direct GME we are interested in how we should pay them.

Section 413.86(f)(1) allows hospitals to include resident time in nonhospital sites when the hospital incurs all or substantially all of the costs. Under § 413.86(f)(1)(iii)(B) we have defined ''all or substantially all'' to mean that the hospital has a written agreement with the nonhospital site that it will continue to pay the resident's salary for training time in that setting. We are interested in receiving comments on whether this is an appropriate standard for determining which institution should be paid for the resident's training time or whether there are other financial arrangements we should consider in determining which entity incurs ''all or substantially all'' of the costs.

d. Medicare Special Reimbursement Rule for Primary Care Combined Residency Programs (§ 413.86(g)(1))

Section 413.86(g)(2) requires full payment for residents within an initial residency period. Section 413.86(g)(3) requires residents beyond the initial residency period to be weighted as 0.5 FTE for purposes of determining GME payment. The initial residency period is defined as the minimum number of years required to become board eligible in specialty and is determined at the time a resident enters a medical residency training program. In the August 30, 1996 final rule (61 FR 46211), we clarified that the initial residency period for residents in combined medical residency training programs is limited to the time required to complete the longer of the composite programs.

Effective for residents in or beginning training on or after July 1, 1997, section 4627 of Public Law 105–33 amends section 1886(h)(5)(G) of the Act to require that the initial residency period for combined programs consisting only of primary care training, equals the longer of the composite programs plus one year. A primary care resident is a resident enrolled in an approved medical residency training program in

family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. This provision also adds one year to the initial residency period for combined primary care and obstetrics and gynecology programs. We are amending § 413.86(g)(1) to implement the provisions of section 1886(h)(5)(G) for residents in or beginning training on or after July 1, 1997.

J. Medicare Rural Hospital Flexibility Program

1. Previous Law—EACH/RPCH Program

Section 1820 of the Act, before the enactment of the Public Law 105–33 of 1997, established the Essential Access Community Hospital (EACH) program. Under that program, seven States received grants to develop rural health networks consisting of Rural Primary Care Hospitals (RPCHs) and EACHs. RPCHs are limited-service rural hospitals that provide outpatient and short-term inpatient hospital care on an urgent or emergency basis. They then release patients or transfer them to an EACH or other acute care hospital. To be designated as RPCHs, hospitals had to meet certain criteria, including requirements that they not have more than 6 inpatient beds for acute (hospital-level) care and maintain an average inpatient length of stay of no more than 72 hours.

Montana also has a separate, limited-service hospital program called the Medical Assistance Facility (MAF) program, which has been in operation since 1988. This program operates under a demonstration waiver from HCFA that allows these limited service hospitals to be reimbursed for providing treatment to Medicare beneficiaries even though they are not required to meet all requirements applicable to hospitals. In addition, HCFA supplies grant funding to the Montana Hospital Research and Education Foundation to provide technical assistance, liaison, public education, and other services to the MAFs. The first MAF was licensed and began participating in the demonstration in 1990. At this point a total of 12 MAFs have been licensed and certified. Additional facilities are in the process of considering a conversion to MAF status.

2. Changes Made by Balanced Budget Act of 1997

The new legislation replaces the current 7-State EACH/RPCH program with a new Medicare Rural Hospital Flexibility Program that will be available in any State that chooses to set up such a program and provide HCFA with the necessary assurances that it has developed, or is in the process of developing, a State rural health care plan meeting certain requirements, and that it has designated, or is in the process of designating, rural nonprofit hospitals or facilities as critical access hospitals (CAH).

To be eligible as a CAH, a facility must be a rural public or nonprofit hospital located in a State that has established a Medicare rural hospital flexibility program, and must be located more than a 35-mile drive from any other hospital or critical access hospital. In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and keep each inpatient for no longer than 96 hours, unless a longer period is required because of inclement weather or other emergency conditions, or a PRO or other equivalent entity, on request, waives the 96-hour restriction. An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. The facility is also required to meet certain staffing and other requirements that closely parallel the requirements for RPCHs.

The new legislation also defines a rural health network as an organization consisting of at least one CAH and at least one acute care hospital, the members of which have entered into agreements regarding patient referral and transfer, the development and use of communications systems, and the provision of emergency and nonemergency transportation. In addition, each CAH in a network must have an agreement for credentialing and quality assurance with at least one hospital that is a member of the network, or with a PRO or equivalent entity, or with another appropriate and qualified entity identified in the rural health care plan for the State.

3. Grandfathering of Existing Facilities

Under the new legislation, no new EACH designations would be made, but rural hospitals designated as EACHs under previous law would continue to be paid as sole community hospitals. The previous payment provisions applicable to RPCHs are repealed, and the law instead provides that CAHs will be paid on a reasonable cost basis for their inpatient and outpatient services. The law specifically provides that existing RPCHs and MAFs will be deemed as CAHs if these facilities or hospitals are otherwise eligible to be designated by the State as CAHs. Under a special provision applicable to the MAF program, the MAF demonstration project is extended until at least October 1, 1998, to allow for an appropriate transition between the MAF and CAH programs.

4. Provision of SNF-Level Care in RPCHs

Previous law provided specific rules relating to the number of beds that an RPCH could use to provide SNF-level care. As noted above, the new legislation provides considerable flexibility to a CAH with a swing-bed agreement to use inpatient beds for either SNF or acute care, as long as the total number of inpatient beds does not exceed 25 and the number of beds used at any one time for acute care does not exceed 15.

5. Implementing Regulations

To allow the changes made by the enactment of Public Law 105–33 to be implemented by the statutory effective date of October 1, 1997, we are publishing the interim rules set forth below. In developing these rules, our general approach has been to retain the provisions of existing RPCH regulations, except where the new legislation clearly requires us to make a change. We believe this approach will allow the new amendments to be implemented with a minimum of inconvenience for existing facilities and will serve as the basis for a smooth transition between the RPCH and CAH programs.

To implement the section 4201 amendments, we are revising existing regulations as follows:

- Part 409 (Hospital Insurance Benefits), § 409.30(a) is revised to specify that to qualify for posthospital SNF care in a hospital or CAH, a beneficiary must have received inpatient CAH care for at least 3 consecutive calendar days (rather than the 72 hours required previously for RPCHs). This change ensures that care in CAHs and in acute care hospitals is counted uniformly toward the prior stay requirement.
- Part 410 (Supplementary Insurance Benefits), § 410.2 is revised to add a ''CAH'' in the definitions of both ''*Participating*'' providers and ''*nonparticipating*'' providers. Also, § 410.152(k) is revised to delete the description of payment methods for RPCH outpatient services that were mandated under previous law and to reflect the new statutory provision. As

explained more fully below, the statute now provides that payment for these services is to be made on a reasonable cost basis. We are specifying that ''reasonable cost'' is to be determined under section 1861(v)(1)(A) of the Act and existing regulations in Parts 413 and 415. Then, § 410.155(a) is revised to add a critical access hospital (CAH) that meets the requirements of part 485 in the definition of *''Hospital''*. Furthermore, paragraph (b) is revised to add a CAH as a provider in which inpatient mental health services that are identified in paragraphs (b) (1) through (4) are not subject to mental health services limitations described in paragraph (b).

- Part 412 (Prospective Payment Systems for Inpatient Hospital Services) § 412.109 is revised to reflect the elimination of the EACH designation. However, we are retaining the provisions in current regulations that are needed to allow rural hospitals designated as EACHs under previous law to continue to be paid as sole community hospitals and, where appropriate, to obtain adjustments to their hospital-specific rates. We are revising the regulations to clarify that HCFA will terminate the EACH designation of a hospital that no longer complies with the terms, conditions, and limitations that were applicable when it was designated as an EACH.
- Part 413 (Principles of Reasonable Cost Reimbursement; Payment for End-Stage Renal Disease Services; Optional Prospectively Determined Payment Rates for Skilled Nursing Facilities), §§ 413.1(a)(1)(G), 413.13(c)(2)(iv), and 413.70 are revised to reflect the elimination of the previously applicable payment methods for RPCHs. As noted above, the provisions of the Medicare law applicable to payment for both inpatient and outpatient RPCH services (sections 1814(l) and section 1834(g) of the Act, respectively) were amended by sections 4201 (c)(3)(B) and (c)(5) of Public Law 105–33 to remove the previous payment provisions, including the provisions of section 1834(g)(1)(B), and require that payment to CAHs for these services be made on a reasonable cost basis. Reasonable cost is defined at section 1861(v)(1)(A) of the Act and in regulations. We have specified that ''reasonable cost'' is to be determined under section 1861(v)(1)(A) of the Act and existing Medicare reimbursement regulations at 42 CFR parts 413 and 415 and in the statute.
- Part 485, Subpart F (previously Conditions of Participation for Rural Primary Care Hospitals) is revised to reflect the new CAH statutory requirements regarding the definition of a rural health network, status and location requirements, designation requirements for CAHs, the requirements regarding the content of network agreements, number of beds and length of stay permitted, and the special requirements for CAHs that provide SNF-level services.

We recognize that some facilities which received approval from HCFA under previous law to provide SNF-level services, may wish to continue operating under the terms of that approval. To authorize this, the regulations will allow a CAH that participated in the Medicare program as a rural primary care hospital (RPCH) on September 30, 1997 and, on that date, had in effect an approval from HCFA to use its inpatient facilities to provide posthospital SNF care, to continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

However, a CAH that was granted swing-bed approval under previous law may request by January 1, 1998 that HCFA evaluate its application to be a CAH and a swing-bed provider under the current law and the regulations set forth below. If this request is approved, the approval is effective not earlier than October 1997. As of the date of approval, the CAH no longer has any status based on its previous approval and may not request reinstatement under previously effective provisions.

We are also making nomenclature changes in various sections of Parts 400, 409, 410, 411, 413, 414, 424, 440, 485, 488, 489, and 498 to reflect the statutory change from RPCHs to CAHs.

6. Other Implementation Issues

a. Process for Review and Acceptance of State Assurances

States interested in establishing a Medicare rural hospital flexibility program will submit to the Regional Administrator of the HCFA Regional Office responsible for oversight of Medicare and Medicaid in the State, an application signed by an official of the State. The application will express the State's interest in establishing a Medicare rural hospital flexibility program and will contain, at a minimum, the following assurances and other information:

The State must provide assurances that—

(1) The State has developed, or is in the process of developing, a State rural health care plan that provides for the creation of one or more rural health networks as defined in § 485.603(a), promotes regionalization of rural health services in the State, and improves access to hospitals and other health services for rural residents of the State;

(2) The State has developed a rural health care plan in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such a plan, that assures the Secretary that the State will consult with these organizations); and

(3) The State has designated or is in the process of designating (consistent with the rural health plan), rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

The State must also provide other information to support its assurances, as follows:

(1) A copy of the State rural health care plan. If the State is in the process of developing the plan, the State should submit a copy of the current draft of the plan along with an anticipated completion date;

(2) An explanation of how the State rural health plan will provide for the creation of one or more rural health networks, promote regionalization of rural health services, and improve access to hospitals and other health services for rural residents of the State; and

(3) a listing of the facilities which the State has designated, or plans to designate, as critical access hospitals.

Section 1820(b)(3) of the Act authorizes HCFA to require other information and assurances in support of a State rural health plan. Therefore, HCFA will send the State a written request for any other information it may need to complete review of the application to establish a Medicare Rural Hospital Flexibility Program. HCFA will review the application from the State for the assurances listed above and will notify the State in writing of its decision on the State's application. Facilities designated under an approved plan will be eligible for certification by the HCFA Regional Office as CAHs, in accordance with the regulations in 42 CFR Part 485, Subpart F.

We welcome comments on whether the information and assurances set forth above are sufficient, or whether other information or assurances are needed. We will consider this issue carefully and notify States in writing of any changes in the information or assurances required.

b. Designation of Facilities in Border States

Section 1820(k), as in effect prior to the enactment of the Public Law 105–

33, explicitly authorized States with EACH programs to designate facilities in adjacent States as EACHs or RPCHs if certain conditions were met. Section 4201 of Public Law 105–33 deleted that authority. Therefore, a facility can be designated as a CAH only by a State in which it is located. The regulations as revised at § 485.606 have deleted any reference to this authority.

c. Designation of Closed Facilities

Section 1820(f)(1)(B), as in effect prior to the enactment of Public Law 105–33, explicitly allowed, under certain circumstances, States with EACH programs to designate facilities as RPCHs even though the facilities had closed and were not longer functioning as hospitals at the time they applied for RPCH status. The new legislation removed that authority so there is now no basis on which a closed facility can be designated as a CAH. We have revised § 485.612 to reflect this change.

K. Changes to the Update Factors for Federal Rates for Inpatient Operating Costs (§ 412.63)

Public Law 105–33 made several revisions to the applicable percentage change (the update factor) to the Federal rates for prospective payment hospitals. Section 4401(a)(1) of Public Law 105–33 amended section 1886(b)(3)(B)(i) of the Act to revise the update factors for the Federal rates for inpatient operating costs for FYs 1998 through 2002. The update factor for FY 1998 is now 0 percent for hospitals in all areas. For FY 1999, the update for hospitals in all areas is the market basket rate of increase minus 1.9 percentage points. (As discussed in detail in section V.D. of this final rule with comment period, section 4401(b) provides for a higher update in FY 1998 and FY 1999 for certain hospitals that do not receive disproportionate share or indirect medical education payments and are not designated as Medicare-dependent, small rural hospitals.) For FY 2000, the update for all areas is the market basket rate of increase minus 1.8 percentage points. For FY 2001 and FY 2002, the update for all areas is the market basket rate of increase minus 1.1 percentage points. For FY 2003 and subsequent years, the update for all areas is the market basket rate of increase. The specific updates to be applied for FY 1998 are discussed in the addendum and Appendix D to this document.

In this final rule with comment period, we are making the necessary changes to § 412.63 to implement these provisions.

L. Change in the Publication Date of the Proposed and Final Rules for the Hospital Inpatient Prospective Payment System (§ 412.8)

Section 4644(b) of Public Law 105–33 amends section 1886(e) of the Act to require the Secretary to publish the proposed and final rules that contain her proposed and final recommendations on the annual update factor applicable to the hospital payment rates by the April 1 and August 1 prior to the start of the fiscal year to which the rates apply beginning with the FY 1999 rates. The current schedule calls for publication on May 1 and September 1. We are revising § 412.8(b) and (c) of the regulations to implement this change. In that section, we are also deleting the current paragraph (a) since it is redundant.

M. Technical Change: Correction of Statutory Citation

The August 30, 1996 final rule (61 FR 46165) included an amendment to § 489.27 that reprinted the statutory reference governing the distribution of an ''Important Message from Medicare.'' This reference, ''section 1886(a)(1)(M)'', was incorrect. We are correcting this reference to read ''section 1866(a)(1)(M)''.

VI. Changes to the Prospective Payment System for Capital-Related Costs

A. Possible Adjustment to Capital Prospective Payment System Minimum Payment Levels

Section 412.348(b) of the regulations provides that, during the capital prospective payment system transition period, any hospital may receive an additional payment under an exceptions process if its total inpatient capital-related payments under its payment methodology (that is, fully prospective or hold-harmless) are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment levels are established by class of hospitals under § 412.348(c). The minimum payment levels for portions of cost reporting periods occurring in FY 1997 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 for previous cost reporting periods exceeds its cumulative minimum payment levels for those cost reporting periods is deducted from the additional payment that would otherwise be payable for a cost reporting period.

Section 412.348(g) also provides for a separate special exceptions process for hospitals undertaking major renovations or replacement of aging facilities during the decade of the transition. For as long as 10 years beyond the end of the transition period, certain hospitals may be eligible to receive special exceptions payments at a 70 percent minimum payment level. For hospitals that qualify for the special exceptions provision before the end of the transition, the general and special exceptions provisions will run concurrently during the later years of the transition. However, since the minimum payment level for the special exceptions provision is at the same level that applies to all hospitals under the general provision (currently 70 percent), the special exceptions provision will generate no additional payment to hospitals until the end of the transition period.

Section 412.348(h) further provides that total aggregate estimated exceptions payments under both the regular exceptions process and the special exceptions 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. In the FY 1997 final rule implementing the prospective payment system for capital-related costs, we stated that the minimum payment levels in subsequent transition years would be revised, if necessary, to keep the projected percentage of payments under the exceptions process at no more than 10 percent of capital prospective payments.

In section III of the Addendum to the June 2, 1997, proposed rule (62 FR 29951), we discussed the factors and adjustments used to develop the FY 1998 Federal and hospital-specific rates. In particular, we discussed the FY 1998 exceptions payment reduction factor. This factor adjusts the annual payment rates for the estimated level of additional payments for exceptions in FY 1998. In the proposed rule, we estimated that exceptions payments would equal 7.24 percent of aggregate

payments based on the Federal rate and the hospital-specific rate. We indicated that in the final rule we would develop a new estimate of the level of exceptions payments, and revise the exceptions payment adjustment factor accordingly, on the basis of the data that became available to us prior to publication of the final rule for FY 1998. We model exceptions payments based on the best information available on hospitals' actual payment methodology. We also indicated that while it was not necessary at that time to propose reductions in the minimum payment levels, we might find it necessary to implement adjustments to the minimum payment levels in the final rule. We, therefore, provided public notification that adjustments to the minimum payment levels were possible in the FY 1998 final rule.

As explained in Appendix B, since publication of the proposed rule, we have made a change to our model with regard to admissions. This change has caused the number and dollar value of exceptions to drop significantly. We are now estimating that exceptions payments will equal 3.41 percent of aggregate payments based on the Federal rate and hospital-specific rate in FY 1998, instead of the 7.24 percent we estimated in the proposed rule. This also means the exceptions payment reduction factor, which accounts for expected exceptions payments, will reflect a 3.41 percent reduction to the rates for FY 1998, rather than a 7.24 percent reduction. Because of this change in our estimate of exceptions payments, we will not have to adjust minimum payment levels for FY 1998 to keep exceptions within 10 percent of total payments.

In the proposed rule we indicated that when it did become necessary to adjust the minimum payment levels in accordance with § 412.348(h), we would contemplate adjusting each of the existing levels (that is, 90 percent for sole community hospitals, 80 percent for large urban DSH hospitals, and 70 percent for all other hospitals and special exceptions) by 5 percentage point increments until estimated exceptions payments were within the 10 percent limit. For example, we would set minimum payment levels at 85 percent for sole community hospitals, 75 percent for large urban DSH hospitals, and 65 percent for all other hospitals and special exceptions, provided that aggregate exceptions payments at those minimum payment levels were projected to be no more than 10 percent of total rate-based payments. We indicated our belief that this policy appropriately provided for all classes of hospitals to share in the reduction in exceptions payments, while simultaneously preserving the special protections provided by higher minimum payment levels for sole community hospitals and large urban DSH hospitals relative to all other hospitals. If aggregate exceptions payments at those minimum payment levels still exceeded 10 percent of total rate-based payments, we proposed to continue reducing the minimum payment levels by 5 percentage point increments each until the requirement of § 412.348(h) was satisfied. We provided notification of our thinking on this issue in order to solicit public comment on the appropriate method for adjusting the minimum payment levels.

Comment: We received several comments expressing concern about our proposal to cut minimum payment levels in five percentage point increments, if necessary, to stay within the ten percent limit on overall exceptions payments. The commenters expressed concern that cutting the minimum payment levels by five percentage increments might reduce exception payments more than necessary to stay within the ten percent cap. Some commenters stated that using five percent incremental adjustments instead of something more exact was not consistent with the level of specificity that HCFA uses to make other types of adjustments, and recommended that we use the same level of specificity in making adjustments to the minimum payment levels that we use in making other types of adjustments. Some commenters recommended that we adjust minimum payment levels by tenths of a percent. One commenter noted that because the minimum payment levels vary by type of hospital—90 percent for sole community hospitals, 80 percent for urban DSH hospitals, and 70 percent for all other hospitals and special exceptions, cutting all hospitals by the same percentages would affect some hospitals more than others.

Response: After considering the commenters' concerns, we have decided it would be appropriate to adjust each of the minimum payment levels by one percentage point increments in order to meet the ten percent limit. We are changing the regulations at § 412.348 to reflect this change in our policy. We will make an adjustment to the minimum payment levels when necessary by applying this policy.

We decided not to implement the suggestion made by some commenters that we adjust the minimum payment levels to the tenth of a percent level. We believe such precise adjustments are inappropriate in this context because our calculations reflect estimates, not exact figures. We have also decided not to adjust groups with higher minimum payment levels, such as sole community hospitals and urban DSH hospitals, more than groups with lower minimum payment levels, such as all other hospitals and special exceptions. At the time we established the minimum payments, at the inception of capital PPS, we decided that some groups warranted higher exception payments because of the type of care they provided or their location in a particular community. We believe it is still appropriate to maintain those higher levels of exception payments for sole community hospitals and urban DSH hospitals.

Comment: One commenter suggested that we use excess funds not paid out for outliers to fund the shortfall in capital exceptions.

Response: The commenter misunderstands the prospective nature of outlier and capital exceptions policies and projections. We set payment parameters such as outlier thresholds and capital minimum payment levels before a fiscal year based on estimates. We also make prospective adjustments to the applicable rates (operating standardized amounts or capital Federal rates) to account for the projected level of outlier payments or capital exceptions payments. Thus, for example, we set outlier thresholds so that the outlier payments for operating costs are projected to equal 5.1 percent of total DRG operating payments, and we adjust the operating standardized amounts correspondingly. We do not set aside a pool of money to fund outlier cases. Moreover, once the payment parameters and adjustments are established for a fiscal year, we do not make retroactive adjustments based on differences between estimated and actual payments, whether actual payments are higher or lower than estimated payments.

B. Special Exceptions Application Process

As discussed in section VI.A above, a separate special exceptions provision extends protection to certain hospitals undertaking major renovation or replacement of aging facilities during the decade of the transition. The regulation establishing eligibility for this special exceptions provision, and describing the criteria by which eligible hospitals qualify for special exceptions payments (§ 412.348(g)), was finalized on September 1, 1994 (59 FR 45385). In the proposed rule, we did not propose to make any policy changes to the

special exceptions provision. However, we had received questions from hospitals and intermediaries about the special exceptions process, and we discussed a few aspects of that process particularly with regard to the age of assets test and the excess capacity test. We reviewed the application process, the project need requirement, the project size requirement, and the excess capacity test. We specified that based on the latest data available, we had decided to set the 75th percentile for the age of assets test at 15.4 years rather than the 16.4 years we had originally contemplated.

We received no comments on these clarifications to the special exceptions process.

C. Reduction to the Standard Federal Capital Payment Rate and the Unadjusted Hospital-Specific Rate

Section 4402 of Public Law 105–33 amended section 1886(g)(1)(A) of the Act to require that, for discharges occurring on or after October 1, 1997, the Secretary must apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in § 412.352) to the unadjusted standard Federal capital payment rate (as described in § 412.308(c)) effective September 30, 1997, and the unadjusted hospital-specific rate (as described in § 412.328(e)(1)) effective September 30, 1997. For discharges occurring on or after October 1, 1997, and before September 30, 2002, the Secretary must reduce the same rates an additional 2.1 percent.

The budget neutrality adjustment factor effective September 30, 1995 was .8432 (59 FR 45416) which is equivalent to a 15.68 percent ((1.0 − .8432) * 100) reduction in the unadjusted standard Federal capital payment rate and the unadjusted hospital-specific rate in effect on September 30, 1997. The additional 2.1 percent reduction to the rates reduces the rates in effect on September 30, 1997 by a total of 17.78 percent. The unadjusted standard Federal rate must be distinguished from the annual Federal rate actually used in making payment under the capital PPS system. The unadjusted standard Federal rate is the underlying or base rate used to determine the Federal rate for each Federal fiscal year by applying the formula described in § 412.308(c). The annual Federal rate is the result of that determination process in § 412.308(c).

Under the statute, the additional 2.1 percent reduction applies for a limited time. The language at section 4402 indicates the 2.1 percent reduction applies to discharges occurring ''*before* September 30, 2002''. This would require that we calculate special rates that would be in effect for only one day. We believe that Congress intended to apply the reduction to discharges occurring *through* September 30, 2002. Accordingly, we plan to seek a technical correction to change the date that the 2.1 percent reduction expires from September 29, 2002, to September 30, 2002. Since we assume this technical error will be corrected, we are using the September 30, 2002 expiration date in our regulations.

When we restore the 2.1 percent reduction to the Federal rate after September 30, 2002, we plan to restore the rate to the level that it would have been without the reduction. We determined the adjustment factor for FY 1998 by deducting both cuts (.1568 and .021) from 1 (1 − .1568 − .021 − .8222). We then applied .8222 to the unadjusted standard Federal rate. The adjustment factor to restore the 2.1 percent cut would be the adjustment without the 2.1 percent cut (.8432) divided by the adjustment with the 2.1 percent cut (.8222) (.8432/.8222=1.02554). To restore the 2.1 percent reduction, we will apply 1.02554 to the unadjusted standard Federal capital payment rate in setting rates for discharges after September 30, 2002.

Section 412.328(e) of the regulations provides that the hospital-specific rate for each fiscal year is determined by adjusting the previous fiscal year's hospital specific rate by the hospital specific rate update factor and the exceptions payment adjustment factor. After these two adjustments are applied, a net adjustment to the rate is determined. The previous year's hospital specific rate is analogous to the standard Federal rate, which is updated each year to become the annual Federal rate.

When the 2.1 percent reduction is restored, most hospitals will have completed the transition to a fully prospective payment system for capital related costs. However, new hospitals might be eligible for hold harmless payments beyond the transition, so we may need to continue to compute a hospital specific rate. If we need to restore the 2.1 percent reduction to the hospital specific rates, we will do so in a manner similar to that described above with respect to the unadjusted standard Federal capital payment rate.

In this final rule with comment period, we are revising two sections of the capital prospective payment system regulations to implement these statutory requirements. Specifically, we are revising the regulations at §§ 412.308(c) and 412.328(e) to provide for the required 15.68 and 2.1 percent reduction to the rates. The 2.1 percent reduction will be restored after September 30, 2002.

We discuss the effect of this reduction to the standard Federal rate and other changes in the adjustment factors to the FY 1998 Federal rate in section III of the Addendum to this final rule with comment period.

D. Revision to the Calculation of the Puerto Rico Rate

Currently, operating and capital payments to hospitals in Puerto Rico are paid on a blend of 75 percent of the Puerto Rico rate based on data from Puerto Rico hospitals only, and 25 percent of the national rate based on data from all hospitals nationwide. As described in section V.I of this preamble, the Balanced Budget Act of 1997 increases the national share of the operating payment from 25 percent to 50 percent, and decreases the Puerto Rico share of the operating payment from 75 percent to 50 percent. Under the broad authority of section 1886(g) of the Act, we are revising the calculation of capital payments to Puerto Rico as well, to parallel the change that is being made in the calculation of operating payments to Puerto Rico. Effective October 1, 1997, we will base capital payments to hospitals in Puerto Rico on a blend of 50 percent of the national rate and 50 percent of the Puerto Rico specific rate. This change will increase payments to Puerto Rico hospitals since the national rate is higher than the Puerto Rico rate.

In this final rule with comment period, as required by Public Law 105–33, we are reducing the unadjusted standard Federal rate and hospital-specific rate by 17.78 percent for discharges occurring on or after October 1, 1997, and before October 1, 2002. Section 1886(g) of the Act confers broad authority on the Secretary to implement a capital prospective payment system. In accordance with this authority, we are extending the reduction to the capital rates to the Puerto Rico capital rates as described in § 412.374(a).

VII. Changes for Hospitals and Units Excluded From the Prospective Payment System

A. New Requirements for Certain Hospitals Excluded From the Prospective Payment System (§ 412.22(e))

In the September 1, 1994 final rule (59 FR 45330), we established several additional criteria for excluding from

the prospective payment system long-term care hospitals that occupy space in the same building or on the same campus as another hospital (§ 412.23(e)). Under these criteria, such facilities (sometimes called ''hospitals within hospitals'') could qualify for exclusion only if the two entities have separate governing bodies, chief executive officers, medical staffs, and chief medical officers. In addition, they were required to be capable of performing certain basic hospital functions without assistance from the hospitals with which they are co-located, or they had to receive at least 75 percent of their inpatients from sources other than the co-located hospital. We further revised these regulations on September 1, 1995 (60 FR 45778), by adding a third option under which hospitals that did not meet the criteria specified above could establish separate operation by showing that no more than 15 percent of their inpatient operating costs were attributable to the hospital with which they share space.

The regulations were necessary to prevent inappropriate Medicare payments to entities that are in effect, long-stay units of other hospitals. At the same time, the regulations set forth criteria to ensure that entities may qualify for exclusion from the prospective payment system if an exclusion is warranted. Exclusion of long-term care hospitals from the prospective payment system is appropriate when hospitals have few short-stay or low-cost cases and might be systematically underpaid if the prospective payment system were applied to them. These reasons for exclusion do not apply if the entity that provides the long-term care is part of a larger hospital, which does have short-stay and low-cost cases and can be paid appropriately under the prospective payment system.

ProPAC has recommended that HCFA monitor the growth in the number of long-term care hospitals within hospitals and evaluate whether the current Medicare certification rules that apply to these facilities should be changed (Recommendation 31). ProPAC noted that there is concern that the hospital-within-a-hospital model was devised as a way for acute care hospitals to receive higher payments for their long-stay cases. At the same time, the model may be an appropriate and efficient alternative to acute inpatient care for cases that require additional services, but at a more intense level than those provided in other post-acute settings. ProPAC recommended that HCFA conduct a comprehensive study of the characteristics, patient mix, treatment patterns, costs, and financial performance of hospitals within hospitals.

We have been monitoring the development of the hospital-within-a-hospital model. We agree with ProPAC that our policy should simultaneously strive to prevent inappropriate exclusions of units as separate hospitals, while allowing an appropriate degree of flexibility for facilities to respond to changing patient care needs. As a result of our monitoring efforts, in the June 2, 1997 proposed rule, we proposed two changes to the hospital-within-a-hospital regulations (62 FR 29928). We proposed to add a new § 412.22(f) to address hospitals that are unable to meet certain exclusion criteria solely because of State law. In addition, we proposed to extend the application of these rules to other classes of facilities that might seek exclusion from the prospective payment system as hospitals-within-hospitals.

As discussed in detail in the proposed rule, the first proposed change concerned the relationship between the exclusion criteria and State laws. Specifically, we proposed to add § 412.22(f) to address hospitals that, as a matter of State law, would be unable to make the necessary organizational changes to meet the hospital-within-a-hospital criteria. Under our proposal, if a hospital could not meet the criteria in §§ 412.23(e)(3) (i) or (iii) (proposed to be redesignated as §§ 412.22(e) (1) and (3)) solely because its governing body or medical staff is under the control of a third entity that also controls the hospital with which it shares a building or a campus or cannot meet the criteria in §§ 412.23(e)(3) (ii) or (iv) (proposed to be redesignated as §§ 412.22 (e)(2) and (e)(4)) solely because its chief medical officer or chief executive officer is employed by or under contract with such a third entity, the hospital could nevertheless qualify for an exclusion if that hospital meets the other applicable criteria and:

- Is owned and operated by a State university;
- Has been continuously owned and operated by that university since October 1, 1994;
- Is required by State law to be subject to the ultimate authority of the university's governing body; and
- Was excluded from the prospective payment system as a long-term care hospital for any cost reporting period beginning on or after October 1, 1993, but before October 1, 1994.

We solicited comments and suggestions on this issue as well as on whether the language of the proposed rule effectively addressed the situation of hospitals disadvantaged by State law.

We also proposed to redesignate § 412.23 (e)(3) through (e)(5) which specifies the criteria for hospitals-within-hospitals as § 412.22(e), (g), and (h). This change would have extended the application of the hospital-within-a-hospital rules to all types of facilities that can be excluded from the prospective payment system. As we stated in the proposed rule, we believe it is important to exclude, *as hospitals* only bona fide separate hospitals, not units of larger hospitals. We also proposed to incorporate, within this extended hospital-within-a-hospital rule, the above provisions that we proposed for facilities owned and operated by a State university.

At the same time, we were considering whether it was appropriate for new hospitals-within-hospitals to receive the exemption from the TEFRA rate-of-increase ceiling during the first 2 years of operation. We stated that the purpose of the new hospital exemption was to recognize that a hospital might face a period of cost distortions as it began operations and tried to establish its presence in its market. We did not believe that newly established hospitals-within-hospitals would necessarily face the same degree of cost distortion during their initial periods of operation since they operate within existing, identifiable hospitals. While we did not formally propose elimination of the new hospital exemption for hospitals-within-hospitals at this time, we proposed considering adoption of such a provision in this year's final rule. We invited comment on whether elimination of the new hospital exemption for hospitals-within-hospitals would be advisable.

As discussed in detail below, Public Law 105–33 made changes in the treatment of certain long-term care hospitals. As a result of this new legislation, we are withdrawing our proposal regarding State owned hospitals-within-hospitals and implementing our proposal concerning the extension of the hospital-within-hospital rules with some changes. The discussion that follows details the provisions of section 4417 of Public Law 105–33, explains how these provisions will be implemented, and responds to comments on the proposed rule.

Section 4417 of Public Law 105–33 specifies that a hospital that was classified by the Secretary on or before September 30, 1995, as an excluded long-term care hospital shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

This statutory provision supersedes certain aspects of the current regulatory requirements for long-term care hospitals-within-hospitals, and affects our proposal to extend the hospital-within-a-hospital criteria to excluded hospitals other than long-term care hospitals. While the amendment made by section 4417 of Public Law 105–33 is specific to long term care hospitals, we believe the considerations underlying the legislation also apply to other types of hospitals-within-hospitals.

In view of this statutory change and to provide for consistent treatment of all excluded hospitals-within-hospitals, we have decided to withdraw our proposal to include a specific provision for State-owned hospitals-within-hospitals. Instead, we are revising § 412.22(e) of the regulations to provide that for cost reporting periods beginning on or after October 1, 1997, if a hospital 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, the hospital must meet the hospital-within-a-hospital criteria unless the hospital was excluded from the prospective payment system on or before September 30, 1995, in which case the hospital-within-a-hospital criteria do not apply. This provision would apply to all types of excluded hospitals, not just long-term care hospitals. The extension of the hospital-within-a-hospital criteria to hospitals not exempt from the criteria based on their status before October 1995 would be prospective only for cost reporting periods beginning on or after October 1, 1997. We wish to emphasize that the grandfathering provision based on a hospital's pre-October 1995 status would not be made available to any hospital which may have been excluded at one time but lost its exclusion for reasons unrelated to hospital-within-a-hospital status.

Comment: One commenter argued that many hospitals sharing space with others will need additional time to comply with the hospital-within-a-hospital rules, since they may need to recruit added staff, make arrangements with new vendors, and reorganize their administrative staff and governing bodies. The commenter suggested that, to allow these changes to be made, the effective date should be changed so that these hospitals would first have to meet the requirements for cost reporting periods beginning on or after October 1, 1998 or October 1, 1999. Another commenter suggested that the proposed effective dates would result in impermissible retroactive rulemaking, and recommended that each hospital potentially subject to the new rules be grandfathered for at least one cost reporting period to allow for an orderly transition. Another commenter suggested that the proposal regarding State-owned hospitals may be moot as a result of section 4417 of Public Law 105–33, which specifically requires grandfathering of all long-term care hospitals-within-hospitals that were excluded on September 30, 1995.

Response: We agree that, in view of section 4417 of Public Law 105–33, it would not be appropriate to adopt our proposals regarding hospitals-within-hospitals as stated in the proposed rule. We have considered the commenter's concerns; however, we believe use of a single effective date of October 1, 1997 will result in the most simple and consistent implementation of the rule.

Comment: One commenter objected to the parts of the proposal under which a hospital would have been required to have been continuously owned and operated by a State university since October 1, 1994, and would have been required to have been excluded for a cost reporting period beginning after September 30, 1993 but before October 1, 1994. The commenter asserted that these provisions would exclude otherwise qualified facilities from the grandfathering provision.

Response: As noted above, we are not adopting the proposal regarding State-owned hospitals, but have extended the grandfathering provision to all types of excluded hospitals which were excluded on or before September 30, 1995.

Comment: A commenter suggested that the provisions of the proposed rule not be applied to hospitals co-located with long-term care hospitals or to any excluded hospitals that share space. The commenter reasoned that this would be unnecessary because in such cases where both hospitals are excluded and serve discrete patient types, there is no incentive for inappropriate transfers, referrals, or other abusive practices. The commenter also recommended that the organizational separateness requirements not be applied where 75 percent or more of a hospital's referrals come from outside sources.

Response: We believe the rule should be applied to situations in which the hospitals that share space are all excluded. Even in the absence of a new provider exemption to the TEFRA limit, a hospital may have incentives to inappropriately establish a hospital-within-a-hospital. For example, the two facilities may have different target rates and this may lead to the diversion of some patients to one of the hospitals for reasons of payment rather than for the benefit of the patient. Moreover, the types of populations treated by different types of excluded facilities are not mutually exclusive: rehabilitation patients can be treated in a long-term care hospital, and rehabilitation hospitals are not precluded from accepting and treating long-stay patients. Thus, permitting exclusion of such ''hospitals'' within other hospitals may create incentives for abuse that would be diluted or absent if the facilities were freestanding. Regarding the 75 percent referral requirement, we note that it is intended to measure functional separateness and thus complements, but cannot replace, the structural separateness tests.

Comment: One commenter stated that although some hospitals have been co-located with others for many years they have not gained an unfair advantage. The commenter also believed that the hospital-within-a-hospital criteria relating to control over two co-located hospitals by a third entity are too stringent and do not recognize that such arrangements are common among nonprofit hospitals and are used by organizations to carry out their fiduciary responsibilities with respect to subordinate corporations. The commenter suggested that the proposed rules be withdrawn or, if they are not withdrawn, applied only to requests for exclusion received on or after October 1, 1997, applied only where the rate of referral between hospitals is over 25 percent, or both.

Response: As explained above, we agree that our proposals to extend the application of the hospital-within-a-hospital rules should be applied only prospectively, starting with cost reporting periods beginning on or after October 1, 1997. Further, the rules will not apply to all excluded hospitals which were excluded on or before September 30, 1995. However, we do not agree that our criteria regarding control by a third entity are too stringent or that they unfairly disadvantage nonprofit hospitals. While it may be common for corporations to exercise significant control over their subordinate components, we continue to believe this control indicates that the components are part of a larger organization, not bona fide separate hospitals. We also do not agree that a low rate of referrals between co-located hospitals is sufficient to avoid the need to determine that an entity is a bona fide separate hospital. Even in the absence of a significant level of referrals, a hospital unit may be misrepresented as a separate hospital in order to obtain a more favorable reimbursement. Thus,

avoiding referrals does not eliminate all incentives for abuse.

Comment: ProPAC recommended that the Secretary conduct an extensive review of hospitals-within-hospitals, to determine if the existence of this model undermines the incentives of the prospective payment system.

Response: We share this concern and are monitoring the status of these facilities. We will continue to review the status of these facilities and evaluate the implications of the changes in Public Law 105–33 affecting newly excluded hospitals and the hospital-within-a-hospital issue.

In addition to the changes discussed above, in § 412.22(e)(5) (ii) and (iii), we are adding a reference to ''the six-month period immediately preceding the first cost reporting period for which exclusion is sought.'' This language clarifies that the criteria in these paragraphs also apply to excluded hospitals other than long term care or children's hospitals, since excluded hospitals other than long-term care or children's hospitals do not always have a prior cost reporting period of at least 6 months that is used to establish length of stay or treatment of an inpatient population which is predominantly individuals under age 18.

B. Exclusion of New Rehabilitation Units and Expansion of Existing Rehabilitation Units (§ 412.30(b)(4))

In the September 1, 1995 final rule (60 FR 45839), we made certain changes to clarify the regulations applicable to the exclusion of new rehabilitation units and the expansion of units already excluded. These changes were intended only to clarify existing policy, not to change it. However, in making these changes we inadvertently omitted a paragraph that explicitly allowed newly participating hospitals to open new rehabilitation units and also to allow the new rehabilitation units to be excluded immediately from the prospective payment system. In omitting this paragraph, we had no intention of rescinding the policy. In the June 2, 1997 proposed rule, we indicated that we would restore this paragraph to the regulations, which the proposed rule would have redesignated at (§ 412.30(b)(4)), to correct this omission and to reaffirm current policy. (For further information on this policy, see the **Federal Register** published September 1, 1992 (57 FR 39746)). We received no comments on this proposal and are implementing the change in this final rule with comment period.

C. Delicensing and Relicensing of Beds (§ 412.30)

We have received a number of questions about cases in which hospitals remove some bed capacity from their State license and Medicare certifications, then later increase the number of their licensed and certified beds and seek to have the bed capacity ''added'' and considered part of a new, or newly expanded, prospective payment system-exempt rehabilitation unit. Assuming that simultaneous delicensure and relicensure of beds would not be accepted as the addition of new bed capacity, we also have been asked how long bed capacity would have to be excluded from a hospital's licensure and certification to be considered ''new'' for purposes of the prospective payment system exclusion rules at § 412.30.

Section 412.30 establishes separate ways for new and converted units to meet the exclusion criterion related to the type of patient population treated. New units are allowed to qualify for initial exclusion based in part on a certification regarding their intent to treat a patient population of the kind described in § 412.23(b)(2), rather than on a showing that they have actually treated such a population during the hospital's most recent cost reporting period. Converted units may not be excluded based on a certification, but must show that they actually met the § 412.23(b) requirement during the hospital's most recent 12-month cost reporting period. New units are defined as those that are part of a hospital that has not previously sought exclusion for any rehabilitation unit and that comprise greater than 50 percent of the newly licensed and certified bed capacity, while converted units are those that do not qualify as new. Section 412.30 also provides for separate treatment of new and converted bed capacity that is used to expand existing units.

Different rules apply to the addition of new (as opposed to converted) bed capacity, and it would not be appropriate to recognize an ''increase'' in the bed capacity that coincides with a decrease in bed capacity in another area, resulting in no net increase in the hospital's total licensed and certified bed capacity. Similarly, it would not be appropriate to allow a hospital to circumvent those rules simply by removing some bed capacity from its licensure and certification on a temporary basis, and then increasing its bed size a few days, weeks, or months later. Thus, when a hospital seeks to add a new excluded rehabilitation unit, or to increase the size of an existing unit by adding new bed capacity, the bed size of the hospital in the past must be taken into account.

The current regulations do not specify how long a decrease in a hospital's bed capacity must be effective before a subsequent increase in the hospital's licensure and certification can be considered as ''new'' capacity. However, to ensure consistent and equitable treatment of all hospitals with excluded rehabilitation units, in the June 2, 1997 proposed rule, we proposed to provide in the regulations (proposed § 412.30(a)) that a decrease in capacity must remain effective for at least a full 12-month cost reporting period before an equal or lesser number of beds can be added to the hospital's licensure and certification and considered ''new''. This means that when a hospital seeks to establish a new unit, or to enlarge an existing unit, under the criteria in § 412.30, the HCFA Regional Office will review its records on the facility to determine whether any beds have been delicensed and decertified during the 12-month cost reporting period before the period for which the new beds are to be added. To the extent that bed capacity was removed from the hospital's licensure and certification during that period, that amount of bed capacity cannot be considered ''new'' under § 412.30. For example, if a hospital with a calendar year cost reporting period had removed 15 beds from its licensure and certification in calendar year 1997 and, for calendar year 1998, sought to set up a new rehabilitation unit that would include 20 beds that would be added to its licensure and certification as of January 1, 1998, only 5 of those beds could be considered ''new'' under § 412.30. The remaining beds would be considered converted beds.

This guideline applies to changes in a hospital's total licensed and certified bed capacity, regardless of whether specific beds or physical areas within a hospital have previously been operational and available to rehabilitation patients. Thus, if a hospital delicenses 25 beds on one floor in the third month of a cost reporting period and, 2 months later, increases its licensure and certification by adding a 25-bed unit in a previously unoccupied area on another floor, that unit could not be considered ''new'' under § 412.30 even though it occupies different space from the beds that represented the delicensed capacity. This guideline applies only for purposes of exclusion from the prospective payment system and is not intended to limit a hospital's ability to add to its licensed and certified bed capacity for the provision

of services paid for under the prospective payment system.

We are also revising § 412.30(c)(1)(ii) to state that beds that a hospital wishes to add to an excluded rehabilitation unit can be considered ''new,'' and thus subject to earlier exclusion than existing beds, only if the hospital's total inpatient bed capacity has increased by an amount that is more than 50 percent of the number of beds the hospital seeks to add to the unit, so that the added beds represent primarily newly licensed and certified capacity.

Comment: One commenter suggested that the proposal is too stringent, in that it does not take into account that hospitals may be pursuing separate CON activities—construction of a new facility to replace an older, larger facility, and creation of a new rehabilitation unit. The commenter suggested that the coincidence of these events could result in an inadvertent appearance of shifting of bed capacity and recommended that we not impose the delicensing rule but instead rely solely on CON approval to determine the appropriateness of expansions in rehabilitation units. Another commenter suggested that the proposal is unnecessarily restrictive.

Response: We understand that there may be situations in which it is appropriate for a hospital, acting in response to community needs and changes in demand for specific types of services, to separately pursue changes in bed size as described by this commenter. While such changes would not be undertaken with any intent to evade exclusion requirements, it nevertheless is clear that they would constitute a shift of the hospital's existing net bed capacity from acute to rehabilitation use, rather than an increase in bed capacity. Thus, we believe such shifts would appropriately be treated under the rules for conversion of bed capacity, and thus have not adopted this comment.

D. Special Excluded Hospital Criteria Added by Public Law 105–33 (§ 412.23)

Public Law 105–33 added special criteria for certain hospitals to be excluded from the prospective payment system. Section 1886(d)(1)(B)(iv) of the Act as amended by section 4417(b) of Public Law 105–33 allows certain hospitals with an average length of stay of less than 25 days to be excluded from the prospective payment system as a long-term care hospital. In order to be excluded under this provision, a hospital must have first been excluded as a long-term care hospital in calendar year 1986, have an average inpatient length of stay of greater than 20 days, and demonstrate that 80 percent or more of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in Federal fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease. The exclusion under this provision is effective for cost reporting periods beginning on or after August 5, 1997 (the date of enactment of Pub. L. 105–33). We are revising § 412.23(e) to implement this provision.

Section 4418 of Public Law 105–33 provides an additional category of hospitals that can qualify as cancer hospitals for purposes of exclusion from the prospective payment system. As amended, section 1886(d)(1)(B)(v) of the Act includes a hospital that meets the following criteria:

- The hospital was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.
- The hospital must have applied for and been denied, on or before December 31, 1990, classification as a cancer hospital.
- The hospital was licensed for fewer than 50 acute care beds as of the date of enactment of this subclause (that is, August 5, 1997).
- The hospital is located in a State that, as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act.
- The hospital demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of the hospital's total discharges have a principal finding of neoplastic disease; that is, the discharge has a principal diagnosis code of 140–239, V58.0, V58.1, V66.1, V66.2, or 990.

A hospital that meets these criteria is classified as an excluded cancer hospital for cost reporting periods beginning on or after January 1, 1991. In addition, for purposes of payment, the base period applicable to such a hospital is the hospital's cost reporting period beginning during FY 1990 or the period under new section 1886(b)(3)(F) of the Act (discussed below). We are revising the regulations at § 412.23(f) to incorporate this provision.

E. Changes Based on New Legislation for the Payment of Hospitals and Units Excluded from the Prospective Payment System (§ 413.40)

Public Law 105–33 significantly altered the payment provisions for excluded hospitals and units. Prior to the passage of Public Law 105–33, the payment provisions for excluded hospitals and units applied consistently to all categories of excluded providers (that is, psychiatric, rehabilitation, long-term care, children's, and cancer). However, effective for cost reporting periods beginning on or after October 1, 1997, there are specific payment provisions for psychiatric, rehabilitation, and long-term care providers and modifications to payment provisions for all excluded providers. Following is a complete discussion of the new provisions and the revised regulations.

1. Rate-of-Increase Percentages for Excluded Hospitals and Units (§ 413.40 (c) and (g))

Hospitals and units excluded from the prospective payments system receive payment for inpatient hospital services they furnish on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) is set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount is multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period.

Section 4411 of Public Law 105–33 amended sections 1886(b)(3)(B) of the Act regarding the rate-of-increase percentages to be applied to each target amount as set forth below.

The applicable rate-of-increase percentage for the cost reporting period beginning during FY 1998 is 0 percent.

For cost reporting periods beginning in FY 1999 through FY 2002, the applicable rate-of-increase percentage is the market basket rate of increase percentage minus a factor based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recent cost reporting period for which information is available.

- If the hospital's operating costs are equal to or exceed 110 percent of the ceiling amount, the rate-of- increase percentage increase is equal to the market basket percentage.
- If the hospital's costs exceed the ceiling but are less than 110 percent of the ceiling, the rate-of-increase percentage is the market basket rate of increase minus .25 percentage points for each percentage point by which costs are less than 10 percent over the ceiling. The rate-of- increase percentage is in no case less than 0 percent.
- If the hospital's costs are equal to or less than ceiling but greater than 66.7 percent of the ceiling, the rate-of-increase percentage is the greater of the market basket minus 2.5 percentage points or 0 percent.

• If the hospital's costs do not exceed 66.7 percent of the ceiling, the rate-of-increase percentage is 0 percent.

• If the hospital first receives payments as an excluded provider on or after October 1, 1997, the new statutory payment methodology for new hospitals applies.

Examples of how the rate-of-increase percentage provision applies in determining the applicable rate-of-increase percentages are as follows:

Example 1

Cost reporting period beginning in FY 1999:	
FY 1997 target amount	$8,000
Medicare discharges	×100
FY 1997 ceiling	$800,000
FY 1997 allowable inpatient operating costs	$1,000,000
FY 1997 costs over (under) of the ceiling	$200,000
FY 1997 costs as percentage of the ceiling	125
FY 1998 rate-of-increase percentage	0
FY 1999 rate-of-increase percentage: market basket	2.60
FY 1999 target amount (FY 1998 target amount of $8,000×1.026)	$8,208

Example 2

Cost reporting period beginning in FY 1999:	
FY 1997 target amount	$9,800
Medicare discharges	×100
FY 1997 ceiling	$980,000
FY 1997 allowable inpatient operating costs	$1,000,000
FY 1997 costs over (under) the ceiling	$20,000
FY 1997 percent by which costs exceed (do not exceed) the ceiling	2.04
FY 1998 rate-of-increase percentage	0
FY 1999 rate-of-increase percentage:	
Market basket	2.60
Percentage point reduction (.25×(10 − 2.04))	(1.99)
Update (percent)	.61
FY 1999 target amount (FY 1998 target amount $9,800×1.0061)	$9,859.78

Example 3

Cost reporting period beginning in FY 1999:	
FY 1997 target amount	$10,500
Medicare discharges	×100
FY 1997 ceiling	$1,050,000
FY 1997 allowable inpatient operating costs	$1,000,000
FY 1997 costs over (under) the ceiling	$(50,000)

Example 3—Continued

FY 1997 costs as percentage of the ceiling	95.2
FY 1998 rate-of-increase percentage	0
FY 1999 percentage increase:	
Market basket	2.60
Percentage point reduction	(2.50)
Update (percent)	.10
FY 1999 target amount (FY 1998 target amount $10,500×1.001)	$10,510.50

Example 4

Cost reporting period beginning in FY 1999:	
FY 1997 target amount	$16,000
Medicare discharges	×100
FY 1997 ceiling	$1,600,000
FY 1997 allowable inpatient operating costs	$1,000,000
FY 1997 costs over (under) the ceiling	$(600,000)
FY 1997 costs as percentage of the ceiling	62.5
FY 1998 rate-of-increase percentage:	0
FY 1999 rate-of-increase percentage	0
FY 1999 target amount (FY 1998 target amount of $16,000×1.0)	$16,000

We are revising § 413.40(c)(3)(vi) and adding new paragraphs (c)(3)(vii) and (c)(3)(viii) and (g)(5) to set forth the new rate-of-increase percentage provisions.

2. Request for a new base period (§ 413.40(b))

Sections 4413(a) and 4413(b) of Public Law 105–33 amended sections 1886(b)(3) of the Act in order to permit excluded hospitals and units to elect (''in a form and manner determined by the Secretary'') a rebasing of the target amount for the 12-month cost reporting period beginning during FY 1998 (October 1, 1997 through September 30, 1998). Except for a qualified long-term care hospital, as discussed below, each excluded hospital or unit under present or previous ownership that received Medicare payments during cost reporting periods beginning before October 1, 1990 may submit to its fiscal intermediary a request for rebasing its target amount. The new section 1886(b)(3)(F) of the Act instructs the Secretary to determine the rebased target amount as follows:

(1) The Secretary shall determine the hospital's allowable inpatient operating costs ''for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of enactment (August 5, 1997)''.

(2) For each of the 5 cost reporting periods, the Secretary shall update the inpatient operating cost per case to FY 1998 using the update factors cited at section 1886(b)(3)(B) of the Act (§ 413.40(c)).

(3) The Secretary shall exclude the highest and lowest of the five updated amounts for inpatient operating cost per case.

(4) The Secretary shall compute the average for the remaining three updated inpatient operating cost per case.

Under the statute the methodology for determining a rebased target amount uses the updated inpatient operating costs per case from the five most recent cost reports that have been settled as of the date of the enactment of the statute (August 5, 1997). For purposes of this provision, we will not recalculate the target amount to reflect cost report reopenings, changes, or other adjustments made after August 5, 1997. Reopenings (or even multiple reopenings) of any of the five settled cost reports at later dates could create a uncertainty of the applicable FY 1998 target amount until well after the end of FY 1998 and uncertainty about target amounts for subsequent years. Accordingly, the hospital must carefully consider the inpatient operating costs per case of its five most recent settled cost reports as of August 5, 1997 in deciding whether to apply for rebasing under this provision.

Similarly, if a hospital that received payments during cost reporting periods beginning before October 1, 1990 has reorganized or acquired another similar excluded provider so that its five most recent settled cost reports reflect substantial differences in the size and expenses of the excluded hospital or unit, the same considerations apply. It is not permissible to use fewer than (or more than) the five most recent settled cost reports in an attempt to reflect an operational reorganization. Also, if the hospital elects rebasing under this provision, the revised target amount for FY 1998 continues to be subject to the 75th percentile cap established on the target amount by Section 4414 of Public Law 105–33 (discussed below). Exception payments as governed by §§ 413.40(g) and (i) will be evaluated based on a comparison of the hospital's operating costs and its costs during the three years used to calculate the rebased target amount.

In order to implement the statutory provision, we are adding § 413.40(b)(1)(iv) to describe the manner in which a hospital must request a rebased target amount. The hospital submits the request to its fiscal intermediary. Due to the extremely short timeframe between enactment of Public Law 105–33 on August 5, 1997 and the

beginning of FY 1998 (on October 1), we believe it is necessary and appropriate to establish special rules to address those hospitals whose cost reporting periods begin early in FY 1998, in order to treat all hospitals equitably. Therefore, the hospital must submit its request for rebasing by the later of November 1, 1997 or 60 days prior to the beginning of its cost reporting period beginning during FY 1998. We emphasize that the intermediary must receive the request by the deadline. Also, we note that this is a one time request that must be received by the deadline for the FY 1998 cost reporting period.

Upon receipt of a request for a rebased FY 1998 target amount, the fiscal intermediary should verify the submitted request and notify the hospital of its FY 1998 target amount.

The request for a new base period must include the following:

• Cover letter, which must include the items listed below.

—The name of the excluded hospital or unit;
—The Medicare provider number;
—The beginning and ending dates for the FY 1998 cost reporting period;
—The fiscal year of the existing base period and FY 1998 updated target amount;
—A statement requesting a rebased FY 1998 target amount under § 413.40(b)(1)(iv);
—A statement of the rebased FY 1998 target amount per discharge with supporting documentation in attachment work papers;
—A list of attachments; and
—A contact person: name, phone number, and address

• Attachments

—Copies of the Notices of Program Reimbursement for the five most recent settled cost reporting periods
—Copies of Worksheet D–1 for the five most recent settled cost reporting periods
—A list and/or calculation of the following for each of the five most recent settled cost reporting periods:

+ Total Medicare inpatient operating costs (excluding pass through costs);
+ Total Medicare discharges;
+ Medicare inpatient operating costs per case; and
+ Medicare inpatient operating costs per case updated to FY 1998

—A list the highest and lowest of the five updated inpatient operating cost per case; and
—A calculation of the average for the remaining three updated inpatient operating cost per case

Section 4413(b) of Public Law 105–33 also specified a separate rebasing election for a qualified long-term care hospital. The statute defines a qualified long-term care hospital as a long-term care hospital that meets the following two conditions for its two most recent settled cost reports as of August 5, 1997:

(1) The hospital's Medicare inpatient operating costs exceed 115 percent of the ceiling; and

(2) The hospital would have had a disproportionate patient percentage (as defined in § 412.106) equal to or greater than 70 percent if it were a prospective payment system hospital. A qualified long-term care hospital must submit a request to its fiscal intermediary to have a rebased target amount in the same manner as discussed above for other excluded hospitals. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days prior to the beginning of its cost reporting period during FY 1998. For a qualified long-term care hospital, the methodology for rebasing the target amount differs. The FY 1998 rebased target amount is the hospital's FY 1996 inpatient operating costs updated by the market basket percentage to FY 1997 only, not to FY 1998, subject to the 75th percentile cap.

To assist with the application of the updating of the cost per case to the subject fiscal period, the increase in the market basket and the applicable update factors for excluded hospitals and units since FY 1990 are:

Fiscal year	Market basket (percent)	Update factor
1990	5.5	1.055
1991	5.3	1.053
1992	4.7	1.047
1993	4.2	1.042
1994	4.3	[1] 1.043
1995	3.7	[1] 1.037
1996	3.4	[1] 1.034
1997	2.5	[1] 1.025
1998	2.7	1.000

[1] See § 413.40(b)(3)(v) for method of determining applicable reduction.

We are adding §§ 413.40(b) (iv) and (v) to set forth the new provisions regarding request for new base periods.

3. Limitation on the Target Amount for Excluded Hospitals and Units (§ 413.40(c))

Section 4414 of Public Law 105–33 amended section 1886(b)(3) of the Act, to establish caps on the target amounts for excluded hospitals or units for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on the target amounts apply to the following three categories of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. For purposes of calculating the caps, the statute requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within [each] class for cost reporting periods ending during fiscal year 1996''. For cost reporting periods beginning in FY 1998, the Secretary shall update the amount so determined by the market basket percentage increase to FY 1998. For cost reporting periods beginning during FY 1999 through 2002, the Secretary shall update the resulting amount by the market basket percentage.

The estimates of the 75th percentile of the target amounts were developed from the best available data on the hospital specific target amounts for cost reporting periods ending during fiscal year 1996 and then updated by the market basket percentage to FY 1998. Given the extraordinarily short time frame between the enactment of Public Law 105–33 (August 5, 1997) and the required publication date of this final rule, we used the best available data that has been reported to HCFA by the fiscal intermediaries for over 3,000 hospitals and units within the classes specified by the statute.

When an exact target amount was not available for a particular hospital, we used the best available information to estimate the hospital's target amount. For example, if the hospital's target amount for its cost reporting period ending during FY 1996 was not available but the target amount for FY 1995 was available, we updated the FY 1995 target amount by the applicable percentage increase to determine an estimate of the hospital's target amount for its cost reporting ending during FY 1996. We note that, with respect to long-term care hospitals, we were able to obtain exact target amount figures for virtually all hospitals within the class.

A hospital that has a target amount that is capped at the 75th percentile would not be granted an exception payment as governed by §§ 413.40 (a) and (i) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year. Since the hospital's target amount would not be determined based on its own experience in a base year, any comparison of costs or patient mix in its base year to costs or patient mix in the payment year would be irrelevant. However, exception payments would still be available for hospitals that have target amounts that are determined by the hospital's costs in a base year unaffected by the 75th percentile cap.

The 75th percentile of the target amounts for cost reporting periods ending during fiscal year 1996, and updated by the market basket up to FY 1998 are as follows:

(1) Psychiatric hospitals and units: $10,188

(2) Rehabilitation hospitals and units: $18,476

(3) Long-term care hospitals: $36,449

We are revising § 413.40(c)(4) (i) and (ii) to set forth the limitation on the ceiling provisions.

4. Bonus and Relief Payments (§ 413.40(d))

a. Bonus Payments

For cost reporting periods beginning before October 1, 1997, a hospital that had inpatient operating costs less than its ceiling is paid costs plus the lower of 50 percent of the difference between the inpatient operating costs and the ceiling; or 5 percent of the ceiling. Section 4415 of Public Law 105–33 amended section 1886(b)(1)(A) of the Act to provide that for cost reporting periods beginning on or after October 1, 1997, the amount of bonus payment is the lower of the following:

(1) 15 percent of the difference between the inpatient operating costs and the ceiling, or

(2) 2 percent of the ceiling.

In addition, section 4415 of Public Law 105–33 amended Section 1886(b)(2) of the Act to provide for ''continuous improvement bonus payments''. Under this new provision, for cost reporting periods beginning on or after October 1, 1997, an ''eligible hospital'' will receive payments in addition to the bonus payment discussed above. An ''eligible hospital'' is a hospital that been an excluded provider for at least three full cost reporting periods prior to the subject period and whose operating costs per discharge for the subject period are below the lower of its target amount, trended costs (as defined by the statute), or expected costs (as defined by the statute) for the subject period. The amount of the continuous improvement bonus payment will be equal to the lesser of—

(1) 50 percent of the amount by which operating costs were less than the expected costs for the period; or

(2) 1 percent of the ceiling.

Under the statute, for a hospital with its third or subsequent cost reporting period ending in FY 1996, trended costs are the lesser of allowable inpatient costs per discharge or the target amount in FY 1996, increased (in a compounded manner) for each succeeding fiscal year by the percentage increase in the market basket. For all other hospitals, trended costs are the allowable inpatient operating costs per discharge for its third full cost reporting period increased (in a compounded manner) for each succeeding fiscal year by the percentage increase in the market basket.

Expected costs are the lesser of operating costs per discharge or the target amount for the previous cost reporting period, updated by the percentage increase in the market basket for the fiscal year.

b. Relief Payments

For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1991, hospitals that had inpatient operating costs in excess of their ceiling are to be paid no more than the ceiling. Section 4005(a) of Public Law 101–508 (OBRA 1990, enacted November 5, 1990) amended section 1886(b)(1)(B) of the Act to provide that for cost reporting periods beginning on or after October 1, 1991, a hospital could receive relief payments equal to 50 percent of the costs in excess of the ceiling not to exceed 10 percent of the ceiling (after any exceptions or adjustments).

Section 4415 of Public Law 105–33 amended section 1886(b)(1) of the Act to provide that for cost reporting periods beginning on or after October 1, 1997, if a hospital's operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment will be the ceiling. If a hospital's costs are greater than 110 percent of the ceiling, payment will be the ceiling plus 50 percent of the costs in excess of 110 percent of the ceiling. Total payment may not exceed 110 percent of the ceiling.

Because section 4415 of Public Law 105–33 does not provide relief for costs that are within 110 percent of the ceiling, we are making a corresponding change to the exception payment provision at § 413.40(g)(1) so that qualification for the amount of an exception payment does not encompass costs within 110 percent of the ceiling.

We have revised §§ 413.40(d)(3) and added (d)(4) and (d)(5) to implement these provisions.

5. New Excluded Hospitals and Units (§ 413.40(f))

Under § 413.40(f), a new excluded hospital is exempted from the rate-of-increase ceiling until the end of the first cost reporting period ending at least two years after the hospital accepts its first patient (through the second 12-month cost reporting period). As we discussed in the June 2, 1997 proposed rule (62 FR 29937), the growth of new excluded hospitals increasingly includes a large number of hospitals that are merely reconfigurations of existing facilities. These new providers do not require the same length of time to establish a presence in the marketplace and increase patient load. As a result, there is evidence that the new hospital exemption does not always serve its original purpose to recognize certain cost distortions that may be present as a hospital begins operations. In addition, the new hospital exemption period could create incentives to increase costs in the exempt years. In its March 1, 1997 report, ProPAC recommended that the new hospital exemption period should be eliminated and that Medicare payments for new providers should be based on an average target amount for facilities serving comparable types of patients.

With the enactment of sections 4416 and 4419 of Public Law 105–33, which amend section 1886(b)(4) of the Act and add section 1886(b)(7) of the Act, Congress has established a new framework for payments for new excluded providers. First, section 4419(a) amends section 1886(b)(4)(A)(i) of the Act, to eliminate ''exemptions'' for all classes of excluded entities except children's hospitals. This provision applies to entities that first qualify for exclusion for cost reporting periods beginning on or after October 1, 1997. Thus, effective October 1, 1997, we will no longer grant new provider exemptions under section 1886(b)(4) of the Act except with respect to children's hospitals.

Second, section 4416 adds a new section 1886(b)(7) of the Act to establish a new statutory payment methodology for certain new hospitals. For purposes of this provision, the statute specifies three classes of hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and which first receives payments on or after October 1, 1997, the amount of payment shall be determined as follows.

For each of the first two cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated and adjusted for differences in area wage levels. For purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period

is equal to the amount determined under the methodology above for the preceding period.

To determine payments for a new hospital's first two cost reporting periods, the statute requires a calculation of a national median of the target amounts for hospitals in the same class, updated and adjusted. For each class of hospitals, using the best available data we determined the national median of the target amounts for hospitals within the class for cost reporting periods ending during fiscal year 1996. In determining the national median, the Secretary makes adjustments to account for area differences in wage-related costs. Pursuant to the broad authority conferred on the Secretary to determine an appropriate wage adjustment, we are making an adjustment on the basis of the data used to calculate the FY 1998 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), without taking into account reclassifications under section 1886(d)(10) and (d)(8)(B) of the Act. We recognize that wages may differ for prospective payment hospitals and excluded hospitals, but we believe the wage data do reflect area differences in wage-related costs; moreover, in light of the extraordinarily short timeframe for implementing this provision, this is the only feasible data source.

We note that, under the statute, the special payment methodology for new hospitals applies for each of the hospital's first 2 cost reporting periods. However, a new hospital might begin operations on a date other than the first day of its ''usual'' cost reporting period, so that its first cost reporting period is a short period. In order to treat these hospitals equitably, we believe the special payment methodology should be applied to the hospital's first two *full* cost reporting periods.

We also note that, under the calculation prescribed in new section 1886(b)(7)(A)(i)(II), the limit on payment for *each* of the hospital's first two cost reporting periods is based on the national median target amount for cost reporting periods ending during FY 1996, updated by the hospital market basket ''to the fiscal year in which the hospital first received payments''. That is, the limit on payment is not updated by the market basket for the second cost reporting period. For example, if a new rehabilitation hospital commences operation on January 1, 1999 (during FY 1999), it receives the lower of the hospital's operating costs or 110 percent of the applicable national median of target amounts for cost reporting periods ending during FY 1996 updated to FY 1999. For its second 12-month cost reporting period (FY 2000), the limit on payment is the same (110 percent of the applicable national median updated to FY 1999). The statute appears to provide that the target amount for succeeding cost reporting periods will be based on the payment amount in the second 12-month cost reporting period increased by the applicable update factors. Although we are codifying the policies for subsequent cost reporting periods in this final rule with comment period, a technical amendment may be needed to clarify statutory intent.

The updating process also raises an issue with respect to hospitals with short cost reporting periods. The statute requires that the national median is updated ''to the fiscal year in which the hospital first received payments.'' Thus, for hospitals with short cost reporting periods, we would calculate the limit based on the beginning of its short cost reporting period, even though the limit would not be applied until its first full cost reporting period (as discussed earlier). We believe these policies treat such hospitals equitably, so that they are neither benefitted nor disadvantaged by the short cost reporting period.

We are revising §§ 413.40(f) (1) and (2) to incorporate these changes for new excluded providers.

The table below lists 110 percent of the national median target amounts for each class of excluded hospitals for cost reporting periods ending during FY 1996, adjusted for area wages updated by the market basket to FY 1998.

(1) Psychiatric hospitals and units	$8,203
(2) Rehabilitation hospitals and units	16,129
(3) Long-term care hospitals	18,324

6. Capital Payments for Excluded Hospitals and Units (§ 413.40(j))

Section 4412 of Public Law 105–33 amended section 1886(g) of the Act to establish a 15 percent reduction on capital payments for certain hospitals and hospital distinct part units excluded from the prospective payment system for portions of cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The capital reduction applies to psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

We are adding § 413.40(j) to set forth the capital reduction provision.

7. Report on Adjustment Payments to the Ceiling (§ 413.40(g))

Section 1886(b)(4) of the Act provides for an adjustment (exception) payment to the ceiling if a hospital submits a request to its fiscal intermediary within 180 days of the date of the Notice of Program Reimbursement. Changes in the types of patients served or in-patient care services that distort the comparability of a cost reporting period to the base year are grounds for requesting an adjustment request. The reasons and process for requesting an adjustment request are implemented at § 413.40(g). Section 4419(b) of Public Law 105–33 amended section 1886(b)(4) of the Act. This section requires the Secretary to publish annually, in the **Federal Register**, a report describing the total adjustment payments made to excluded hospitals and units for cost reporting periods ending during the previous fiscal year. Effective with the FY 1999 notice of changes to the hospital inpatient payment systems, we will publish the total adjustment payments made to excluded hospitals and units by category of hospital (psychiatric, rehabilitation, long-term care, cancer, and children's) during the previous fiscal year.

VIII. ProPAC Recommendations

As required by law, we reviewed the March 1, 1997 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. Recommendation 2, concerning the update for the prospective payment system operating payment rates, is discussed in Appendix D of this final rule with comment period. Recommendations 3 and 4, concerning the prospective payment system capital payment rates, are discussed in section III. of the Addendum of this final rule with comment period. Recommendation 13, concerning updating the target amounts for excluded hospitals and distinct part units, is discussed in Appendix D of this final rule with comment period. Recommendation 31, concerning long-term care hospitals within hospitals, is discussed in section VII. of this final rule with comment period. The remaining recommendations on which we received comments are discussed below.

A. Improving Medicare's Disproportionate Share Hospital (DSH) Payments and Distribution of those Payments (Recommendation 9, 10, and 11)

Recommendation: DSH payments should be concentrated among hospitals with the highest shares of poor patients. Therefore, a minimum threshold should be established for the low-income patient cost share. Hospitals falling just above the threshold should receive only a minimal per case payment, with the amount then increasing as low-income share rises. The same general approach for distributing payments should apply to all PPS hospitals.

Response in the Proposed Rule: Congress set the current threshold payments for Medicare disproportionate share hospitals in section 6003(c) of the Omnibus Budget Reconciliation Act of 1989. This provision expanded both the number of hospitals that could qualify for disproportionate share payments as well as the level of those payments for some categories. We note that large urban hospitals already receive payments based on this graduated payment structure. ProPAC notes that 95 percent of the hospitals receiving disproportionate share payments are designated as large urban hospitals. A May 1990 Congressional Budget Office (CBO) report to Congress, found that only large urban hospitals were overburdened by the cost of caring for the indigent population.

We agree with ProPAC that the disproportionate share payments should be concentrated on the hospitals in greatest need of assistance.

Comment: ProPAC indicated that the goal of DSH payments should be to protect access to hospital care for Medicare beneficiaries, not merely to compensate a hospital for the added costs of treating Medicare patients due to the hospital's indigent patient load. To that end, ProPAC recommended that the same distribution formula be applied to all hospitals, regardless of their size or location. A ProPAC simulation of a payment system based on its recommendations showed that some payments would be redistributed to rural hospitals (largely because the current system imposes a stricter standard for those hospitals to qualify for a DSH payment) and to hospitals with large shares of uncompensated care costs (because the current system does not recognize this important component of the hospital industry's commitment to treating indigent patients). This redistribution would be appropriate, in ProPAC's view, because it would result in DSH payments more closely reflecting the burden borne by hospitals that treat a large share of poor patients.

ProPAC's approach to distributing DSH payments is aimed at ensuring that available funds are used to help those hospitals most in need of assistance. Accordingly, it is important to reflect all low-income hospital care in the variable upon which payments will be based, and ProPAC's low-income share measure would capture the costs associated with all Medicaid patient days. However, a system based on ProPAC's recommendations could be designed to distribute any level of DSH funding, and so the inclusion of all Medicaid costs need not have any implications for HCFA's overall expenditures. The number of hospitals receiving payments can also be determined through the choice of the threshold (minimum low-income cost share needed to qualify for a DSH payment).

ProPAC firmly agreed with the Secretary's goal of targeting payments to hospitals with the largest shares of low-income patients. But this goal can only be achieved through the development of a comprehensive and consistently measured low-income share indicator. ProPAC's recommended measure reflects all relevant groups of low-income patients (low-income Medicare, Medicaid, local indigent care program, and uncompensated care patients), measured in a consistent fashion that automatically weights each group according to its contribution to the hospital's overall patient care costs.

The Commission believes that including bad debts in its recommended measure of low-income costs would not materially weaken the incentive to attempt collection on unpaid accounts. For the majority of hospitals, the amount of additional DSH payment that might be received by foregoing collection efforts would be dwarfed by the amount they stand to gain from the patient. These institutions, therefore, can be expected to continue their collection efforts. On the other hand, those few hospitals with very large low-income shares, rarely serve the type of patients among whom aggressive collection would be worthwhile.

ProPAC believes that the data needed to implement the low-income cost share measure it recommends could be obtained by straightforward means. Each hospital's low-income patient cost share could be estimated by dividing the sum of charges for all low-income patient groups by total patient charges. In its simplest form, only five variables would need to be collected from each hospital—aggregate charges for: (1) patients sponsored by Medicaid, (2) patients sponsored by indigent care programs other than Medicaid, (3) Medicare patients, (4) uncompensated care, and (5) all patients. Because hospitals currently must use the same price schedule for all patients, a measure of low-income charges as a percent of total charges would yield reasonable, accurate, and comparable estimates of the proportion of costs devoted to treating low-income patients across all hospitals.

Another commenter supported ProPAC's approach to calculating DSH payments, and urged HCFA to include both bad debt and uncompensated care. This commenter supported HCFA's intention to move away from the current DSH formula, which is based on Medicaid and Supplemental Security Income eligibility.

Response: We continue to believe that there are inconsistencies in the current Medicare disproportionate share adjustment calculation, because Medicaid data varies from State to State. Therefore, we continue to be interested in ways to improve the data and the calculation to better target those hospitals that treat a disproportionate share of indigent patients.

We are reluctant to include bad debts in the calculation because we continue to believe that it provides an incentive for hospitals to discontinue their collection efforts. In addition, examination of bad debt data has shown no correlation between bad debts and hospitals that currently receive some level of a Medicare disproportionate share adjustment. In other words, our examination of the data has shown that a hospital that currently receives a large Medicare disproportionate share adjustment does not necessarily have a correspondingly large amount of bad debt.

We also continue to believe that collection of uncompensated care data would be burdensome to both the hospital industry and HCFA and its fiscal intermediaries. In addition, as noted in the proposed rule, HCFA has no means to verify such data. As we have consistently stated on many previous occasions, in order for a data source to be considered usable, it must be nationally available and auditable.

Hospitals should also be aware that a change in the formula will almost certainly produce a change in the universe of qualifying hospitals and the levels of the adjustments that these hospitals receive. We note that section 4403(b) of Public Law 105–33 requires us to submit a report to Congress by August 5, 1998 that contains a revised DSH formula. In determining this formula, we must do the following:

- Establish a single threshold for costs incurred by hospitals in serving low-income patients.
- Consider the costs incurred by the hospital in serving both Medicare Part A beneficiaries who receive SSI and Medicaid beneficiaries (including those enrolled in managed care organizations) who are not entitled to Medicare Part A benefits.

B. Modifying the Tax Equity and Fiscal Responsibility Act (TEFRA) Payment System (Recommendation 14)

Recommendation: Congress should consider modifying the TEFRA payment system to correct for the payment disparity between new and old providers.

Response in the Proposed Rule: HCFA has developed legislative proposals to modify the TEFRA payment system. Our proposals include rebasing the target rates for excluded hospitals and units using an average of each facility's two most recent cost reporting periods. This measure would realign payment rates with costs for both old and new providers. In conjunction with rebasing, the new target rates would be capped at 150 percent of a national mean rate for each type of facility in order to prevent newer high cost hospitals from receiving excessive target rates. Lower cost hospitals would be protected by establishing a floor of 70 percent of the national mean rate for each type of facility. Incentive payments would be modified by providing that no such payment would be made where a provider incurs costs that are less than or equal to 110 percent of the target amount. Finally, the President's FY 1998 budget proposal would revise the payment of capital costs to excluded hospitals and units by reducing reimbursement for capital to 85 percent of reasonable costs. TEFRA providers are the only hospitals that continue to be reimbursed for capital on a dollar-for-dollar basis; consequently, they have no incentive to control their capital expenditures. This policy would make capital reimbursement policy more consistent among all hospitals and provide a needed incentive for cost control, particularly for newer excluded hospitals and units that may have more resources for capital expenditures because they are not as limited by the target rates on inpatient operating costs.

Comment: Based on its analytic framework, ProPAC supported an average update of 2.0 percent for prospective payment system-excluded facilities. ProPAC believes that imposing the prospective payment system update on prospective payment system-excluded facilities is not appropriate. Medicare payment policies for specialty hospitals and units excluded from the prospective payment system differ from those for general acute care hospitals because these provider types historically have treated different patient populations. Likewise, the financial performance of prospective payment system-excluded providers is dissimilar from their prospective payment system counterparts, largely because of the underlying payment policy differences. Consequently, ProPAC maintains that separate methodologies should be used to arrive at appropriate updates.

Both the Secretary and ProPAC agree that the payment system for prospective payment system-excluded providers should be modified to correct for the payment disparity between new and old providers. ProPAC will continue to monitor the financial performance of providers paid under this system.

Response: We believe that ProPAC's concerns are addressed by Section 4411 of Pub. L. 105–33, which amended sections 1886(b)(3) of the Act regarding the rate-of-increase percentages. We have discussed the statutory changes in section VII of this preamble.

C. Prospective Payment System for Skilled Nursing Facilities (SNFs) (Recommendation 19)

Recommendation: A case-mix adjusted prospective payment system for skilled nursing facilities should be implemented as soon as possible.

Response in the Proposed Rule: We concur with the recommendation to implement a prospective payment system for SNFs as soon as possible. The President's FY 1998 budget includes a provision for a prospective payment system for SNFs to be implemented on July 1, 1998. This system will include payment for all costs (routine, ancillary, and capital) related to the services furnished to beneficiaries under Medicare Part A. By including all costs of services in the payment rates, spending growth per day of care can be contained. In addition, the provision includes authority to adjust payments to providers where inappropriate utilization (that is, excessive lengths of stay) of SNF services is found. Finally, the proposed prospective payment system would include case-mix adjustments using a resident classification system based on resource utilization groups. These resource utilization groups are tied to elements contained on the Minimum Data Set (MDS) 2.0 resident assessment instrument for nursing homes.

Comment: ProPAC commended the Secretary's efforts to create a prospective payment system for SNF services, and looks forward to reviewing HCFA's analyses of resource utilization groups and their ability to describe the services provided by SNFs. ProPAC is concerned about the incentive created under a per diem payment system for facilities to increase length of stay, and believes, therefore, that the Secretary should continue efforts to develop a case-mix classification system for use with an admission-based payment system. In addition, ProPAC believes that the Secretary's efforts to discourage inappropriate utilization are particularly important.

Response: While the significant copayment associated with the Medicare SNF benefit ($95.00 per day) acts as a powerful force limiting the growth of overall length of stay in SNFs, HCFA is concerned about increases in utilization under the new prospective payment system and plans to study this issue. In addition, HCFA will continue its efforts towards the development of a per diem integrated payment and delivery system that applies to all Medicare post-acute services. This type of system has the greatest potential for providing system-wide financial integrity, while assuring high quality care.

D. Home Health Visit Coding (Recommendation 26)

Recommendation: Medicare should require consistent home health visit coding. Such information is essential for monitoring and evaluating the home health benefit and developing an effective case-mix adjustment system.

Response in the Proposed Rule: Currently, there is no standard definition of what comprises a visit and there is variation in the type of service and length of time for providing those services. We agree such information is critical to developing an effective case-mix measure for a home health prospective payment system. In the case-mix research we are beginning, we will collect information on the length of time and procedures performed during a visit. This information will feed into the development of a prospective payment system and related coding system. We cannot proceed with specific coding refinements until the findings are available and a prospective payment system is designed. We are researching aspects of that approach rather than imposing reporting burdens on all home health agencies.

Comment: ProPAC indicated that although the Secretary agrees that information about home health visit length and content is critical to developing an effective case-mix

measure, she does not want to proceed with specific coding refinements until the findings from the case-mix demonstration project are available and a prospective payment system is designed.

ProPAC is concerned that without uniform coding requirements, the implementation of a prospective payment system would be further delayed. ProPAC notes that there is little information about the types of services that are provided during a visit and that the case-mix demonstration project should guide coding requirements. Concurrent with the research on a prospective payment system, the Commission believes it is important to begin gathering basic data about the content of home health visits, which would be critical in any efforts to improve the payment method. The Medicare Home Health Agency Manual contains a series of aggregate code definitions that would capture some detail about the services that are provided during a visit. HCFA's Common Procedure Coding System (HCPCS) describe some skilled nursing services and a range of therapy services. Time increments also could be useful in understanding visit duration.

Response: Section 1895(c) of the Act, as added by section 4603 of Public Law 105–33, requires payment information on all claims for home health services furnished on or after October 1, 1998. All claims for home health services must include a unique physician identifier and a code (or codes) specified by the Secretary that identifies the length of time of the home health visit as measured in 15 minute increments. Since there is no standard definition of what comprises a visit and there is variation in the length of time for providing those services, the new payment information requirements will provide needed information on the length of time required for the provision of home health services. Additionally, as discussed in our previous response in the August 30, 1996 final rule, a contract was awarded to develop a case-mix measurement for a home health prospective payment system. Under the terms of this contract, extensive information about the characteristics of patients and resource utilization will be collected. Information also will be collected about visit lengths and procedures performed during all home health visits during an episode of care.

E. Home Health Copayments (Recommendation 27)

Recommendation: Modest beneficiary copayments, subject to an annual limit, should be introduced for home health care services.

Response in the Proposed Rule: We are concerned about the impact that higher beneficiary out-of-pocket expenses would have on poorer Medicare beneficiaries who are not covered by Medicaid and cannot afford supplemental insurance. Poorer beneficiaries spend a greater proportion of their income on out-of-pocket costs. Our proposed interim system of limits should help control the growth in service use.

Comment: The Commission continued to maintain its position that copayments for home health services are appropriate. ProPAC believes that Medicare beneficiaries who receive home health services should participate financially in the payment for those services. Such a policy would be consistent with Medicare cost-sharing requirements for other services and could result in increased involvement by beneficiaries in treatment decisions. Copayments also might limit fraudulent billing practices, since beneficiaries could identify services for which Medicare was billed but that were never delivered. ProPAC recognizes that a copayment policy would have a more direct financial impact on beneficiaries who lack Medicaid or supplemental coverage. Accordingly, ProPAC believes that the copayment amount should be minimal and subject to an annual limit.

Response: The issue of copayments was thoroughly considered in the deliberations over Public Law 105–33 and ultimately not adopted in the legislation. We remain concerned about the impact that higher beneficiary out-of-pocket costs would have on poorer Medicare beneficiaries who are not covered by Medicaid and cannot afford supplemental insurance. Our interim system of limits should help control the growth in service use.

F. Prospective Payment System for Rehabilitation Hospitals and Distinct-Part Units (Recommendation 29)

Recommendation: A case-mix adjusted prospective payment system for rehabilitation hospitals and distinct-part units should be implemented as soon as possible.

Response in the Proposed Rule: We have sponsored research on possible patient classification systems for rehabilitation care. In particular, a study by the RAND Corporation evaluated the prospects for a prospective payment system based on the rehabilitation coding system known as Functional Independence Measure (FIM) and the patient classification system known as Function-Related Groups (FRGs). The final report on this research will soon be complete. However, the preliminary results indicate much work would be necessary before a prospective payment system based on FRGs could be implemented. There are at least two important implementation issues: the reliability of the patient status measures and the recognition of patient complications and comorbidities. In addition, implementation of a case-mix payment system for rehabilitation hospitals and units would require significant program resources and impose data reporting and collection requirements on providers. As a result, fewer resources would be available for research into developing an integrated payment approach for payment of rehabilitation care across all settings (excluded hospitals, SNFs, HHAs, comprehensive outpatient rehabilitation facilities, etc.) Thus, we prefer to focus our efforts on developing a coordinated payment system for post-acute care that relies on a core assessment tool.

Comment: ProPAC strongly supported coordinating payment methods across postacute sites. The Commission believes that a separate prospective payment system for rehabilitation hospitals and units could be implemented in the near term, however, as an incremental step toward a more comprehensive system for all post-acute care services. ProPAC's understanding is that most Medicare-certified inpatient rehabilitation facilities already collect and use the types of data necessary for the FIM or other standardized patient assessment instruments. Therefore, reporting these data to HCFA would not be an undue burden on providers.

Response: Section 4421 of Public Law 105–33 amended section 1886 of the Act by adding a new subsection (j), which provides for implementation of a prospective case-mix payment system for excluded rehabilitation hospitals and units, and begins to phase-in payments under that system for cost reporting periods beginning on or after October 1, 2000. The case-mix payment system is to be fully implemented for cost reporting periods beginning on or after October 1, 2002. We will continue to work on developing a prospective payment system for rehabilitation hospitals and units consistent with this statutory requirement.

G. Prospective Payment System for Long-Term Care Hospitals (Recommendation 30)

Recommendation: A case-mix adjusted prospective payment system for long-term care hospitals should be developed and implemented as soon as possible.

Response in the Proposed Rule: We continually examine data and analyze proposals to simplify payment mechanisms and ensure that Medicare payments reflect efficient and high quality health care. We will be interested in evaluating the results of independent studies on case-mix measurement for long-stay hospital patients. At the same time, it is evident that many long-term care hospitals furnish extensive rehabilitation care that overlaps with care furnished in rehabilitation hospitals. Thus, a prospective payment system for postacute care providers which includes SNFs and rehabilitation hospitals and units could conceivably be used for patients in long-term care hospitals. As a result, we have concerns that the development and implementation of a separate prospective payment system for fewer than 200 Medicare-certified, long-term care hospitals may not be an efficient use of program resources and may result in overlapping complexity and manipulation of payment.

Comment: ProPAC asserted that a better understanding of long-term care hospitals with respect to the types of patients they treat, patterns of care, and facility costs would be necessary before these providers could be folded into an integrated payment system. ProPAC, therefore, believes that the Secretary should begin researching patient classification systems and resource use for long-term care hospitals soon.

Response: We will continue to examine data and analyze proposals consistent with the requirements of section 4422 of Public Law 105–33. This section requires the Secretary to submit a report to Congress not later than October 1, 1999, regarding different payment methodologies which may be feasible for paying long-term care hospitals under the Medicare program.

IX. Other Required Information

A. 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, and on the Internet at HTTP://WWW.HCFA.GOV/STATS/PUBFILES.HTML. In our June 2 proposed rule, we published a list of data files that are available for purchase (62 FR 29939).

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

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of the rule take effect. However, section 1871(b) of the Act provides that publication of a notice of proposed rulemaking is not required before a rule takes effect where ''a statute establishes a specific deadline for the implementation of the provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained.'' In addition, we may waive a notice of proposed rulemaking if we find good cause that notice and comment are impracticable, unnecessary, or contrary to the public interest.

On June 2, 1997, we published a proposed rule addressing FY 1998 payment rates and policies for prospective payment system hospitals and excluded hospitals (62 FR 29902). Subsequently, on August 5, 1997, Public Law 105–33 was enacted. Public Law 105–33 contains a number of provisions relating to issues addressed in the proposed rule, as well as issues that were not specifically addressed in the proposed rule. These statutory provisions are generally effective October 1, 1997.

In accordance with section 1871(b) of the Act, publication of a notice of proposed rulemaking is not required before implementing the statutory provisions of Public Law 105–33 that take effect on October 1, 1997. In addition, given the extremely short timeframe for implementing these statutory provisions, we find good cause to waive notice and comment procedures with respect to the provisions of this final rule with comment period that implement Public Law 105–33, because it would be impracticable to undertake such procedures *before* those provisions take effect. We are, however, providing a 60-day period for public comment on those provisions.

C. Response to Comments

Because of the large number of items of correspondence we normally receive on FR documents published for comment, we are not able to acknowledge or respond to them individually. Comments on the provisions of this final rule that implement provisions of the Balanced Budget Act of 1997 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 June 2, 1997 proposed rule or that were changed based on public comments.

List of Subjects

42 CFR Part 400

Grant programs-health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Recovery against third parties, Reporting and recordkeeping requirements, Secondary payments.

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 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 440

Grant programs—health, Medicaid.

42 CFR Part 485

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

42 CFR Part 488

Administrative practice and procedure, Forms and guidelines, Health facilities, Survey and certification.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

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

42 CFR chapter IV is amended as set forth below:

PART 400—INTRODUCTION; DEFINITIONS

A. Part 400 is amended as follows:

1. The authority citation for Part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

2. In § 400.202, the introductory text is republished, the definitions of ''Essential access community hospital (EACH)'', ''Provider'', and ''Services'' are revised, the definition of ''Rural primary care hospital (RPCH)'' is removed, and a new definition of ''Critical access hospital (CAH)'' is added in alphabetical order, to read as follows:

§ 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

* * * * *

Critical access hospital (CAH) means a facility designated by HFCA as meeting the applicable requirements of section 1820 of the Act and of subpart F of part 485 of this chapter.

* * * * *

Essential access community hospital (EACH) means a hospital designated by HCFA as meeting the applicable requirements of section 1820 of the Act and of subpart G of part 412 of this chapter, as in effect on September 30, 1997.

* * * * *

Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

* * * * *

Services means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital, CAH, or SNF facilities.

* * * * *

PART 409—HOSPITAL INSURANCE BENEFITS

B. Part 409 is amended as follows:

1. The authority citation for Part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart D—Requirements for Coverage of Posthospital SNF Care

2. In § 409.30, the introductory text of paragraph (a) is republished and paragraph (a)(1) is revised to read as follows:

§ 409.30 Basic requirements.

* * * * *

(a) *Preadmission requirements.* The beneficiary must—

(1) Have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge; and

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

C. Part 410 is amended as follows:

1. The authority citation for Part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh)), unless otherwise noted.

2. Section 410.2 is amended by revising the definition of ''Participating'' to read as follows:

§ 410.2 Definitions.

* * * * *

Participating refers to a hospital, CAH, SNF, HHA, CORF, or hospice that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has a provider agreement to participate in Medicare but only for purposes of providing outpatient physical therapy, occupational therapy, or speech pathology services; or a CMHC that has in effect a similar agreement but only for purposes of providing partial hospitalization services, and *nonparticipating* refers to a hospital, CAH, SNF, HHA, CORF, hospice, clinic, rehabilitation agency, public health agency, or CMHC that does not have in effect a provider agreement to participate in Medicare.

3. Section 410.152 is amended by revising paragraph (k) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(k) *Amount of payment: Outpatient CAH services.* Payment for critical access hospital outpatient services is the reasonable cost of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act and with the applicable principles of cost reimbursement in part 413 and in part 415 of this chapter. Payment for CAH outpatient services is subject to the applicable Medicare Part B deductible and coinsurance amounts, as described in § 413.70(b)(3) of this chapter.

§ 410.155 [Amended]

4. Section 410.155 is amended by adding the phrase ''; or a critical access hospital (CAH) meeting the requirements of Part 485, subpart F of this chapter'' at the end of the last sentence of paragraph (a); and adding the phrase ''or CAH'' at the end of the last sentence of the introductory text of paragraph (b).

D. 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 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. In § 412.2, the introductory text of paragraph (f) is republished and paragraph (f)(8) is revised to read as follows:

§ 412.2 Basis of payment.

* * * * *

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

* * * * *

(8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

3. Section 412.8 is amended by revising paragraph (b) to read as follows:

§ 412.8 Publication of schedules for determining prospective payment rates.

* * * * *

(b) *Annual publication of schedule for determining prospective payment rates.* (1) HCFA proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a **Federal Register** document published for public comment not later than the April 1 before the beginning of the Federal

fiscal year in which the proposed changes would apply.

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

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

4. Section 412.22 is amended by revising paragraph (a) and adding new paragraphs (e), (f), and (g), to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems if it meets the criteria for one or more of the excluded classifications described in § 412.23.

* * * * *

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment system:

(1) *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.

(2) *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.

(3) *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.

(4) *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.

(5) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(i) The hospital performs the basic 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 same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital 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, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph (e)(5)(ii), however, the costs of preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(c)(5).

(iii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital 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.

(f) *Application for certain hospitals.* If a hospital has been excluded from the prospective payment systems under this section on or before September 30, 1995, the criteria in paragraph (e) of this section do not apply to the hospital.

(g) *Definition of control.* 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.

5. Section 412.23 is amended by revising paragraphs (e) and (f) 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) or (e)(2) of this section, and, where applicable, the additional requirements § 412.22(e).

(1) The hospital must have a provider agreement under part 489 of this chapter to participate as a hospital and an average inpatient length of stay greater than 25 days as calculated under paragraph (e)(3) of this section.

(2) For cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the prospective payment system under this section in 1986 must have an average inpatient length of stay of greater than 20 days, as calculated under paragraph (e)(3) of this section, and must demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(3) The average inpatient length of stay is calculated—

(i) 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;

(ii) If a change in the hospital's average length-of-stay is indicated, by the same method for the immediately preceding 6-month period; or

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the preceding 6 months, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

(f) *Cancer hospitals*—(1) *General rule.* Except as provided in paragraph (f)(2) of this section, if a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after October 1, 1989. A hospital classified after December 19, 1989, is excluded beginning with its first cost reporting period beginning after the date of its classification.

(i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.

(ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a State operating a demonstration project under section 1814(b) of the Act, the classification is made on or before December 31, 1991.

(iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center).

(iv) It shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. For the purposes of meeting this definition, only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect neoplastic disease.)

(2) *Alternative.* A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria set forth in paragraph (f)(1) of this section is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after January 1, 1991, if it meets the criterion set forth in paragraph (f)(1)(i) of this section and the hospital is—

(i) Licensed for fewer than 50 acute care beds as of August 5, 1997;

(ii) Is located in a State that as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act; and

(iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

* * * * *

6. Section 412.30 is amended by redesignating paragraphs (a) through (d) as paragraphs (b) through (e), respectively, and adding a new paragraph (a). Redesignated paragraph (b) is further amended by redesignating paragraph (b)(4) as paragraph (b)(5), and adding a new paragraph (b)(4). The introductory text of redesignated paragraph (d)(1) is republished and redesignated paragraph (d)(1)(ii) is revised to read as follows:

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

(a) *Bed capacity in units.* A decrease in bed capacity must remain in effect for at least a full 12-month cost reporting period before an equal or lesser number of beds can be added to the hospital's licensure and certification and considered ''new'' under paragraph (b) of this section. Thus, when a hospital seeks to establish a new unit under the criteria under paragraph (b) of this section, or to enlarge an existing unit under the criteria under paragraph (d) of this section, the regional office will review its records on the facility to determine whether any beds have been delicensed and decertified during the 12-month cost reporting period before the period for which the hospital seeks to add the beds. To the extent bed capacity was removed from the hospital's licensure and certification during that period, that amount of bed capacity may not be considered ''new'' under paragraph (b) of this section.

(b) *New units.*

* * * * *

(4) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital. The written certification described in paragraph (b)(2) of this section also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

* * * * *

(d) *Expansion of excluded rehabilitation units.*

(1) *New bed capacity.* The beds that a hospital seeks to add to its excluded rehabilitation unit are considered new beds only if—

* * * * *

(ii) The hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit.

* * * * *

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

7. In § 412.63, paragraph (p) is revised, paragraphs (q) through (s) are redesignated as paragraphs (u) through (w), respectively, and new paragraphs (q) through (t) are added to read as follows:

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

* * * * *

(p) *Applicable percentage change for fiscal year 1998.* The applicable percentage change for fiscal year 1998 is 0 percent for hospitals in all areas.

(q) *Applicable percentage change for fiscal year 1999.* The applicable percentage change for fiscal year 1999 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.9 percentage points for hospitals in all areas.

(r) *Applicable percentage change for fiscal year 2000.* The applicable percentage change for fiscal year 2000 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.8 percentage points for hospitals in all areas.

(s) *Applicable percentage change for fiscal years 2001 and 2002.* The applicable percentage change for fiscal years 2001 and 2002 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.1 percentage points for hospitals in all areas.

(t) *Applicable percentage change for fiscal year 2003 and for subsequent years.* The applicable percentage change for fiscal year 2003 and for subsequent years is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)) for hospitals in all areas.

* * * * *

Subpart F—Payment for Outlier Cases

8. Section 412.80 is revised to read as follows:

§ 412.80 General provisions.

(a) *Basic rule*—(1) *Discharges occurring on or after October 1, 1994 and before October 1, 1997.* For discharges occurring on or after October 1, 1994, and before October 1, 1997, except as provided in paragraph (b) 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 following conditions is met:

(i) The beneficiary's length-of-stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length-of-stay for the applicable DRG by the lesser of the following:

(A) A fixed number of days, as specified by HCFA; or

(B) A fixed number of standard deviations, as specified by HCFA.

(ii) The beneficiary's length-of-stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to 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.

(2) *Discharges occurring on or after October 1, 1997.* For discharges occurring on or after October 1, 1997, except as provided in paragraph (b) of this section concerning transfers, HCFA provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, 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.

(b) *Outlier cases in transferring hospitals.* HCFA provides cost outlier payments to a transferring hospital that does not receive payment under § 412.2(b) for discharges specified in § 412.4(d)(2), if the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a national cost/charge ratio, exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA, divided by the geometric mean length of stay for the DRG and multiplied by the beneficiary's length of stay plus 1 day.

(c) *Publication and revision of outlier criteria.* HCFA will issue threshold criteria for determining outlier payment in the annual notice of the prospective payment rates published in accordance with § 412.8(b).

§ 412.82 [Amended]

9. In § 412.82(a), in the first sentence, the word ''If'' is removed and the phrase ''For discharges occurring before October 1, 1997, if'' is added in its place.

§ 412.84 [Amended]

10. In § 412.84, in the first sentence of paragraph (a), the reference ''§ 412.80(a)(1)(ii)'' is revised to read ''§ 412.80(a)'', and the last sentence of paragraph (g) is removed.

§ 412.86 [Amended]

11. In the introductory text to § 412.86, the word ''If'' is removed and the phrase ''For discharges occurring before October 1, 1997, if'' is added in its place.

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

12. Section 412.90 is amended by redesignating paragraphs (i) and (j) as paragraphs (j) and (k), respectively, adding a new paragraph (i), and revising newly designated paragraphs (j) and (k), to read as follows:

§ 412.90 General rules.

* * * * *

(i) *Hospitals that receive an additional update for FYs 1998 and 1999.* For FYs 1998 and 1999, HCFA makes an upward adjustment to the standardized amounts for certain hospitals that do not receive indirect medical education or disproportionate share payments and are not Medicare-dependent, small rural hospitals. The criteria for identifying these hospitals are set forth in § 412.107.

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2001, HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital. Criteria for identifying these hospitals are set forth in § 412.108.

(k) *Essential access community hospitals (EACHs).* If a hospital was designated as an EACH by HCFA as described in § 412.109(a) and is located in a rural area as defined in § 412.109(b), HCFA determines the prospective payment rate for that hospital, as it does for sole community hospitals, under § 412.92(d).

13. In § 412.96, the introductory text of paragraph (c)(1) is revised, paragraph (f) is removed and reserved, and paragraph (g) is revised, to read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(c) * * *

(1) *Case-mix index.* HCFA sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (g) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by HCFA from the hospital's own billing records for Medicare discharges as processed by the fiscal intermediary and submitted to HCFA. The hospital's case-mix index for discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part) during the most recent Federal fiscal year that ended at least one year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to—

* * * * *

(e)–(f) [Reserved]

(g) *Hospital cancellation of referral center status.* (1) A hospital may at any time request cancellation of its status as a referral center and be paid prospective payments per discharge based on the applicable rural rate as determined in accordance with § 412.63, as adjusted by the hospital's area wage index value.

(2) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(3) If a hospital requests that its referral center status be canceled, it may not be reclassified as a referral center unless it meets the qualifying criteria set

forth in paragraph (a) of this section in effect at the time it reapplies.

* * * * *

14. In § 412.105, paragraphs (a) and (d) are revised, paragraph (f) is removed, paragraph (g) is redesignated as paragraph (f), and a new paragraph (g) is added. In redesignated paragraph (f), paragraph (f)(1)(i) introductory text is republished, paragraph (f)(1)(i)(B) is revised, paragraph (f)(1)(ii) introductory text is republished and paragraph (f)(1)(ii)(C) is revised, paragraph (f)(1)(iv) is revised, and a new paragraph (f)(1)(v) is added, to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(a) *Basic data.* HCFA determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (f) of this section, to the number of beds (as determined in paragraph (b) of this section). For a hospital's cost reporting periods beginning on or after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period.

(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of § 412.106 .

* * * * *

(d) *Determination of education adjustment factor.* Each hospital's education adjustment factor is calculated as follows:

(1) *Step one.* A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent residents to beds, as determined under paragraph (a)(1) of this section, is raised to an exponential power equal to the factor set forth in paragraph (c) of this section.

(2) *Step two.* The factor derived from step one is reduced by 1.00.

(3) *Step three.* The factor derived from completing steps one and two is multiplied by 'c', and where 'c' is equal to the following:

(i) For discharges occurring on or after October 1, 1988, and before October 1, 1997, 1.89.

(ii) For discharges occurring during fiscal year 1998, 1.72.

(iii) For discharges occurring during fiscal year 1999, 1.6.

(iv) For discharges occurring during fiscal year 2000, 1.47.

(v) For discharges occurring on or after October 1, 2000, 1.35.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

(i) The residents must be enrolled in an approved teaching program. An approved teaching program is one that meets one of the following requirements:

* * * * *

(B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(*1*) The Directory of Graduate Medical Education Programs published by the American Medical Association.

(*2*) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

* * * * *

(ii) In order to be counted, the resident must be assigned to one of the following areas:

* * * * *

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(1)(iii) are met.

* * * * *

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of full-time equivalent residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such full-time equivalent residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

(v) For a hospital's cost reporting periods beginning on or after October 1, 1997, and before October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident counts (subject to the requirements listed in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding cost reporting period. For a hospital's cost reporting periods beginning on or after October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident count (subject to the requirements listed in paragraphs (f)(10)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding two cost reporting periods.

* * * * *

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods beginning on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period.

15. Section 412.106 is amended by revising paragraphs (a)(2) and (d)(1) and adding a new paragraph (e) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) *General considerations.* * * *

* * * * *

(2) The payment adjustment is applied to the hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs under subpart F of this part and additional payments made under the provisions of § 412.105.

* * * * *

(d) *Payment adjustment.*

(1) *Method of adjustment.* Subject to the reduction factor set forth in paragraph (e) of this section, if a hospital serves a disproportionate number of low-income patients, its DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

* * * * *

(e) *Reduction in payments for FYs 1998 through 2002.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

(1) For FY 1998, 1 percent.
(2) For FY 1999, 2 percent.
(3) For FY 2000, 3 percent.
(4) For FY 2001, 4 percent.
(5) For FY 2002, 5 percent.
(6) For FYs 2003 and thereafter, 0 percent.

16. A new § 412.107 is added to read as follows:

§ 412.107 Special treatment: Hospitals that receive an additional update for FYs 1998 and 1999.

(a) *Additional payment update.* A hospital that meets the criteria set forth in paragraph (b) of this section receives the following increase to its applicable percentage amount set forth in § 412.63 (p) and (q):

(1) For FY 1998, 0.5 percent.

(2) For FY 1999, 0.3 percent.

(b) *Criteria for classification.* A hospital is eligible for the additional payment update set forth in paragraph (a) of this section if it meets all of the following criteria:

(1) *Definition.* The hospital is not a Medicare-dependent, small rural hospital as defined in § 412.108(a) and does not receive any additional payment under the following provisions:

(i) The indirect medical education adjustment made under § 412.105.

(ii) The disproportionate share adjustment made under § 412.106.

(2) *State criteria.* The hospital is located in a State in which the aggregate payment made under § 412.112 (a) and (c) for hospitals described in paragraph (b)(1) of this section for their cost reporting periods beginning in FY 1995 is less than the allowable operating costs described in § 412.2(c) for those hospitals.

(3) *Hospital criteria.* The aggregate payment made to the hospital under § 412.112 (a) and (c) for the hospital's cost reporting period beginning in the fiscal year in which the additional payment update described in paragraph (a) of this section is made is less than the allowable operating cost described in § 412.2(c) for that hospital.

17. In § 412.108 paragraph (a)(1) is revised, the introductory text of paragraphs (c) and (c)(2) are republished, and the introductory text of paragraph (c)(2)(ii) is revised to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.*

(1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2001, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in § 412.63(b)) and meets all of the following conditions:

* * * * *

(c) *Payment methodology.* A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient operating costs the sum of paragraphs (c)(1) and (c)(2) of this section.

* * * * *

(2) The amount, if any, determined as follows:

* * * * *

(ii) For discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, and for discharges occurring on or after October 1, 1997 and before October 1, 2001, 50 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

* * * * *

18. In § 412.109, paragraph (a) is revised, paragraphs (c) and (d) are removed, paragraphs (e), (f), and (g) are redesignated as paragraphs (c), (d), and (e), respectively, and redesignated paragraphs (c)(3)(ii), (d), and (e) are revised to read as follows:

§ 412.109 Special treatment: Essential access community hospitals (EACHs).

(a) *General rule.* For payment purposes, HCFA treats as a sole community hospital any hospital that is located in a rural area as described in paragraph (b) of this section and that HCFA designated as an EACH under section 1820(i)(1) of the Act as in effect on September 30, 1997, for as long as the hospital continues to comply with the terms, conditions, and limitations that were applicable at the time HCFA designated the hospital as an EACH. The payment methodology for sole community hospitals is set forth at § 412.92(d).

* * * * *

(c) *Adjustment to the hospital-specific rate for rural EACHs experiencing increased costs.*

* * * * *

(3) *Intermediary recommendation.*

* * *

(ii) The intermediary's analysis and recommendation of the request.

* * * * *

(d) *Termination of EACH designation.* If HCFA determines that a hospital no longer complies with the terms, conditions, and limitations that were applicable at the time HCFA designated the hospital as an EACH, HCFA will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

(e) *Review of HCFA determination.* A determination by HCFA 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—Payment to Hospitals Under the Prospective Payment Systems

19. Section 412.115 is amended by revising paragraph (b) to read as follows:

§ 412.115 Additional payments.

* * * * *

(b) *Administration of blood clotting factor.* For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac.

* * * * *

Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

20. Section 412.204 is revised to read as follows:

§ 412.204 Payment to hospitals located in Puerto Rico.

(a) *FY 1988 through FY 1997.* For discharges occurring on or after October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 75 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 25 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(b) *FY 1998 and thereafter.* For discharges occurring on or after October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 50 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 50 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

§ 412.210 [Amended]

21. In § 412.210(e), the phrase ''the national average hospital wage level'' is revised to read ''the Puerto Rico average hospital wage level''.

Subpart L—The Medicare Geographic Classification Review Board

22. Section 412.230 is amended by revising paragraphs (a)(5)(ii), (e)(1) introductory text, and (e)(1)(iv)(B) and adding new paragraphs (e)(3) and (e)(4), to read as follows:

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

(a) * * *

(5) * * *

(ii) For redesignations effective in fiscal years 1997 and 1998 and 2002 and thereafter, a hospital may not be redesignated for purposes of the standardized amount if the area to which the hospital seeks redesignation does not have a higher standardized amount than the standardized amount the hospital currently receives.

* * * * *

(e) *Use of urban or other rural area's wage index.*—(1) *Criteria for use of area's wage index.* Except as provided in paragraphs (e)(3) and (e)(4) of this section, to use an area's wage index, a hospital must demonstrate the following:

* * * * *

(iv) One of the following conditions apply:

* * * * *

(B) For redesignations effective before fiscal year 1999, the hospital's average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wages of hospitals in the area to which it seeks redesignation.

* * * * *

(3) *Rural referral center exception.* If a hospital is a rural referral center, it does not have to demonstrate that it meets the criterion set forth in paragraph (e)(1)(iii) of this section concerning its average hourly wage.

(4) *Special dominating hospital exception.* The requirements of paragraph (e)(1)(i) and (e)(1)(iii) of this section do not apply if a hospital meets the following criteria:

(i) Its average hourly wage is at least 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located.

(ii) It pays at least 40 percent of the adjusted uninflated wages in the MSA.

(iii) It was approved for redesignation under this paragraph (e) for each year from fiscal year 1992 through fiscal year 1997.

23. Section 412.232 is amended by revising paragraph (c)(2) to read as follows:

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

* * * * *

(c) *Wage criteria.* * * *

(2) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate 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.

* * * * *

24. Section 412.234 is amended by revising paragraph (b)(2) to read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

* * * * *

(b) *Wage criteria.* * * *

(2) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate average hourly wage for all hospitals in the county, weighted for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

* * * * *

25. In § 412.256, paragraphs (a)(2) and (c)(1) are revised to read as follows:

§ 412.256 Application requirements.

(a) * * *

(2) A complete application must be received not later than the first day of the month preceding the Federal fiscal year for which reclassification is requested.

* * * * *

(c) *Opportunity to complete a submitted application.* (1) The MGCRB will review an application within 15 days of receipt to determine if the application is complete. If the MGCRB determines that an application is incomplete, the MGCRB will notify the hospital, with a copy to HCFA, within the 15 day period, that it has determined that the application is incomplete and may dismiss the application if a complete application is not filed by September 1 .

* * * * *

26. Section 412.274 is amended by revising paragraph (b) to read as follows:

§ 412.274 Scope and effect of an MGCRB decision.

* * * * *

(b) *Effective date and term of the decision.* Any classification change is effective for one year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

* * * * *

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

27. Section 412.308 is amended by adding new paragraphs (b)(4) and (b)(5) to read as follows:

§ 412.308 Determining and updating the Federal rate.

* * * * *

(b) *Standard Federal rate.* * * *

(4) Effective FY 1998, the unadjusted standard Federal capital payment rate in effect on September 30, 1997, used to determine the Federal rate each year under paragraph (c) of this section is reduced by 15.68 percent.

(5) For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted standard Federal capital payment rate as in effect on September 30, 1997, used to determine the Federal rate each year under paragraph (c) of this section is further reduced by 2.1 percent.

* * * * *

28. Section 412.328 is amended by revising paragraph (e)(4) and adding new paragraphs (e)(5) and (e)(6) to read as follows:

§ 412.328 Determining and updating the hospital-specific rate.

* * * * *

(e) *Hospital-specific rate.* * * *

(4) *Payment for transfer cases.* Effective FY 1996, the intermediary reduces the updated amount determined in paragraph (d) of this section by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

(5) *Reduction of rate: FY 1998.* Effective FY 1998, the unadjusted hospital-specific rate as in effect on September 30, 1997 described in paragraph (e)(1) of this section is reduced by 15.68 percent.

(6) *Reduction of rate: FY 1998 through FY 2002.* For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted hospital-specific rate in effect on September 30, 1997, described in paragraph (e)(1) of this section is further reduced by 2.1 percent.

* * * * *

29. Section 412.348 is amended by revising paragraph (c)(2) to read as follows:

§ 412.348 Exception payments.

* * * * *

(c) *Minimum payment level by class of hospital.*

* * * * *

(2) When it is necessary to adjust the minimum payment levels set by class of hospitals specified in paragraphs (c)(1)(i) and (g)(6) of this section, HCFA will adjust those levels for each class of hospitals in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exception process not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

* * * * *

30. Section 412.374 is revised to read as follows:

§ 412.374 Payments to hospitals located in Puerto Rico.

(a) Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of a Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) Effective for fiscal year 1998, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997, is reduced by 15.68 percent.

(c) For discharges occurring on or after October 1, 1997 through September 30, 2002, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997 is further reduced by 2.1 percent.

E. Part 413 is amended as set forth below:

PART 416—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. Section 413.1 is amended by revising paragraph (a)(1)(ii)(G) to read as follows:

§ 413.1 Introduction.

(a) * * *

(ii) * * *

(G) Section 1834(g) of the Act provides that payment for critical access hospital (CAH) outpatient services is the reasonable costs of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter.

* * * * *

§ 413.13 [Amended]

3. In § 413.13, paragraph (c)(2)(iv) is removed.

4. Section 413.40 is amended by adding new paragraphs (b)(1)(iv) and (b)(1)(v); revising paragraph (c)(3)(vi) and adding new paragraphs (c)(3)(vii) and (c)(3)(viii); revising paragraph (c)(4); revising paragraphs (d)(2) and (d)(3) and adding new paragraphs (d)(4)and (d)(5); revising paragraphs (f)(1), (f)(2), (g)(1), and (g)(5); and adding a new paragraph (j), to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) * * *

(iv) *Request for rebased target amount for the cost reporting period beginning on or after October 1, 1997 and on or before September 30, 1998.* Except for qualified long-term care hospitals as defined in paragraph (b)(1)(v) of this section, each hospital or unit under present or previous ownership that received payment under section 1886(b) of the Act during cost reporting periods beginning before October 1, 1990, may submit a request to its fiscal intermediary to rebase its target amount. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days before the beginning of its cost reporting period beginning during fiscal year 1998. The rebased target amount for the cost reporting period beginning during fiscal year 1998 is determined as follows:

(A) Determine the hospital's inpatient operating costs per case for each of the five most recent settled cost reports as of August 5, 1997.

(B) For each of the five cost reports, update the operating costs per case by the applicable update factors up to the hospital's cost reporting period beginning during FY 1998.

(C) Exclude the highest and lowest of the five updated amounts determined under paragraph (b)(1)(iv)(B) of this section.

(D) Compute the average for the remaining three updated amounts for operating cost per case.

(v) *Request by qualified long-term care hospital.* A qualified long-term care hospital may file a request to its fiscal intermediary for a rebased FY 1998 target amount. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days before the beginning of its cost reporting period beginning during fiscal year 1998. The rebased FY 1998 target amount is the hospital's FY 1996 inpatient operating costs updated to FY 1997. A qualified long-term care hospital means a long-term care hospital that meets the following two conditions for its two most recent settled cost reports as of August 5, 1997:

(A) Its Medicare inpatient operating costs exceed 115 percent of the ceiling.

(B) The hospital would have had a disproportionate patient percentage (as defined in § 412.106) equal to or greater than 70 percent if it were a prospective payment hospital.

* * * * *

(c) *Costs subject to the ceiling.*

* * * * *

(3) *Rate-of-increase percentages and update factors.* * * *

(vi) *Federal fiscal year 1998.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1997 is 0 percent.

(vii) *Federal fiscal year 1999 through Federal fiscal year 2002.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1998, and before October 1, 2002, based on data from the most recent available cost report, is:

(A) The percentage increase in the market basket, if inpatient operating costs are equal to or exceed the ceiling amount by 10 percent or more of the ceiling.

(B) The percentage increase in the market basket minus .25 percentage points for each percentage point by which inpatient operating costs are less than 10 percent over the ceiling (but not less than 0), if inpatient operating costs exceed the ceiling by less than 10 percent of the ceiling.

(C) The greater of the percentage increase in the market basket minus 2.5 percentage points or 0 percent, if inpatient operating costs are equal to or less than the ceiling but greater than 66.7 percent of the ceiling.

(D) 0 percent, if inpatient operating costs do not exceed 66.7 percent of the ceiling.

(viii) *Federal fiscal year 2003 and following.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 2002, is the percentage increase projected by the hospital market basket index.

(4) *Target amount.* The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

(i) Except as provided in paragraph (c)(4)(iv) of this section, and subject to the provisions of paragraph (c)(4)(iii) of this section, for the first cost reporting period to which this ceiling applies, the target amount equals the hospital's allowable net inpatient operating costs per case for the hospital's base period increased by the update factor for the subject period.

(ii) Subject to the provisions of paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period, unless the provisions of paragraph (c)(5)(ii) of this section apply.

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long term care hospital, the target amount may not exceed—

(A) For cost reporting periods beginning during fiscal year 1998, the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long term care hospital) for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1997.

(B) For cost reporting periods beginning during FYs 1999 through 2002, the amount determined under paragraph (c)(4)(iii)(A) increased by the market basket percentage increase up through the subject period, subject to paragraph (c)(4)(iv) of this section.

(iv) In the case of a hospital that received payments under paragraph (f)(2)(ii) of this section, for purposes of determining the hospital's target amount for the hospital's third 12-month cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under paragraph (f)(2)(ii)(A) of this section.

* * * * *

(d) *Application of the target amount in determining the amount of payment.*

* * *

(2) *Net inpatient operating costs are less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 1997, if a hospital's allowable net inpatient operating costs do not exceed the hospital's ceiling, payment to the hospital will be determined on the basis of the lower of the—

(i) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or

(ii) Net inpatient operating costs plus 2 percent of the ceiling.

(3) *Net inpatient operating costs are greater than the ceiling.* For cost reporting periods beginning on or after October 1, 1997—

(i) If a hospital's allowable net inpatient operating costs do not exceed 110 percent of the ceiling (or the adjusted ceiling, if applicable), payment will be the ceiling (or the adjusted ceiling, if applicable);

(ii) If a hospital's allowable net inpatient operating costs are greater than 110 percent of the ceiling (or the adjusted ceiling, if applicable), payment will be the ceiling (or the adjusted ceiling, if applicable) plus the lesser of:

(A) 50 percent of the allowable net inpatient operating costs in excess of 110 percent of the ceiling (or the adjusted ceiling, if applicable); or

(B) 10 percent of the ceiling (or the adjusted ceiling, if applicable).

(4) *Continuous improvement bonus payments.* For cost reporting periods beginning on or after October 1, 1997, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs for the period; or

(ii) 1 percent of the ceiling.

(5) *Eligibility requirements for continuous improvement bonus payments.* To qualify, a hospital must have been paid as a prospective payment excluded hospital for at least three full cost reporting periods prior to the applicable period, and the hospital's operating costs per discharge for the period must be less than the least of the following:

(i) The hospital's target amount.

(ii) The hospital's trended costs.

(A) For a hospital for which its cost reporting period ending during fiscal year 1996 was its third or subsequent full cost reporting period, trended costs are the lesser of the allowable inpatient operating costs per discharge or the target amount for the cost reporting period ending in fiscal year 1996, increased in a compounded manner for each succeeding fiscal year by the market basket percentage increase;

(B) For all other hospitals, trended costs are the allowable inpatient operating costs per discharge for its third full cost reporting period increased in a compounded manner for each succeeding fiscal year by the market basket increase.

(iii) The hospital's expected costs. The hospital's expected costs are the lesser of its allowable inpatient operating costs per discharge or the target amount for the previous cost reporting period, updated by the market basket percentage increase for the fiscal year.

* * * * *

(f) *Comparison to the target amount for new hospitals and units*—(1) *New hospitals and units*—(i) *New hospitals.* For purposes of this section, a new hospital is a provider of hospital inpatient services that—

(A) Has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than 2 full years; and

(B) Has provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program, for less than 2 years.

(ii) *New units.* A newly established unit that is excluded from the prospective payments system under the provisions of §§ 412.25 through 412.30 of this chapter does not qualify for the exemption afforded to a new hospital under paragraph (f)(2)(i) of this section unless the unit is located in an acute care hospital that, if it were subject to the provisions of this section, would qualify as a new hospital under paragraph (f)(1)(i) of this section.

(2) *Comparison*—(i) *Exemptions.* (A) A new children's hospital is exempt from the rate-of-increase ceiling imposed under this section. The exemption begins when the hospital accepts its first patient and ends at the end of the first cost reporting period ending at least 2 years after the hospital accepts its first patient. The first cost reporting period of at least 12 months beginning at least 1 year after the hospital accepts its first patient is the base year, in accordance with paragraph (b) of this section.

(B) Within 180 days of the date a hospital is excluded from the prospective payment system, the intermediary determines whether the hospital is exempt from the rate-of-increase ceiling. The intermediary notifies the hospital of its determination and the hospital's base period.

(C) A decision issued under paragraph (f)(2)(ii)(B) of this section is considered final unless the hospital submits additional information and requests a review of the decision no later than 180 days after the date on the intermediary's notice of the decision. The final

decision is subject to review under subpart R of part 405 of this chapter, provided the hospital has received a notice of program reimbursement (NPR) for the cost reporting period in question and the NPR does not reflect an exemption (see the definitions in § 405.1801(a) of this chapter and the provisions regarding a provider's right to a Board hearing in § 405.1835 of this chapter).

(ii) *Median target amount.* (A) For cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long-term care hospital that was not paid as an excluded hospital prior to October 1, 1997, is the lower of the hospital's net inpatient operating costs per case or 110 percent of the national median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, long-term care) as adjusted and updated. This methodology applies to the hospital's first two 12-month cost reporting periods.

(B) The national median of the target amounts is the FY 1996 median target amount—

(*1*) Adjusted to account for differences in area wage levels;

(*2*) Updated by the market basket percentage increase to the fiscal year in which the hospital first received payments as an excluded provider.

* * * * *

(g) Adjustments.—(l) *General rule.* HCFA may adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified below. When an adjustment is requested by the hospital, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately identified by the hospital, and verified by the intermediary. HCFA may grant an adjustment requested by the hospital only if a hospital's operating costs exceed the rate-of-increase ceiling imposed under this section. The amount of payment made to a hospital after an adjustment under paragraph (g) of this section is based on the difference between the hospital's operating costs and 110 percent of the ceiling.

* * * * *

(5) *Adjustment limitations.* For cost reporting periods beginning on or after October 1, 1993, and before October 1, 2003, the payment reductions under paragraph (c)(3)(v) through (c)(3)(vii) of this section will not be considered when determining adjustments under this paragraph.

* * * * *

(j) *Reduction to capital-related costs.* For psychiatric hospitals and units, rehabilitation hospitals and units, and long-term hospitals, the amount otherwise payable for capital-related costs is reduced by 15 percent for portions of cost reporting periods occurring on or after October 1, 1997, through September 30, 2002.

5. Section 413.70 is revised to read as follows:

§ 413.70 Payment for services of a CAH.

Payment for inpatient and outpatient services of a CAH is the reasonable costs of the CAH in providing such services, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter.

Subpart F—Specific Categories of Costs

6. In § 413.86, the introductory text of paragraph (b) is republished, paragraph (b) is amended by adding the definition of ''Affiliated group'' in alphabetical order, paragraph (d)(3) is redesignated as paragraph (d)(5) and redesignated paragraph (d)(5) is revised, new paragraphs (d)(3) and (d)(4) are added, paragraph (e)(4)(i)(B) is revised, the introductory text of paragraph (g)(1) is amended by adding a sentence to the end, and new paragraphs (g)(4), (g)(5), (g)(6) and (g)(7) are added, to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* For purposes of this section, the following definitions apply:

Affiliated group means two or more hospitals located in the same geographic wage area (as that term is used under part 412 of this subchapter for the prospective payment system) in which individual residents work at each of the hospitals seeking to be treated as an affiliated group during the course of the approved program; or, if the hospitals are not located in the same geographic wage area, the hospitals are jointly listed as major participating institutions for one or more programs as that term is used in *Graduate Medical Education Directory, 1997–1998.*

* * * * *

(d) *Calculating payment for graduate medical education costs.* * * *

(3) *Step three.* For portions of cost reporting periods beginning on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to—

(i) 20 percent for 1998;

(ii) 40 percent for 1999;

(iii) 60 percent in 2000;

(iv) 80 percent in 2001; and

(v) 100 percent in 2002 and subsequent years.

(4) *Step four.* Add the results of steps 2 and 3.

(5) *Step five.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

* * * * *

(e) *Determining per resident amounts for the base period.* * * *

(4) *Exceptions.* (i) *Base period for certain hospitals.*

* * * * *

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the calculation of the per resident amounts includes all hospitals in the hospital's region as that term is used in § 412.62(f)(1)(i).

* * * * *

(g) *Determining the weighted number of FTE residents.* * * *

(1) * * * If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in paragraph (b) of this section) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus one year.

* * * * *

(4) For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's

unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996. If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996. Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis. The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(5) For purposes of determining direct graduate medical education payment, for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods. The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph based on the equivalent of 12-month cost reporting periods.

(6) If a hospital established a new medical residency training program as defined in this paragraph (g) after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no residents before January 1, 1995, and it establishes a new medical residency training program on or after that date, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the number of first year residents in the program in the third year of the program's existence and the number of years in which residents are expected to complete that program based on the minimum accredited length for the type of program. For these hospitals, the cap will only be adjusted based on the first program (or programs, if established simultaneously) beginning on or after January 1, 1995. The cap will not be revised for programs subsequently established.

(ii) If a hospital had residents in its most recent cost reporting period ending before January 1, 1995, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and August 5, 1997. Increases in the hospital's FTE resident limit are permitted for the new program based on the product of the number of first-year residents in the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program. The hospital's unweighted FTE limit for a cost reporting period may be adjusted to reflect the number of residents in its most recent cost reporting period ending on or before December 31, 1996 and up to the incremental increase in its FTE count only for the newly established programs.

(iii) If a hospital with residents in its most recent cost reporting period ending on or before January 1, 1995, is located in a rural area (or other hospitals located in rural areas which added residents under paragraph (g)(6)(i) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (g)(6)(ii) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(iv) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(7) For purposes of paragraph (g) of this section, *new medical residency training program* means a medical residency training program that receives initial accreditation by the appropriate accrediting body on or after July 1, 1995.

* * * * *

F. Part 424 is amended as set forth below:

PART 424—CONDITIONS FOR MEDICARE PAYMENT

1. The authority citation for Part 424 continues to read as follows:

Authority: Section 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 424.1(a)(1), the introductory text is republished and a new statutory citation is added in numerical order, to read as follows:

§ 424.1 Basis and scope.

(a) Statutory basis. (1) This part is based on the indicated provisions of the following sections of the Act:

* * * * *

1820—Conditions for designating certain hospitals as critical assess hospitals.

* * * * *

3. In § 424.15, the section heading and paragraph (a) are revised to read as follows:

§ 424.15 Requirements for inpatient CAH services.

(a) *Content of certification.* Medicare Part A pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

* * * * *

H. Part 485 is amended as set forth below:

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. The heading for Subpart F is revised to read as follows:

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

3. In § 485.603, the introductory text is republished, paragraphs (a)(1) and (a)(2) are revised, and a new paragraph (c) is added to read as follows:

§ 485.603 Rural health network.

A rural health network is an organization that meets the following specifications:

(a) It includes—

(1) At least one hospital that the State has designated or plans to designate as a CAH; and

(2) At least one hospital that furnishes acute care services.

* * * * *

(c) Each CAH that is a member of the rural health network has an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network

(2) One PRO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.

4. Section 485.606 is revised to read as follows:

§ 485.606 Designation of CAHs.

(a) *Criteria for State designation.* (1) A State that has established a Medicare rural hospital flexibility program described in section 1820(c) of the Act may designate one or more facilities as CAHs if each facility meets the CAH conditions of participation in this subpart F.

(2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide posthospital SNF care as described in § 482.66 of this chapter.

(b) *Criteria for HCFA designation.* HCFA designates a facility as a CAH if—

(1) The facility is designated as a CAH by the State in which it is located; or

(2) The facility is a medical assistance facility operating in Montana or a rural primary care hospital designated by HCFA before August 5, 1997, and is otherwise eligible to be designated as a CAH by the State under the rules in this subpart.

5. Section 485.610 is revised to read as follows:

§ 485.610 Condition of participation: Status and location.

(a) *Standard: Status.* The facility is a public or nonprofit hospital.

(b) *Standard: Location.* The CAH meets the following requirements:

(1) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under the regulations in § 412.62(f) of this chapter.

(2) The CAH is not deemed to be located in an urban area under § 412.63(b) of this chapter.

(3) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board under § 412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under § 412.232 of this chapter.

(4) The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or the CAH is certified by the State as being a necessary provider of health care services to residents in the area.

6. Section 485.612 is revised to read as follows:

§ 485.612 Condition of participation: Compliance with hospital requirements at time of application.

The hospital has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.

7. Section 485.614 is removed.

8. Section 485.616 is revised to read as follows:

§ 485.616 Condition of participation: Agreements.

(a) *Standard: Agreements with network hospitals.* In the case of a CAH that is a member of a rural health network as defined in § 485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for—

(1) Patient referral and transfer;

(2) The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and

(3) The provision of emergency and nonemergency transportation between the facility and the hospital.

(b) *Standard: Agreements for credentialing and quality assurance.* Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network;

(2) One PRO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.

9. Section 485.620 is revised to read as follows:

§ 485.620 Condition of participation: Number of beds and length of stay.

(a) *Standard: Number of beds.* Except as permitted for CAHs having swing-bed agreements under § 485.645 of this chapter, the CAH maintains no more than 15 inpatient beds.

(b) *Standard: Length of stay.* The CAH discharges or transfers each inpatient within 96 hours after admission, unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions. A PRO or equivalent entity may also, on request, waive the 96-hour restriction on a case-by-case basis.

10. In § 485.623, the address under paragraphs (d)(1) and (d)(2) ''HCFA Information Resource Center, 6325 Security Boulevard, Room G–10–A East High Rise Building, Baltimore, MD 21207'' is revised to read ''HCFA Information Resource Center, 7500 Security Boulevard, Room C2–07–13, Central Building, Baltimore, MD 21244–1850''.

11. In § 485.645, the section heading, the introductory text, paragraphs (a) and the first sentence of the introductory text of paragraph (b) are revised to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (''swing-beds'').

A CAH must meet the following requirements in order to be granted an approval from HCFA to provide post-hospital SNF care, as specified in § 409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (b) of this section.

(a) *Eligibility.* A CAH must meet the following eligibility requirements:

(1) Effective October 1, 1997, a facility that, at the time it applied to the State for designation as a CAH, had an agreement in effect under § 482.66 of this chapter may continue to use its inpatient facilities for the provision of post-hospital SNF care, so long as the total number of beds that are used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds.

(2) Notwithstanding paragraph (a)(1) of this section, a CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997 and on that date had in effect an approval from HCFA to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

(3) A CAH that was granted swing-bed approval under paragraph (a)(2) of this section may request that its application to be a CAH and a swing-bed provider be reevaluated under paragraph (a)(1) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (a)(2) of this section, and may not request reinstatement under paragraph (a)(2) of this section.

(4) Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a)(1) of this section.

(b) *Payment.* Payment for inpatient CAH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made

in accordance with § 413.70 of this chapter. * * *

* * * * *

H. Part 489 is amended as set forth below:

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

1. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, and 1395hh).

§ 489.27 [Amended]

2. In § 489.27, the reference ''section 1886(a)(1)(M) of the Act'' is revised to read ''section 1866(a)(1)(M) of the Act''.

§ 489.53 [Amended]

3. In § 489.53, paragraph (a)(14) is removed.

Nomenclature Changes

1. In the following sections, ''rural primary care hospital (RPCH)'' is revised to read ''critical access hospital (CAH)'':

§ 410.150(b)(12)
§ 440.170(g) heading
§ 498.2 definition of provider

2. In the following parts or sections, ''rural primary care hospitals (RPCHs)'' is revised to read ''critical access hospital (CAHs)'':

§ 413.1(a)(2)(i)
§ 489.2(b)(7)

3. In the following sections or section headings, ''an RPCH'' is revised to read ''a CAH'', wherever it appears:

§ 409.10(b)
§ 409.20(c)(3)
§ 409.27
§ 409.60(b)(1)(ii)
§ 409.61(b) paragraph heading
§ 409.82(a)(1)
§ 410.3(a)(1)
§ 410.10(c)
§ 410.38(b)
§ 410.60(b)
§ 411.15(m)(1)
§ 440.170 (g)(1) and (g)(2)
§ 485.601(b)
§ 485.604 introductory text
§ 489.20(d)

4. In the following sections, ''RPCH'' is revised to read ''CAH'' wherever it appears:

§ 409.5 first sentence
§ 409.10(a) introductory text and (a)(3)
§ 409.11 (b)(1)(ii), (b)(1)(iii), (b)(3) introductory text, and (b)(3)(ii)
§ 409.12 section heading, (a), and (b)
§ 409.13(a) introductory text, (a)(1), (a)(2), (a)(3), and (b)
§ 409.14(a) introductory text, (a)(1), (a)(2), (b) introductory text, (b)(1), and (b)(2)
§ 409.15 introductory text
§ 409.16 introductory text, (a), (b), and (c)
§ 409.20(a) introductory text
§ 409.30 introductory text,(a)(2), (b)(1), (b)(2), and footnote 1
§ 409.31 (b)(2)(i) and (b)(2)(ii)
§ 409.60(a)
§ 409.61(a) paragraph heading, (a)(1)(i), (a)(2), (a)(3), (b), and (c)
§ 409.64(a)(2)(ii)
§ 409.65 (a)(1), (a)(3), (a)(4), (d)(1), (d)(2), (d)(3), (e)(1), (e)(2) introductory text, (e)(2)(i), and (e)(2)(ii)
§ 409.66(b) and (c)(2)
§ 409.68 heading, (a) introductory text, (a)(1), (a)(2), (a)(3), (a)(4), (b)(2), and (c)
§ 409.80 (a)(1) and (a)(2)
§ 409.82(c)
§ 409.83(a)(1) and (c)(1)
§ 409.87(a)(3) and (b)(1)
§ 410.10(d)
§ 410.28 heading, (a) introductory text, (a)(1), (a)(2), and (a)(4)
§ 410.32(b)(1)
§ 410.40(a) in the definitions of ''Appropriate hospital'', ''Hospital inpatient'', ''Locality'', and ''Outside supplier'', (b)(3) introductory text, (b)(3)(i), (c)(1), (c)(2), (c)(3), (e)(1), (e)(2), and (e)(3)
§ 410.60 (b) and (d)
§ 410.62 (b) and (c)
§ 410.150(b)(12)
§ 410.161(b)(2)
§ 413.114(b), definition of ''Swing-bed hospital''
§ 424.15 (a) and (b)
§ 424.20 introductory text
§ 440.170 (g)(1) and (g)(2)
§ 485.602
§ 485.608 introductory text, (a), (c), and (d)
§ 485.618 introductory text, (b) introductory text, and (e)
§ 485.623(a), (b) introductory text, (c) introductory text, (c)(4), and (d)(1), (2), (3), and (4)
§ 485.627(a), (b) introductory text, (b)(1), and (b)(2)
§ 485.631 (a)(1), (a)(3), (a)(4), (a)(5), (b)(1)(i), (b)(1)(ii), (b)(1)(iii), (b)(2), (c)(1) introductory text, (c)(1)(i), (c)(2)(i), (c)(2)(ii), and (c)(3)
§ 485.635 (a)(1), (a)(2), (a)(3)(i), (a)(3)(iii), (a)(3)(vii), (a)(4), (b)(1), (b)(2) introductory text, (b)(3), (b)(4), (c)(1) introductory text, (c)(1)(iii), (c)(1)(iv), (c)(2), (c)(3), (c)(4) introductory text, (c)(4)(i), (c)(4)(ii), (d)(1), and (d)(2)
§ 485.638 (a)(1), (a)(4), (b)(1), and (b)(2)
§ 485.639 introductory text, (a) introductory text, (b), and (c) introductory text
§ 485.641(a)(1) introductory text, (a)(1)(i), (a)(1)(iii), (b) introductory text, (b)(3), (b)(4), (b)(5)(i), (b)(5)(ii), and (b)(5)(iii)
§ 485.645(c) introductory text
§ 489.20(e)

5. In the following sections, ''RPCHs'' is revised to read ''CAHs'', wherever it appears:

§ 485.601(a)

6. In the following parts or sections, ''rural primary care hospital'' is revised to read ''critical access hospital'', whenever it appears:

Part 409, subpart B heading
§ 409.1(c)
§ 414.60(b)
§ 488.1 in the definition of ''Provider of services''
§ 488.10(d)
§ 488.18(d)
§ 489.24(b) in the definitions of ''Hospital'' and ''Participating hospital''
§ 489.53(a)(10) and (b) introductory text

7. In the following sections, ''rural primary care hospitals'' is revised to read ''critical access hospitals'', wherever it appears:

§ 413.124(a)
§ 413.130(j)(1)
§ 488.6(a)
§ 489.102(a)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance)

Dated: August 22, 1997.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 22, 1997.

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 Occurring On or After October 1, 1997 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1997

I. Summary and Background

In this addendum, we set forth the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We also set forth 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, 1997, except for sole community hospitals, Medicare-dependent, small rural hospitals, and

hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yield 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. Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a national rate (section 4406 of Pub. L. 105–33 amended section 1886(d)(9)(A) of the Act to change the basis of the payment per discharge for hospitals in Puerto Rico from 75 percent of a Puerto Rico rate to 50 percent of a Puerto Rico rate and from 25 percent of a national rate to 50 percent of a national 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, affect the calculation of the Federal rates. In section III, we discuss our changes for determining 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 this 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 1998

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. (See section V.I of the preamble for a discussion of the Puerto Rico payment rate.) Below, we discuss the manner in which we are changing some of the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes will be effective with discharges occurring on or after October 1, 1997. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 1998.

In summary, the standardized amounts set forth in Tables 1A and 1C of section V of this addendum reflect—

- Updates of 0 percent for all areas;
- 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 large 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 1997 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 1997 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

The standardized amounts set forth in Tables 1E and 1F of section V of this addendum, which apply to ''temporary relief'' hospitals (see section V.D of the preamble for a discussion of these hospitals), reflect updates of 0.5 percent for all areas but otherwise reflect the same adjustments as the national standardized amounts.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required that Medicare target amounts be determined for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2) (B) and (C) of the Act required that the base-year per discharge costs be updated for FY 1984 and then 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.

Under sections 1886 (d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1996, when the market basket was last revised and rebased, we have considered 71.2 percent of costs to be labor-related for purposes of the prospective payment system. As discussed in section IV of the preamble, we are including data not available when the market basket was last rebased to adjust the market basket effective for FY 1998. Based on the proposed revised market basket, we are revising the labor and nonlabor proportions of the standardized amounts. Effective with discharges occurring on or after October 1, 1997, we are establishing a labor-related proportion of 71.1 percent and a nonlabor-related proportion of 28.9 percent. (We are revising the Puerto Rico standardized amounts by the average labor share in Puerto Rico of 71.3 percent. We are revising the discharged-weighted national standardized amount to reflect the proportion of discharges in large urban and other areas from the FY 1996 MedPAR file.)

2. Computing Large Urban and Other Area Averages

Sections 1886(d) (2)(D) and (3) of the Act require 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 sections 1886(d)(9) (B)(iii) and (C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized

amount and 50 percent of a national standardized payment amount. (Section 4406 of Public Law 105–33 amended section 1886(d)(9)(A) of the Act to change the payment for hospitals in Puerto Rico from 75 percent of the applicable Puerto Rico standardized payment amount and 25 percent of the applicable national standardized payment amount to 50 percent of the applicable Puerto Rico standardized payment amount and 50 percent of the applicable national standardized payment amount.)

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1,000,000. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. 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 1996 population estimates published by the Bureau of the Census, 60 areas meet the criteria to be defined as large urban areas for FY 1998. These areas are identified by a footnote in Table 4A. We note that the Secretary has chosen to exercise the authority granted by section 4408 of Public Law 105–33 to include Stanly County, North Carolina in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA for purposes of payment under the prospective payment system.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban and the other areas average standardized amounts for FY 1998 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. As amended by section 4401 of Public Law 105–33, Section 1886(b)(3)(B)(i)(XIII) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 1998 is equal to zero percent. Section 4401 of Public Law 105–33 also provides for an update of 0.5 percent for hospitals that are not Medicare-dependent small rural hospitals, that receive no IME or DSH payments, that are located in a State in which aggregate Medicare operating payments for such hospitals were less than their aggregate allowable Medicare operating costs for their cost reporting periods beginning during FY 1995, and whose Medicare operating payments are less than their allowable Medicare operating costs in FY 1998.

As in the past, we are adjusting the FY 1997 standardized amounts to remove the effects of the FY 1997 geographic reclassifications and outlier payments before applying the FY 1998 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers in FY 1997. After including new offsets to the standardized amounts for outliers and geographic reclassification for FY 1998, we estimate that there will be an overall decrease of 5.6 percent to the large urban and other area standardized amounts.

Although the update factor for FY 1998 is set by law, we are required by section 1886(e)(4)(A) of the Act to report to Congress on our final recommendation of update factors for FY 1998 for both prospective payment hospitals and hospitals excluded from the prospective payment system. We have included our final recommendation in 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 ensures that aggregate payments to hospitals are not affected. As discussed in section II of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

Section 1886(d)(3)(E) of the Act specifies that the hospital wage index must be updated on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that 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 budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 1997 relative weights and wage index to aggregate payments using the FY 1998 relative weights and wage index. The same methodology was used for the FY 1997 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.997731. We adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999117. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1997 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate 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 1998 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1997, 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 FY 1998 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.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the 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 are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. We are applying an adjustment factor of 0.994720 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1997 budget neutrality adjustment factor. We note that the FY 1998 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 27, 1997. The effects of additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 1998 or from a hospital's request for the withdrawal of a reclassification request are reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the final rule for FY 1998.

c. Outliers. Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs (cost outliers) or long lengths of stay (day outliers). Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other area national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to adjust the large urban and other standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates.

Beginning with FY 1995, section 1886(d)(5)(A) of the Act requires the Secretary to phase out payments for day outliers (correspondingly, payments for cost outliers would increase). Under the requirements of section 1886(d)(5)(A)(v), the proportion of day outlier payments to total outlier payments is reduced from FY 1994 levels as follows: 75 percent of FY 1994 levels in FY 1995, 50 percent of FY 1994 levels in FY 1996, and 25 percent of FY 1994 levels in FY 1997. For discharges occurring after September 30, 1997, the Secretary will no longer pay for day outliers under the provisions of section 1886(d)(5)(A)(i) of the Act.

i. FY 1998 Outlier Payment Thresholds. For FY 1997, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations. The marginal cost factor for day outliers (the percent of Medicare's average per diem payment paid for each outlier day) is 33 percent for FY 1997. The fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $9,700 ($8,850 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1997 standardized amounts of 0.948766 for the large urban and other areas rates and 0.9481 for the capital Federal rate.

As noted above, section 1886(d)(5)(A)(v) of the Act provides that payment will not be made for day outliers beginning with discharges occurring in FY 1998.

In the proposed rule, we proposed to establish a fixed loss cost outlier threshold in FY 1998 equal to the prospective payment rate for the DRG plus $7,600 ($6,950 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we proposed to maintain the marginal cost factor for cost outliers at 80 percent. Section 4405 of Public Law 105–33 amended section 1886(d)(5)(A)(ii) of the Act to revise the definition of the cost outlier threshold. For FY 1997, the statute required the fixed loss cost outlier threshold to be based on ''the applicable DRG prospective payment rate plus a fixed dollar amount determined by the Secretary''. Public Law 105–33 provides that, beginning in FY 1998, the fixed loss cost outlier threshold is based on ''the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) [IME payments] and (F) [DSH payments] plus a fixed dollar amount determined by the Secretary''. Consistent with this statutory change, the methodology for setting the final FY 1998 cost outlier threshold differs from the methodology used for the proposed rule because we no longer adjust hospital costs to exclude IME and DSH payments (see section V.A. of the preamble). In addition, in setting the final FY 1998 outlier thresholds, we used updated data and revised cost inflation factor (discussed below). Thus, for FY 1998, in order for a case to qualify for cost outlier payments, the costs must exceed the prospective payment rate for the DRG plus the IME and DSH payments plus $11,050 ($10,080 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, as proposed.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the FY 1998 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 1998 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.2 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 1998 were as follows:

	Operating standardized amounts	Capital federal rate
National	0.949117	0.9449
Puerto Rico	0.961448	0.9449

The final outlier adjustment factors applied to the standardized amounts for FY 1998 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948840	0.9382

	Operating standardized amounts	Capital federal rate
Puerto Rico	0.971967	0.9598

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 1997 outlier adjustment factors on the standardized amounts.

ii. Other Changes Concerning Outliers. Table 8A in section V of this addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios would replace the ratios published in the August 30, 1996 final rule (61 FR 46302), effective October 1, 1997. Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.227808 or greater than 1.29731 and capital cost-to-charge ratios lower than 0.01270 or greater than 0.18955. 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. We note that the cost-to-charge ratios in Tables 8A and 8B will be used for all cost reports settled during FY 1998 (regardless of the actual cost reporting period) when hospital-specific cost-to-charge ratios are either not available or outside the three standard deviations range.

iii. FY 1996 and FY 1997 Outlier Payments. In the August 30, 1996 final rule (61 FR 46229), we stated that, based on available data, we estimated that actual FY 1996 outlier payments would be approximately 4.0 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1995 bill data available at the time. That is, the estimate of actual FY 1996 outlier payments did not reflect actual FY 1996 bills but instead reflected the application of FY 1996 rates and policies to available FY 1995 bills. Our current estimate, using available FY 1996 bills, is that actual outlier payments for FY 1996 were approximately 4.2 percent of actual total DRG payments. We note that the MedPAR file for FY 1996 discharges continues to be updated.

We currently estimate that actual outlier payments for FY 1997 will be approximately 4.8 percent of actual total DRG payments (slightly lower than the 5.1 percent we projected in setting outlier policies for FY 1997). This estimate is based on simulations using the June 1997 update of the provider-specific file and the June 1997 update of the FY 1996 MedPAR file (discharge data for FY 1996 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1997 by applying FY 1997 rates and policies to available FY 1996 bills.

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. This refinement was made to improve our estimation methodology. We believe that actual FY 1996 and FY 1997 outlier payments as a percentage of total DRG payments may be lower than expected in part because actual hospital costs may be lower than reflected in the methodology used to set outlier thresholds for those years. Our most recent data on hospital costs show that rates of increase are continuing to decline. Thus, the cost inflation factor of 0.871 percent used to set FY 1996 outlier policy (based on the best data then available) appears to have been overstated. For FY 1997, we used a cost inflation factor of minus 1.906 percent (a cost per case decrease of 1.906 percent). In the proposed rule, based on data then available, we used a cost inflation factor of minus 1.969 percent to set outlier thresholds for FY 1998. Based on the most recent data available, we are using a cost inflation factor of minus 2.005 percent for purposes of setting the final 1998 outlier thresholds.

Although we estimate that FY 1996 outlier payments will approximate 4.2 percent of total DRG payments, we note that the estimate of the market basket rate of increase used to set the FY 1996 rates was 3.5 percentage points, while the latest FY 1996 market basket rate of increase forecast is 2.7 percent. Thus, the net effect is that hospitals received higher FY 1996 payments than would have been established based on a more recent forecast of the market basket rate of increase.

Comment: One commenter modeled the outlier payments and was able to replicate HCFA's result of 5.1 percent for operating outlier payments, but the commenter's analysis yielded only 5.3 percent for capital outlier payments as compared with HCFA's result of 5.5 percent.

Response: Although we are unable to analyze the commenter's modeling methodology before publication of this document, we will attempt to ascertain the source of the discrepancy between the commenter's outlier model and HCFA's outlier model before next year's proposed rule.

5. FY 1998 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A (and Table 1E for ''temporary relief'' hospitals) contain the standardized amounts that are applicable to all hospitals, except for hospitals in Puerto Rico. Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Tables 1A and 1E). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C (and Table 1F for ''temporary relief'' hospitals). These tables also include the Puerto Rico standardized amounts.

The Puerto Rico standardized amounts reflect application of a Puerto Rico-specific wage index for FY 1998. Thus, before application of the wage index, the FY 1998 Puerto Rico standardized amounts are lower than the FY 1997 standardized amounts. However, after application of the wage index, the FY 1998 Puerto Rico rate is higher than the rate for FY 1997. This is due to the higher Puerto Rico wage index values that will be applied to these standardized amounts in calculating the FY 1998 Puerto Rico rate. Below, we use two wage areas to illustrate that the FY 1998 Puerto Rico wage-adjusted standardized amounts are higher than the FY 1997 Puerto Rico wage-adjusted standardized amounts.

Puerto Rico Standardized Amounts

Area	FY 1997		FY 1998	
	Labor	Nonlabor	Labor	Nonlabor
Large Urban	$2,488.70	$518.65	$1,323.01	$532.55
Other Areas	$2,449.31	$510.45	$1,302.07	$524.11

Puerto Rico Wage-Adjusted Standardized Amount for the San Juan MSA and Rural Puerto Rico

	FY 1997	FY 1998
San Juan Wage Index	0.4506	1.0156
Wage-Adjusted Standardized Amount	$1,640.06	$1,877.44
Rural Wage Index	0.4026	0.9291
Wage-Adjusted Standardized Amount	$1,496.54	$1,735.01

Table 1E contains the two national standardized amounts that are applicable to the ''temporary relief'' hospitals discussed in section V.D of the preamble to this rule, except those located in Puerto Rico. The labor and nonlabor portions of the national average standardized amounts for hospitals in that group that are located in Puerto Rico are set forth in Table 1F. This table also includes the Puerto Rico standardized amounts for hospitals in that group.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A, 1C, 1E and 1F, as set forth in this addendum, contain the labor-related and nonlabor-related shares used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble, we discuss certain revisions we are making to the wage index. These changes include the calculation of a Puerto Rico-specific wage index that are being applied to the Puerto Rico standardized amounts. The wage index is set forth in Tables 4A through 4F 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 1998, we adjusted the payments for hospitals in Alaska and Hawaii 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	1.225
County of Kauai	1.225
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 classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section V of this addendum contains the relative weights that we will use for discharges occurring in FY 1998. These factors have been recalibrated as explained in section II of the preamble.

One commenter noted that there was a typographical error in the proposed Table 5. The proposed relative weight for DRG 92 was incorrectly printed as .1929 rather than 1.1929. The final weight is 1.1947.

D. Calculation of Prospective Payment Rates for FY 1998

General Formula for Calculation of Prospective Payment Rates for FY 1998

Prospective payment rate for all hospitals located outside Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the updated FY 1982 hospital-specific rate, or 100 percent of the updated FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate plus, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

Prospective payment rate for Puerto Rico = 50 percent of the Puerto Rico rate + 50 percent of a discharge-weighted average of the national large urban standardized amount and the national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 1997 and before October 1, 1998, except for sole community hospitals, Medicare-dependent small rural hospitals, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate. Section 1866(d)(1)(A)(iii) of the Act provides that the Federal rate is comprised of 100 percent of the Federal national rate.

The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Tables 1A or 1E, 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 of 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 of section V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural 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.

Sections 1886(d)(5)(G) and (b)(3)(D) of the Act (as amended by section 4204 of Publ. L. 105–33) provide that Medicare-dependent, small rural hospitals are

paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and 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 period (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 1998. We are increasing the hospital-specific rates by 0 percent for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 1998. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, as amended by section 4401 of Pub. L. 105–33, is 0 percent for FY 1998. Section 1886(b)(3)(D) of the Act (as amended by section 4204 of Publ. L. 105–33) provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, as amended by section 4401 of Pub. L. 105–33, is 0 percent for FY 1998.

b. Calculation of Hospital-Specific Rate. For sole community hospitals and Medicare-dependent, small rural hospitals, the applicable FY 1998 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (0 percent), which is the same as the update for all prospective payment hospitals except temporary relief hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 0.997731) as discussed in section II.A.4.a of this Addendum. This resulting rate would be used in determining under which rate a sole community hospital or Medicare-dependent, small rural hospital is paid for its discharges beginning on or after October 1, 1997, based on the formulas set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1997 and Before October 1, 1998

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 or 1F of section V of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of 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 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of 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 or 1F of section V of the addendum) by the appropriate national wage index (see Tables 4A and 4B of section V of the addendum).

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 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of 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 1998

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 a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the Federal rate and the hospital-specific rates for FY 1998. The rates are effective for discharges occurring on or after October 1, 1997.

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 update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. Furthermore, § 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 FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Finally, § 412.308(b)(2) describes the 7.4 percent reduction to the rate which was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers.

In this final rule with comment period we are implementing section 4402 of Public Law 105–33, which requires that, effective for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate shall be reduced by 17.78 percent. Part of that reduction will be restored effective October 1, 2002.

For each hospital, the hospital-specific rate 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. Since FY 1992, the hospital-specific rate has been updated annually for inflation and for changes in the exceptions payment adjustment factor. For FYs 1992 through 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor. In this final rule with comment period we are implementing section 4402 of Public Law 105–33, which requires that, effective for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital specific rate shall be reduced by 17.78 percent. Part of that reduction will be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor 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. With the expiration of the budget neutrality provision, the model is still used to estimate the exceptions payment adjustment and other factors. The model and its application are described in greater detail 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 for operating costs under a special payment formula. These hospitals are paid a blended rate that comprises 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Under § 412.374, the methodology for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs parallels the blended payment methodology for operating payments to Puerto Rico hospitals. Effective October 1, 1997, as a result of section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico shall be based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. However, in conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we are computing capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

For FY 1997, the Federal rate was $438.92. In the proposed rule, we stated that the proposed FY 1998 Federal rate was $438.43. In this final rule with comment period, we are establishing a FY 1998 Federal rate of $371.51.

In the discussion that follows, we explain the factors that were used to determine the FY 1998 Federal rate. In particular, we explain why the FY 1998 Federal rate has decreased 15.36 percent compared to the FY 1997 Federal rate. The major factor contributing to the decrease in the FY 1998 rate in comparison to the FY 1997 rate is the 17.78 percent reduction to the Federal rate required by Public Law 105–33. Also, capital payments per case are estimated to decrease 8.92 percent. Taking into account the effects of increases in projected discharges, we estimate that aggregate capital payments will decrease 6.74 percent.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals.

1. Reduction to the Standard Federal Rate

Section 4402 of Pub. L. 105–33 requires that for discharges occurring after October 1, 1997 the unadjusted standard Federal rate be reduced by 15.68 percent, and by an additional 2.1 percent from October 1, 1997 through September 30, 2002. Thus, the unadjusted standard Federal rate used to set the Federal rate each year is reduced a total of 17.78 percent from October 1, 1997 through September 30, 2002. After that date the 2.1 percent reduction to the rate will be restored.

The regulation changes we are making to implement this statutory requirement are discussed in section VI.C of the preamble. Here we discuss the effects of the required reduction in computing the FY 1998 Federal capital rate.

Under § 412.308(b), HCFA determines the standard Federal rate by adjusting the FY 1992 updated national average cost per discharge by a factor so that estimated payments based on the standard Federal rate, adjusted by the payment adjustments described in § 412.312(b), equal estimated aggregate payments based solely on the national average cost per discharge. Section 412.308(c) provides further that the standard Federal rate is updated for inflation each Federal fiscal year and adjusted each year by an outlier payment adjustment factor, and an exceptions payment adjustment factor, to determine the Federal capital payment rate for that year. The standard Federal rate is to be distinguished from the annual Federal rate actually used in making payment under the capital prospective payment system. The standard Federal rate is, in effect, the underlying or base rate used to determine the annual Federal rate by means of the formula in § 412.308(c).

Because the 17.78 percent reduction applies to the standard Federal rate before the application of the adjustment factors for outliers, exceptions, and budget neutrality, the reduction to the standard Federal rate does not have the effect of simply lowering the FY 1998 Federal rate by 17.78 percent compared to FY 1997. Rather, the 17.78 percent reduction is one factor contributing to the overall 15.36 percent reduction in the FY 1998 Federal rate compared to FY 1997. The FY 1998 exceptions reduction factor increases the rate by 3.22 percent relative to the FY 1997 exceptions reduction factor. For a more complete description of changes to the Federal rate, see the table that compares the FY 1997 rate with the FY 1998 rate later in this addendum.

As discussed in the proposed rule, ProPAC recommended that the rate be adjusted to a more appropriate level (Recommendation 3). They indicated that the FY 1997 rate was 15 to 17 percent too high and attributed this to the overstatement of the 1992 base payment rates and the method used to update the rates prior to implementation of the update framework. ProPAC outlined several possible approaches we could use for adjusting the rate by regulation. In our response, we agreed with ProPAC that the capital rates were too high and noted that the President's FY 1998 budget included a provision to reduce the base Federal and hospital-specific rates by approximately the magnitude suggested by ProPAC. We restated our belief that it was most appropriate to make such adjustments to the capital rates in the context of a comprehensive package of Medicare program changes. We therefore did not propose to implement a revision to the base capital rates by regulation for FY 1998.

Comment: ProPAC noted that both HCFA and ProPAC had recommended that the base capital rate should be cut. They also noted that a proposal to cut the rate was included in the President's budget under consideration by the Congress. However, ProPAC expressed its belief that absent action by the Congress to cut the capital rate, the Secretary should cut the rate using her regulatory authority.

Response: After ProPAC commented, the Congress passed Public Law 105–33 and the President signed it into law in early August. As anticipated, the legislation included a reduction to the unadjusted standard Federal rate and the unadjusted hospital specific rate along with several other changes to the Medicare program. As discussed previously, we are implementing the reduction to the rate as part of this final rule with comment period.

Comment: One State hospital association expressed its opposition to a reduction in capital payments. The association stated that reducing capital payments to hospitals would likely increase borrowing costs by making hospitals less attractive to investors, and inhibit hospital's abilities to modernize their physical plants. The commenter was especially concerned about the impact of a rate cut on low volume rural hospitals.

Response: As we noted in our response to ProPAC's previous comment, we did not propose to cut the capital rate by regulation in the proposed rule. We stated our belief that the capital rate should be addressed by the Congress in conjunction with other changes to the Medicare program. The Congress included a 17.78 percent reduction to the capital rate and the hospital specific rate in Public Law 105–33, which we are implementing in this final rule with comment period. We have stated on several occasions that due to a variety of factors capital payments to hospitals are over-stated and should be reduced. Based on data we updated for this final rule with comment period, we estimate that for FY 1997 Medicare capital payments to hospitals exceeded Medicare capital costs by 8.7 percent. Many small rural hospitals are also low cost hospitals that have benefitted from the introduction of a capital prospective payment system. Many of these hospitals are paid on the full prospective payment methodology and capital payments are based on an increasing percentage of the Federal rate during the transition to fully prospective capital payment system, where the Federal rate is higher than the hospital specific rate. However, because capital payments are determined on a per discharge basis, hospitals with few discharges will necessarily receive payments that are consistent with the number of Medicare patients they serve. We note however, that sole community hospitals benefit from a higher minimum payment threshold for purposes of capital exceptions payments. Further, together with this capital rate reduction provision, Congress has made other changes that affect small rural hospitals. For example, as of October 1, 1997, the Medicare-dependent hospital provisions are reinstated and the Critical Access Hospital Program is established nationwide.

2. Standard Federal Rate Update

a. Description of the Update Framework. Section 412.308(c)(1) provides that the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor of 1.1 percent, based on data available at that time. The final update factor for FY 1998 under that framework is 0.9 percent. This update factor is based on a projected 1.1 percent increase in the CIPI, and on policy adjustment factors of −0.2. We explain the basis for the FY 1998 CIPI projection in section D of this addendum. Here we describe the policy adjustments that have been applied.

The case-mix index 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 case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs, but do not reflect higher resource requirements. 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 case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-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 have adopted this case-mix index adjustment in the capital update framework as well.

For FY 1998, we are projecting a 1.0 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.8 percent in FY 1998. Therefore, the net adjustment for case-mix change in FY 1998 is -0.2 percentage points.

We estimate that DRG reclassification and recalibration resulted in a 0.0 percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs.

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 upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. In setting a prospective payment rate under this framework, we 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. Because we only introduced this analytical framework in FY 1996, FY

1998 is the first year in which a forecast error adjustment could be required. We estimate that the FY 1996 CIPI was .20 percentage points higher than our current data show, which means that we estimate a forecast error of .20 percentage points for FY 1996. Therefore no adjustment for forecast error will be made in FY 1998.

Under the capital prospective payment system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. 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 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 have, therefore, incorporated the intensity adjustment from the operating update framework into the capital update framework. Without 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 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 thus provides 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.

For FY 1998, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1991–1995. In determining case-mix constant intensity, we found that observed case-mix increase was 2.8 percent in FY 1991, 1.8 percent in FY 1992, 0.9 percent in FY 1993, 0.8 percent in FY 1994, 1.7 percent in FY 1995, and 1.6 percent in FY 1996. For FY 1992, FY 1995, and FY 1996, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC(1991). The study suggested that real case-mix change was not dependent on total change, but was rather a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1991 through FY 1995. Based on this analysis, we believe that all of the observed case-mix increase for FY 1993 and FY 1994 is real.

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. Given estimates of real case-mix increase of 1.0 percent for FY 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, 1.0 percent for FY 1995, and 1.0 percent for FY 1996, we estimate that case-mix constant intensity declined by an average 1.4 percent during FYs 1992 through 1996, for a cumulative decrease of 7.0 percent. If we assume that real case-mix increase was 1.4 percent for FY 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, 1.4 percent for FY 1995, and 1.4 percent for FY 1996, we estimate that case-mix constant intensity declined by an average 1.6 percent during FYs 1992 through 1996, for a cumulative decrease of 7.5 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 1998.

b. Comparison of HCFA and ProPAC Update Recommendations. In Recommendation 4 of the proposed rule, ProPAC recommended a zero update to the standard Federal rate, and we recommended a 1.1 percent update. (See the June 2, 2997 proposed rule for a discussion of the differences between the ProPAC and HCFA update frameworks (62 FR 29950). In this final rule with comment period, as discussed in the previous section, we are implementing a 0.9 update to the capital rate. ProPAC recommended a zero update to the rate for FY 1998 because it believed that a zero update applied to revised base rates would permit hospitals to maintain quality of care while meeting Medicare's responsibility to act as a prudent purchaser.

Comment: In response to our statements in the proposed rule about why we recommended an update to the capital rate, ProPAC stated that it had applied the same reasoning for recommending a zero update to the capital rate that it had used in recommending a zero update to the operating rate. ProPAC restated its belief that a zero update was appropriate for both the operating and capital rates.

Response: As required by Pub. L. 105–33, we are implementing a 17.78 percent reduction to the unadjusted standard Federal capital payment rate and the unadjusted hospital-specific rate effective October 1, 1997. To the extent this statutory reduction to the base capital rate addresses the issues of the rates being overstated, we believe we should not, at the same time, further address the issue through the update framework.

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. We note that as indicated in section V of the preamble, in conjunction with our policy of a unified outlier methodology for operating and capital, we are adopting the change required by Pub. L. 105–33 concerning outlier payments. The law requires the fixed loss cost outlier threshold to be based on the sum of the base DRG payment, indirect medical education (IME) payment and the disproportionate share hospital (DSH) payment effective with discharges occurring on or after October 1, 1997.

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, 70 percent for cost reporting periods beginning in FY 1998 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 proportion of outlier payments under the Federal rate to total inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments. The inpatient capital-related outlier reduction factor reflects the 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 they were 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 August 30, 1996 final rule, we estimated that outlier payments for capital in FY 1997 would equal 5.19 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9481 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d of this Addendum, we estimate that outlier payments for capital will equal 6.18 percent of inpatient capital-related payments based on the Federal rate in FY 1998. We are, therefore, applying an outlier adjustment factor of 0.9382 to the Federal rate. Thus, estimated capital outlier payments for FY 1998 represent a higher percentage of total capital standard payments than for FY 1997.

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 1998 is 0.9896 (0.9382/0.9481). Thus, the outlier adjustment decreases the FY 1998 Federal rate by 1.04 percent (1 − 0.9896) compared with the FY 1997 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration, and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model described in Appendix B to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use 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 use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 1997, we calculated a GAF/DRG budget neutrality factor of 0.9987. In the proposed rule for FY 1998, we proposed a GAF/DRG budget neutrality factor of 1.0001. In this final rule with comment period, based on calculations using updated data, we are applying a factor of 0.9989 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 estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from FY 1997 to FY 1998 is 0.9989. The cumulative change in the rate due to this adjustment is 1.0001 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, and FY 1998: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 = 1.0001$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 1998 geographic reclassification decisions made by the MGCRB compared to FY 1997 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. 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 proportion of additional payments for exceptions under § 412.348 relative to total payments under the hospital-specific rate and Federal rate. We use an actuarial model described in Appendix B to determine the exceptions payment adjustment factor.

For FY 1997, we estimated that exceptions payments would equal 6.42 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9358 (1—0.0642) in determining the FY 1997 Federal rate. For FY 1998, we estimated in the June 2, 1997 proposed rule that exceptions payments would equal 7.24 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore we proposed to apply an exceptions payment reduction factor of .9276 (1—0.0724) to determine the FY 1998 Federal rate. For this final rule with comment period, we estimate that exceptions payments for FY 1998 will equal 3.41 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9659 (1—0.0341) to the Federal rate for FY 1998.

The final exceptions reduction factor for FY 1998 is thus 3.22 percent higher than the factor for FY 1997 and 4.13 percent higher than the factor in the FY 1998 proposed rule. This change is due to a modeling refinement we have implemented since publication of the proposed rule described in Appendix B. The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the net adjustment for exceptions to the FY 1998 Federal rate over the FY 1997 Federal rate is 0.9659/0.9358, or 1.0322.

5. Standard Capital Federal Rate for FY 1998

For FY 1997, the capital Federal rate was $438.92. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1998 Federal rate would be $438.43. In this final rule with comment period, we are establishing a FY 1998 Federal rate of $371.51. The Federal rate for FY 1998 was calculated as follows:

- The FY 1998 update factor is .0090, that is, the update is 0.9 percent.
- The FY 1998 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9989.
- The FY 1998 outlier adjustment factor is 0.9382.
- The FY 1998 exceptions payments adjustment factor is 0.9659.

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 have made no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 1998 affected the computation of the FY 1998 Federal rate in comparison to the FY 1997 Federal rate. We have added the effect of the 17.78 percent reduction to the rate required by Public Law 105–33 to the chart. The FY 1998 update factor has the effect of increasing the Federal rate by 0.90 percent

compared to the rate in FY 1997, while the final geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.11 percent. The FY 1998 outlier adjustment factor has the effect of decreasing the Federal rate by 1.04 percent compared to FY 1997. The FY 1998 exceptions reduction factor has the effect of increasing the Federal rate by 3.22 percent compared to the exceptions reduction for FY 1997. The combined effect of all the changes is to decrease the Federal rate by 15.36 percent compared to the Federal rate for FY 1997.

Comparison of Factors and Adjustments: FY 1997 Federal Rate and FY 1998 Federal Rate

	FY 97	FY 98	Change	Percent change
Public Law 105–33 Standard Federal Rate Reduction	NA	0.8222	0.8222	−17.78
Update factor [1]	1.0070	1.0090	1.0090	0.90
GAF/DRG Adjustment Factor [1]	0.9987	0.9989	0.9989	−0.11
Outlier Adjustment Factor [2]	0.9481	0.9382	0.9896	−1.04
Exceptions Adjustment Factor [2]	0.9358	0.9659	1.0322	3.22
Federal Rate	$438.92	$371.51	0.8464	−15.36

[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 1997 to FY 1998 resulting from the application of the 0.9989 GAF/DRG budget neutrality factor for FY 1998 is 0.9989.

[2] The outlier reduction factor and the exceptions reduction factor 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 1998 outlier reduction factor is 0.9382/0.9481, or 0.9896.

We are also providing a chart that shows how the final FY 1998 Federal rate differs from the proposed FY 1998 Federal rate.

Comparison of Factors and Adjustments: Proposed FY 1998 Federal Rate and Final FY 1998 Federal Rate

	Proposed FY 98	Final FY 98	Change	Percent change
Public Law 105–33 Standard Federal Rate Reduction	NA	0.8222	0.8222	−17.78
Update factor	1.0110	1.0090	0.9980	−0.20
GAF/DRG Adjustment Factor	1.0001	0.9989	0.9988	−0.12
Outlier Adjustment Factor	0.9449	0.9382	0.9929	−0.71
Exceptions Adjustment Factor	0.9276	0.9659	1.0413	4.13
Federal Rate	$438.43	$371.51	0.8474	−15.26

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of this section, in the past, hospitals in Puerto Rico were paid based on 75 percent of the Puerto Rico rate and 25 percent of the Federal rate. To parallel the change to the Puerto Rico blended payment amount mandated for operating payments by Public Law 105–33, effective with discharges on or after October 1, 1997, capital payments to hospitals in Puerto Rico will be based on 50 percent of the Puerto Rico capital rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended rate. The GAF is calculated using the operating PPS wage index, and varies depending on the MSA or rural area in which the hospital is located. Since the GAF is based on the wage index, we are revising the method of accounting for geographical variation in Puerto Rico, to parallel the change that is being proposed on the operating rate, where a Puerto Rico-specific wage index is being calculated (see section III.B. of this preamble). Specifically, we used the new Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital blended rate, and retained the use of the national wage index to determine the GAF for the national part of the blended rate. As noted above, effective October 1, 1997, hospitals in Puerto Rico will be paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. This means that, in computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate will be multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate will be multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico).

We have adjusted the Puerto Rico rate to account for the application of Puerto Rico-specific GAFs. We did this in order to be consistent with the method by which we originally determined the national and Puerto Rico rates. This resulting standard Puerto Rico rate does not translate into a reduction in payments to Puerto Rico hospitals. The Puerto Rico-specific GAFs are higher than the national GAFs because they use the Puerto Rico mean only rather than the national mean. As a result, application of Puerto Rico-specific GAFs means Puerto Rico hospitals receive more money.

For FY 1997, before application of the GAF, the special rate for Puerto Rico hospitals was $337.63. With the changes we proposed to the factors used to determine the rate, the proposed FY 1998 special rate for Puerto Rico was $204.46. In this final rule with comment period, the FY 1998 capital rate for Puerto Rico is $177.57. Since publication of the proposed rule, the Puerto Rico rate has declined because of the effect of the 17.78 percent reduction to the rate implemented as a result of Public Law 105–33.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1998 be determined by adjusting the FY 1997 hospital-specific rate by the

hospital-specific rate update factor and the exceptions payment adjustment factor. Before application of these factors the FY 1997 unadjusted hospital-specific rate was reduced 17.78 percent to comply with the provisions of Public Law 105–33. The 17.78 percent reduction will be in force from October 1, 1997 through September 30, 2002. A 15.68 percent reduction to the unadjusted hospital specific rate will remain in effect from October 1, 2002 onward.

1. Impact of Public Law 105–33

Public Law 105–33 reduces the hospital specific rate 17.78 percent through September 30, 2002. After that date a 15.68 percent reduction to the rate shall remain in effect.

2. 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 1998, we have updated the hospital-specific rate by a factor of 1.0090.

3. Exceptions Payment Adjustment Factor

For FYs 1992 through 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, which is determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 1998, we estimated in the proposed rule that exceptions payments would be 7.24 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 0.9276. In this final rule with comment period, we estimate that exceptions payments will be 3.53 percent of aggregate payments based on the Federal rate and the hospital specific rate. We are applying an exceptions reduction factor of 0.9659 to the hospital-specific rate.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. Therefore, the net adjustment to the FY 1998 hospital-specific rate is 0.9659/0.9358, or 1.0322.

4. Net Change to Hospital-Specific Rate

We are providing a chart to show the net change to the hospital-specific rate. The chart shows the factors for FY 1997 and FY 1998 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 1997 to FY 1998 is 0.8563, which represents a decrease of 13.66 percent to the hospital-specific rate. For each hospital, the FY 1998 hospital-specific rate is determined by multiplying the FY 1997 hospital-specific rate by the cumulative net adjustment of 0.8563.

FY 1998 Update and Adjustments to Hospital-Specific Rates

	FY 97	FY 98	Net adjustment	Percent change
Public Law 105–33 Hospital-Specific Rate Reduction	(1)	0.8222	0.8222	−17.78
Update Factor	1.0070	1.0090	1.0090	0.90
Exceptions Payment Adjustment Factor	0.9358	0.9659	1.0322	3.22
Cumulative Adjustments	0.9424	0.8070	0.8563	−14.37

[1] Not applicable.

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 1997 to FY 1998 is 1.0090. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1997 to FY 1998 is 0.9659/0.9358, or 1.0322.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1998

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 making adjustments as follows:

- 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 GAF, 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) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is termed the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1994 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis for the remainder of the transition period.

Payment for each discharge under the fully prospective methodology is the sum of:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 1998 are 70 percent of the adjusted Federal rate and 30 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 70 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1998. Thus, a fully prospective hospital will receive 70 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1998. 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 1998 are published in section II.A.4.c of this Addendum. For FY 1998, a case qualifies as a cost outlier if the cost for the case is greater than the sum of the prospective payment rate for the DRG plus IME and DSH payments plus $11,050. During the capital prospective payment system transition period, a 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 1998 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.

D. Capital Input Price Index

1. Background

Like the prospective payment hospital operating input price index, the Capital Input Price Index (CIPI) is a fixed-weight price index. A fixed-weight price index measures how much it would cost at a later date to purchase the same mix of goods and services purchased in the base period. For the prospective payment hospital operating and capital input price indices, the base period is selected and cost category weights are determined using available data on hospitals. Next, appropriate price proxy indices are chosen for each cost category. Then a price proxy index level for each expenditure category is multiplied by the comparable cost category weight. The sum of these products (that is, weights multiplied by price proxy index levels) for all cost categories yields the composite index level of the market basket for a given year. Repeating the step for other years produces a time series of composite market basket index levels. Dividing an index level by a later index level produces a rate of growth in the input price index. Since the percent change is computed for the fixed mix of total capital inputs with a 1992 base, the index is fixed-weight.

Like the operating input price index, the CIPI measures the price changes associated with costs during a given year. In order to do so, the CIPI must differ from the operating input price index in one important aspect. The CIPI must reflect the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, AHA data, and Securities Data Corporation data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent explanation of the CIPI was discussed in the proposed rule for FY 1998 published in the June 2, 1997 **Federal Register** (62 FR 29953). The following **Federal Register** documents also describe development and revisions of the methodology involved with the construction of the CIPI: September 1, 1992 (57 FR 40016), May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), and September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), and August 30, 1996 (61 FR 46196).

2. Research on Reweighting the CIPI

After analyzing various data sources and methodologies for determining capital weights for the HCFA PPS CIPI, we will continue to use the weights published in the August 30, 1996 **Federal Register** (61 FR 46196). We

explained in the June 2, 1997 proposed rule that we had decided not to use the 1992 Department of Commerce Asset and Expenditure data to revise the cost category weights in the CIPI. The three reasons why we are staying with the current HCFA PPS CIPI cost category weights are: (1) HCFA's prefers to continue to use the Medicare Cost Reports for the Medicare subset of hospitals (PPS only); (2) the detail needed for future rebasing of the index will be available from the Medicare Cost Reports; and (3) the CIPI cost shares are similar to those provided by the 1992 Asset and Expenditures Survey. We received no comments on this issue.

3. Forecast of the CIPI for Federal Fiscal Year 1998

DRI forecasts a 1.1 percent increase in the CIPI for FY 1998. This is the outcome of a projected 2.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.2 percent increase in other capital expense prices in FY 1998, partially offset by a 2.0 percent decline in vintage-weighted interest rates in FY 1998. The weighted average of these three factors produces the 1.1 percent increase for the CIPI as a whole.

IV. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

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

Each hospital's target amount is adjusted annually, at the beginning of its cost reporting period, by an applicable rate-of-increase percentage. Section 1886(b)(3)(B) of the Act provides that for cost reporting periods beginning on or after October 1, 1997 and before October 1, 1998, the rate- of-increase percentage is 0. In order to determine a hospital's target amount for its cost reporting period beginning in FY 1998, the hospital's target amount for its cost reporting period that began in FY 1997 is increased by 0. In addition, as indicated in section VII of the preamble, Public Law 105–33 significantly altered several aspects of payments for excluded hospitals and units, effective for cost reporting periods beginning on or after October 1, 1997. Section 4413 of Public Law 105–33 permits certain excluded hospitals—hospitals that were excluded for the cost reporting period beginning before October 1, 1990 and are within certain specified classes, as well as ''qualified long-term care hospitals''—to elect a rebasing of the hospital's target amount for the 12-month cost reporting period beginning during FY 1998. The rebased target amount for a hospital would reflect operating costs in recent cost reporting periods. Section 4414 establishes a cap on target amounts for certain classes of excluded hospitals, based on target amounts for hospitals in the same class, for cost reporting periods beginning during FY 1998. Section 4415 revises the formulas for determining bonus and relief payments for excluded hospitals and also establishes an additional bonus payment for continuous improvement, for cost reporting periods beginning during FY 1998. Finally, sections 4416 and 4419 establish a new statutory payment methodology for new hospitals, effective October 1, 1997.

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 before 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 1995, we would use the rate of increase between the wage index based on 1982 wage data and the wage index based on the FY 1994 data, since the FY 1994 data are the most recent data 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 show the following increases:

1992 = 4.8 percent
1993 = 3.6 percent
1994 = 2.7 percent
1995 = 3.3 percent

1996 = 3.1 percent
1997 = 2.2 percent
1998 = 3.2 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 with comment period.

V. Tables

This section contains the tables referred to throughout the preamble to this final rule with comment period and in this Addendum. For purposes of this final rule with comment period, 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, 1C, 1D, 1E, 1F, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 6A, 6B, 6C, 6D, 6E, 6F, 7A, 7B, 8A, 8B, and 10 are presented below. The tables presented below are as follows:

Table 1A—National 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 1E—National Adjusted Operating Standardized Amounts for ''Temporary Relief'' Hospitals, Labor/Nonlabor
Table 1F—Adjusted Operating Standardized Amounts for ''Temporary Relief'' Hospitals in Puerto Rico, Labor/Nonlabor
Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1996 and Hospital Average Hourly Wage for Federal Fiscal Year 1998 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 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Arithmetic Mean Length of Stay 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—Additions to the CC Exclusions List
Table 6F—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 96 MEDPAR Update 06/97 GROUPER V14.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 96 MEDPAR Update 06/97 GROUPER V15.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) August 1997
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) August 1997
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
2,776.21	1,128.44	2,732.26	1,110.58

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,752.36	1,118.74	2,752.36	1,118.74
Puerto Rico	1,323.01	532.55	1,302.07	524.11

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	371.51
Puerto Rico	177.57

TABLE 1E.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR ''TEMPORARY RELIEF'' HOSPITALS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,790.09	1,134.08	2,745.92	1,116.13

TABLE 1F.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR ''TEMPORARY RELIEF'' HOSPITALS IN PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,766.12	1,124.33	2,766.12	1,124.33
Puerto Rico	1,329.63	535.21	1,308.58	526.73

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1996; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1998 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	01.4825	15.78	010095	00.9801	12.06	030004	01.0972	13.75	040002	01.1973	12.84	040107	01.2002	15.29
010004	00.9676	11.63	010097	00.9079	14.47	030006	01.5610	18.02	040003	01.0165	12.72	040109	01.1817	13.56
010005	01.2091	15.74	010098	01.2489	11.65	030007	01.3193	16.96	040004	01.6332	15.84	040114	01.8852	17.60
010006	01.4496	15.81	010099	01.1682	14.38	030008	02.3016	19.75	040005	01.0097	12.83	040116	01.3704	19.05
010007	01.0711	13.52	010100	01.2651	15.26	030009	01.3458	16.25	040007	01.8429	17.91	040118	01.2209	14.54
010008	01.1607	12.11	010101	01.0607	14.05	030010	01.4373	17.79	040008	01.0327	11.22	040119	01.1544	14.58
010009	01.1291	15.17	010102	01.0052	13.60	030011	01.5237	18.32	040010	01.3176	15.80	040124	01.1341	13.82
010010	01.0737	14.78	010103	01.8566	18.70	030012	01.2358	16.41	040011	00.9916	10.85	040126	00.9510	11.98
010011	01.6409	19.62	010104	01.7062	18.20	030013	01.2716	19.56	040014	01.1905	16.40	040132	00.5050	11.69
010012	01.3020	16.65	010108	01.2341	14.48	030014	01.4919	18.50	040015	01.2941	13.52	050002	01.5829	26.90
010015	01.0958	13.70	010109	01.1081	13.36	030016	01.2453	17.47	040016	01.6692	16.02	050006	01.4566	19.54
010016	01.2749	16.88	010110	01.0520	14.12	030017	01.5067	18.11	040017	01.3301	11.89	050007	01.6171	27.21
010018	00.9370	16.77	010112	01.1867	15.28	030018	01.8034	19.31	040018	01.2275	18.03	050008	01.5161	26.68
010019	01.3226	14.52	010113	01.6944	15.80	030019	01.2819	19.75	040019	01.1380	13.94	050009	01.7352	29.57
010021	01.2524	15.75	010114	01.3212	16.45	030022	01.4840	17.44	040020	01.6069	15.06	050013	01.8362	22.18
010022	01.0183	17.25	010115	00.8516	12.02	030023	01.3266	18.26	040021	01.2523	14.96	050014	01.1738	22.16
010023	01.6476	15.43	010117	00.8712	13.59	030024	01.7156	20.56	040022	01.6750	14.96	050015	01.3849	23.94
010024	01.4637	15.95	010118	01.3326	18.41	030025	01.1285	14.24	040024	01.0635	14.26	050016	01.1630	17.90
010025	01.4608	13.24	010119	00.9630	18.53	030027	01.0548	15.39	040025	00.9145	12.38	050017	02.0535	25.36
010027	00.8284	14.12	010120	00.9715	15.39	030030	01.7308	18.21	040026	01.6072	16.65	050018	01.3072	20.37
010029	01.5709	15.54	010121	01.3052	15.80	030033	01.2274	15.72	040027	01.2943	12.96	050021	01.5250	25.59
010031	01.2310	15.57	010123	01.3119	15.81	030034	01.0042	15.05	040028	01.0928	11.93	050022	01.5018	23.58
010032	00.9628	12.86	010124	01.3732	13.53	030035	01.2917	18.82	040029	01.2903	15.78	050024	01.3075	21.10
010033	01.9450	17.81	010125	01.0057	15.83	030036	01.1928	18.51	040030	00.9400	11.36	050025	01.6846	21.84
010034	01.0855	12.64	010126	01.1881	14.11	030037	02.0983	19.86	040032	00.9578	10.60	050026	01.4621	28.03
010035	01.2533	15.94	010127	01.3531	16.36	030038	01.6478	18.39	040035	00.9687	10.26	050028	01.3819	15.43
010036	01.1301	16.08	010128	01.0004	12.39	030040	01.1504	16.07	040036	01.5195	17.87	050029	01.4308	22.42
010038	01.3196	17.78	010129	01.0814	14.62	030041	00.9799	13.77	040037	01.1132	11.92	050030	01.3244	20.23
010039	01.6833	17.26	010130	01.0341	14.47	030043	01.2492	17.86	040039	01.2296	13.00	050032	01.2349	26.01
010040	01.5892	18.14	010131	01.3381	18.57	030044	01.0792	16.15	040040	00.9709	14.02	050033	01.4525	26.08
010043	01.1319	10.75	010134	00.8561	10.10	030046	00.9632	18.53	040041	01.3631	15.91	050036	01.6825	19.57
010044	01.1616	14.54	010137	01.2998	16.93	030047	00.9556	20.45	040042	01.2352	14.76	050038	01.4592	28.87
010045	01.1903	13.53	010138	00.9272	10.96	030049	00.9882	14.67	040044	01.0303	11.22	050039	01.6258	21.59
010046	01.5214	16.79	010139	01.6887	19.60	030054	00.8543	12.51	040045	01.0246	15.07	050040	01.2705	22.01
010047	00.9795	10.30	010143	01.2910	16.04	030055	01.2188	16.56	040047	01.1375	15.13	050042	01.3518	20.78
010049	01.1616	14.77	010144	01.3015	16.55	030059	01.3958	18.88	040048	01.1836	14.02	050043	01.6121	30.35
010050	01.1221	13.88	010145	01.3023	15.68	030060	01.1372	16.21	040050	01.1593	12.27	050045	01.2807	18.28
010051	00.8513	09.93	010146	01.1750	15.81	030061	01.6808	17.13	040051	01.0998	12.97	050046	01.2665	21.20
010052	01.0489	09.88	010148	01.0002	12.52	030062	01.2672	15.94	040053	01.1245	13.04	050047	01.5727	31.60
010053	01.0767	13.31	010149	01.3649	16.73	030064	01.7564	18.53	040054	01.0611	12.44	050051	01.0491	17.04
010054	01.2094	17.02	010150	01.1059	16.28	030065	01.7363	19.65	040055	01.4707	15.29	050054	01.2156	20.60
010055	01.4429	16.99	010152	01.4925	17.56	030067	01.0534	15.78	040058	01.0324	13.64	050055	01.4024	27.81
010056	01.4318	18.78	010155	01.0502	06.99	030068	01.0784	15.77	040060	00.9853	10.20	050056	01.3688	29.73
010058	01.0898	12.93	020001	01.5629	26.31	030069	01.3333	20.13	040062	01.6840	15.85	050057	01.5572	19.64
010059	01.1095	14.92	020002	01.2556	23.88	030071	00.9698	.....	040064	01.0541	11.01	050058	01.4522	21.47
010061	01.1895	15.20	020004	01.1115	25.46	030072	00.8317	.....	040066	01.2232	15.86	050060	01.5351	20.46
010062	01.0358	14.36	020005	00.8208	25.53	030073	01.0031	.....	040067	01.0943	12.18	050061	01.4652	21.87
010064	01.8034	18.52	020006	01.2585	25.07	030074	00.9004	.....	040069	01.1556	14.87	050063	01.4029	21.02
010065	01.3457	15.39	020007	01.0349	22.76	030075	00.8568	.....	040070	00.9323	13.68	050065	01.6381	22.82
010066	00.9479	10.41	020008	01.1380	28.97	030076	01.0931	.....	040071	01.6768	15.73	050066	01.2678	20.99
010068	01.3086	16.70	020009	00.9789	21.88	030077	00.8398	.....	040072	01.1038	13.94	050067	01.3721	21.53
010069	01.1938	13.10	020010	01.0878	26.44	030078	01.1397	.....	040074	01.3224	14.39	050068	01.0669	18.92
010072	01.2125	13.45	020011	00.9374	22.61	030079	00.8800	.....	040075	01.1151	11.73	050069	01.6487	24.14
010073	01.0216	10.41	020012	01.2409	24.23	030080	01.5987	21.05	040076	01.0521	16.33	050070	01.2795	33.06
010078	01.2745	16.51	020013	01.0509	24.21	030083	01.3190	21.06	040077	00.9301	11.30	050071	01.3314	32.76
010079	01.2576	15.43	020014	01.1842	22.13	030084	01.0306	.....	040078	01.5579	17.77	050072	01.3261	32.63
010080	01.0093	11.89	020017	01.6662	24.50	030085	01.5587	23.63	040080	01.1206	14.65	050073	01.3306	32.62
010081	01.8574	14.84	020018	00.7773	.....	030086	01.3371	18.01	040081	00.9499	10.75	050074	01.3610	38.56
010083	01.0102	15.43	020019	00.7868	.....	030087	01.6346	18.93	040082	01.1559	14.31	050075	01.3921	32.75
010084	01.4836	17.66	020020	00.7621	.....	030088	01.4134	19.07	040084	01.1216	14.18	050076	01.8221	32.11
010085	01.2703	17.11	020021	00.9121	.....	030089	01.5854	19.68	040085	01.1894	14.81	050077	01.5831	22.86
010086	01.0808	13.70	020024	01.0845	23.72	030092	01.6117	20.36	040088	01.4011	14.36	050078	01.2955	24.76
010087	01.8483	18.51	020025	00.9808	24.32	030093	01.4070	17.81	040090	00.9226	13.54	050079	01.5781	29.34
010089	01.2615	15.60	020026	01.3051	.....	030094	01.3544	18.46	040091	01.2623	19.82	050080	01.3947	20.59
010090	01.5853	17.57	020027	01.0980	.....	030095	01.1437	18.24	040093	01.0361	10.11	050081	01.7055	22.17
010091	01.0099	14.57	030001	01.3356	20.07	030098	00.9923	.....	040100	01.3209	13.29	050082	01.5529	21.60
010092	01.4076	16.61	030002	01.8070	21.04	030099	00.9435	.....	040105	01.0256	13.29	050084	01.6782	23.55
010094	01.2351	15.11	030003	01.9769	20.37	040001	01.1189	12.95	040106	01.2151	14.08	050088	01.0377	23.02

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
050089	01.4267	20.50	050188	01.3813	26.63	050298	01.2567	21.05	050421	01.3719	24.84	050546	00.7784	22.14
050090	01.2947	23.06	050189	01.0628	21.87	050299	01.3551	22.62	050423	01.0305	19.52	050547	00.8743	21.94
050091	01.1912	22.02	050191	01.4969	20.99	050300	01.3966	22.60	050424	01.8245	22.86	050549	01.7309	25.79
050092	00.9918	15.98	050192	01.1894	18.17	050301	01.3386	22.43	050425	01.3271	33.00	050550	01.5817	23.60
050093	01.5676	23.44	050193	01.3103	23.13	050302	01.3707	27.57	050426	01.3357	22.53	050551	01.2992	24.63
050095	00.7794	29.00	050194	01.2778	28.00	050305	01.5747	30.80	050427	00.8258	17.79	050552	01.2447	21.99
050096	01.3087	19.75	050195	01.6036	32.79	050307	01.3606	21.59	050430	00.8488	17.06	050557	01.5742	21.58
050097	01.4627	18.53	050196	01.4084	17.33	050308	01.5170	30.55	050431	01.0903	19.94	050559	01.4058	24.92
050099	01.4724	23.23	050197	01.8388	28.44	050309	01.3687	24.92	050432	01.6738	24.04	050560	01.4220	.....
050100	01.7325	28.66	050204	01.5056	24.18	050310	01.2220	19.66	050433	01.1020	17.37	050561	01.1895	32.17
050101	01.4330	28.42	050205	01.3804	17.74	050312	01.9988	24.11	050434	01.2082	20.09	050564	01.1459	17.84
050102	01.4247	18.79	050207	01.2943	19.79	050313	01.2235	21.97	050435	01.2970	23.02	050565	01.1268	21.68
050103	01.6353	26.99	050208	00.9009	28.76	050315	01.2143	19.97	050436	00.9665	14.81	050566	00.9128	23.47
050104	01.5264	22.61	050211	01.3133	30.44	050317	01.3259	18.92	050438	01.7470	25.46	050567	01.6154	24.19
050107	01.4795	20.75	050213	01.5197	21.12	050320	01.3153	27.83	050440	01.3246	21.46	050568	01.3628	19.64
050108	01.7215	21.54	050214	01.4983	20.90	050324	01.9108	25.52	050441	02.0088	28.23	050569	01.3434	23.05
050109	02.4142	23.68	050215	01.5327	28.12	050325	01.2376	21.42	050443	00.9266	16.07	050570	01.7746	23.41
050110	01.3004	19.33	050217	01.3523	20.45	050327	01.5961	22.32	050444	01.3956	23.98	050571	01.4447	22.36
050111	01.3067	19.21	050219	01.1281	20.76	050328	01.5403	30.01	050446	00.9652	21.02	050573	01.6566	23.85
050112	01.5376	24.56	050222	01.5805	30.02	050329	01.3549	22.38	050447	01.1512	19.37	050575	01.1815	.....
050113	01.3358	28.10	050224	01.6094	22.29	050331	01.4005	26.07	050448	01.2546	20.75	050577	01.4076	19.70
050114	01.4946	20.53	050225	01.4968	20.67	050333	01.1112	19.36	050449	01.3307	20.38	050578	01.2150	24.65
050115	01.5823	20.21	050226	01.3707	23.58	050334	01.7852	31.52	050454	01.8478	27.56	050579	01.5024	27.75
050116	01.4891	23.17	050228	01.3742	27.09	050335	01.4100	21.78	050455	01.8811	21.07	050580	01.3773	26.95
050117	01.3288	20.76	050230	01.2962	25.94	050336	01.4158	20.42	050456	01.1970	20.18	050581	01.3786	24.80
050118	01.2326	23.37	050231	01.6983	24.69	050337	01.1495	.....	050457	01.9759	28.16	050583	01.6338	23.49
050121	01.3924	19.17	050232	01.7470	25.52	050342	01.3596	18.03	050459	01.2153	28.95	050584	01.3161	19.70
050122	01.7008	25.77	050233	01.2032	27.97	050343	01.0652	16.57	050464	01.8583	23.28	050585	01.3144	25.79
050124	01.2435	19.10	050234	01.3174	22.79	050348	01.6833	23.57	050468	01.4947	16.95	050586	01.3705	21.47
050125	01.3780	27.26	050235	01.6162	27.60	050349	00.9539	14.75	050469	01.1172	18.34	050588	01.3156	27.41
050126	01.4894	23.86	050236	01.4925	23.47	050350	01.3637	23.74	050470	01.1185	18.14	050589	01.3256	24.78
050127	01.3466	23.71	050238	01.5330	22.98	050351	01.4729	25.97	050471	01.8600	22.75	050590	01.4116	23.26
050128	01.6460	23.71	050239	01.5401	23.40	050352	01.3231	23.99	050476	01.3719	21.89	050591	01.3412	24.97
050129	01.6057	20.66	050240	01.4210	25.28	050353	01.6090	24.23	050477	01.5088	26.49	050592	01.3612	10.96
050131	01.2856	30.45	050241	01.1957	25.59	050355	00.9765	14.97	050478	00.9877	20.58	050593	01.2930	29.77
050132	01.3951	24.69	050242	01.4391	28.77	050357	01.6573	22.99	050481	01.4382	25.47	050594	01.7808	24.64
050133	01.3417	21.73	050243	01.5626	20.95	050359	01.3024	19.88	050482	00.9894	17.87	050597	01.2691	22.40
050135	01.4325	26.20	050245	01.4680	22.03	050360	01.4636	31.81	050483	01.2210	22.32	050598	01.3740	28.26
050136	01.3721	22.84	050248	01.2419	24.55	050366	01.4377	20.59	050485	01.6259	22.39	050599	01.6899	23.22
050137	01.4279	33.54	050251	01.0788	18.41	050367	01.2687	27.02	050486	01.4102	24.19	050601	01.5778	29.22
050138	01.8973	33.14	050253	00.4249	18.80	050369	01.3261	23.77	050488	01.3907	29.71	050603	01.4323	20.95
050139	01.3177	32.31	050254	01.1834	20.57	050373	01.4652	23.73	050491	01.2715	24.39	050604	01.5612	32.65
050140	01.3995	31.70	050256	01.7909	19.46	050376	01.5358	29.05	050492	01.3788	21.96	050607	01.1803	21.26
050144	01.6110	25.92	050257	01.1487	21.76	050377	01.0097	16.14	050494	01.3412	24.67	050608	01.3296	18.75
050145	01.3651	30.22	050260	00.9841	19.43	050378	01.1780	21.42	050496	01.7003	32.52	050609	01.4420	33.78
050146	01.3676	.....	050261	01.2252	18.54	050379	01.2054	16.93	050497	00.7910	.....	050613	01.1557	19.90
050147	00.7180	22.54	050262	01.9975	26.95	050380	01.6598	29.85	050498	01.2875	22.93	050615	01.6623	25.67
050148	01.0774	19.07	050264	01.4160	28.04	050382	01.4271	22.15	050502	01.6469	21.94	050616	01.3571	21.21
050149	01.5033	22.14	050267	01.6376	27.72	050385	01.3306	23.94	050503	01.3565	23.35	050618	01.1709	20.05
050150	01.2365	22.69	050270	01.3329	22.02	050388	00.9186	18.08	050506	01.3762	24.67	050623	01.1288	23.78
050152	01.4223	25.51	050272	01.3322	20.79	050390	01.2318	22.09	050510	01.3492	32.12	050624	01.3769	22.51
050153	01.6645	27.98	050274	00.9860	19.47	050391	01.3459	23.34	050512	01.5448	33.56	050625	01.6065	24.95
050155	01.1105	25.69	050276	01.1316	26.93	050392	00.9991	18.23	050515	01.3429	31.82	050630	01.4308	21.07
050158	01.3725	25.37	050277	01.5097	19.57	050393	01.4471	23.72	050516	01.5785	24.92	050633	01.2932	21.92
050159	01.3833	21.88	050278	01.6190	22.89	050394	01.6194	20.12	050517	01.3047	20.14	050635	01.3192	32.09
050167	01.2762	22.00	050279	01.2257	21.00	050396	01.6165	22.02	050522	01.3442	31.46	050636	01.4725	22.11
050168	01.5431	23.71	050280	01.6873	24.62	050397	01.0470	18.22	050523	01.3228	28.96	050638	01.0334	19.35
050169	01.5183	22.75	050281	01.4700	15.36	050401	01.1317	19.06	050526	01.3231	24.45	050641	01.1948	18.27
050170	01.5727	21.33	050282	01.3631	23.18	050404	01.1069	16.60	050528	01.3531	21.06	050643	00.7614	.....
050172	01.2438	18.44	050283	01.1136	26.91	050406	01.0309	15.92	050531	01.1935	20.24	050644	00.8951	22.79
050173	01.3490	20.24	050286	00.9444	17.82	050407	01.3244	28.37	050534	01.4117	24.32	050660	01.3514	.....
050174	01.6348	29.60	050289	01.8946	26.67	050410	01.0841	16.71	050535	01.4595	22.87	050661	00.8437	20.15
050175	01.3591	27.08	050290	01.6535	20.42	050411	01.3692	31.16	050537	01.2746	21.53	050662	00.8759	22.31
050177	01.2483	20.35	050291	01.2360	25.51	050414	01.3039	24.60	050539	01.2817	22.25	050663	01.1244	25.63
050179	01.3109	19.55	050292	01.0631	21.76	050417	01.3222	20.22	050541	01.5423	32.88	050666	00.8852	20.95
050180	01.6207	31.19	050293	01.1601	20.14	050418	01.3206	22.71	050542	01.2228	14.92	050667	00.9877	25.58
050183	01.1383	20.36	050295	01.4631	21.39	050419	01.3474	20.46	050543	00.9027	21.76	050668	01.1152	28.90
050186	01.3308	23.83	050296	01.2093	22.43	050420	01.5283	23.03	050545	00.7751	21.20	050670	00.8585	.....

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
050674	01.2985	30.04	060047	01.1034	11.84	080004	01.3471	18.69	100071	01.3332	16.21	100167	01.4606	19.21
050675	01.8407	17.60	060049	01.4796	17.34	080005	01.3302	18.53	100072	01.3115	16.55	100168	01.3946	20.23
050676	00.9699	14.37	060050	01.2714	14.36	080006	01.3735	19.73	100073	01.7705	21.99	100169	01.8544	16.46
050677	01.4370	34.53	060052	01.0914	13.04	080007	01.4046	17.29	100075	01.5930	18.14	100170	01.4624	16.86
050678	01.1143	24.44	060053	01.0018	14.81	090001	01.5345	21.36	100076	01.3531	16.80	100172	01.3777	13.93
050680	01.2283	26.19	060054	01.3927	17.69	090002	01.2858	19.74	100077	01.4074	16.10	100173	01.6794	16.87
050682	00.9226	15.55	060056	00.9237	14.05	090003	01.3454	20.56	100078	01.1916	16.86	100174	01.5820	20.80
050684	01.2016	21.85	060057	01.0693	21.47	090004	01.8143	23.95	100079	01.6005	20.49	100175	01.2618	16.65
050685	01.2131	28.69	060058	00.9407	13.87	090005	01.3518	17.58	100080	01.6309	23.98	100176	02.1175	22.94
050686	01.3154	32.30	060060	00.8480	12.53	090006	01.3509	19.77	100081	01.0598	17.93	100177	01.3710	18.76
050688	01.2787	27.87	060062	00.9361	14.11	090007	01.2828	20.38	100082	01.4572	17.52	100179	01.6384	19.38
050689	01.3938	29.96	060063	00.9516	11.82	090008	01.5419	23.59	100083	01.3327	17.98	100180	01.3734	19.01
050690	01.5106	32.26	060064	01.4668	20.71	090010	01.1704	22.39	100084	01.4579	18.10	100181	01.2699	19.10
050693	01.6216	28.58	060065	01.3170	21.03	090011	01.9805	25.13	100085	01.4188	18.83	100183	01.3911	19.62
050694	01.5184	22.78	060066	00.9696	12.79	090015	01.1274	.....	100086	01.3132	22.05	100187	01.4032	18.31
050695	01.0993	25.42	060068	01.1323	13.46	100001	01.5737	18.08	100087	01.8737	21.91	100189	01.4251	20.96
050696	02.1091	28.17	060070	01.0209	16.03	100002	01.4879	19.10	100088	01.7306	17.43	100191	01.3109	18.63
050697	01.2473	18.05	060071	01.2383	14.39	100004	01.0696	13.13	100090	01.4094	16.46	100199	01.4361	18.30
050698	00.8012	.....	060073	00.9705	15.25	100006	01.6454	19.01	100092	01.4490	16.27	100200	01.3447	22.72
050699	00.6001	23.01	060075	01.3327	21.20	100007	01.8737	19.63	100093	01.5386	15.36	100203	01.3411	19.70
050700	01.4904	32.32	060076	01.4838	16.86	100008	01.7737	20.00	100098	01.1592	18.36	100204	01.6730	21.27
050701	01.3580	29.00	060085	00.9510	10.30	100009	01.5015	19.22	100099	01.2974	13.12	100206	01.4404	19.98
050702	00.9243	19.02	060087	01.7036	21.04	100010	01.5351	22.50	100102	01.0900	17.62	100207	01.0774	20.37
050704	01.0845	20.41	060088	01.0231	13.86	100012	01.6899	16.77	100103	01.0706	15.41	100208	01.5784	16.92
050707	01.0506	25.90	060090	00.8731	14.19	100014	01.4574	18.79	100105	01.4631	18.87	100209	01.6095	18.40
050708	00.9919	27.17	060096	01.0859	21.65	100015	01.3414	18.06	100106	01.1228	16.92	100210	01.6357	19.34
050709	01.3400	20.44	060100	01.4754	21.75	100017	01.5625	16.86	100107	01.4044	18.26	100211	01.3504	18.47
050710	01.3425	.....	060103	01.3627	22.66	100018	01.3521	20.31	100108	01.0646	13.74	100212	01.6492	18.75
050711	02.0900	.....	060104	01.2956	21.84	100019	01.5370	18.40	100109	01.3642	18.44	100213	01.5697	18.46
050712	01.5251	.....	060107	01.0652	.....	100020	01.3432	20.82	100110	01.4230	17.14	100217	01.2974	.....
050713	00.8063	.....	070001	01.7289	26.42	100022	01.8823	23.14	100112	01.0152	12.61	100220	01.9425	18.82
050714	01.3579	.....	070002	01.7836	26.03	100023	01.3698	16.89	100113	02.1189	19.34	100221	01.6934	19.65
050715	02.1945	.....	070003	01.1170	25.30	100024	01.4033	19.26	100114	01.4437	19.70	100222	01.3988	18.63
060001	01.6077	20.29	070004	01.2533	23.33	100025	01.8800	16.92	100117	01.3112	18.77	100223	01.4942	17.42
060003	01.2643	18.34	070005	01.4033	25.79	100026	01.7115	16.88	100118	01.2401	17.18	100224	01.4283	21.35
060004	01.3542	20.06	070006	01.3414	28.36	100027	00.9127	14.31	100121	01.3095	15.75	100225	01.4063	20.63
060006	01.1533	16.89	070007	01.4048	23.69	100028	01.2619	17.30	100122	01.3639	16.54	100226	01.4196	17.73
060007	01.2498	14.98	070008	01.2617	23.02	100029	01.3384	19.04	100124	01.3668	18.33	100228	01.3737	20.28
060008	01.0677	14.75	070009	01.3499	23.68	100030	01.4021	18.54	100125	01.2986	16.50	100229	01.3312	16.87
060009	01.4393	19.81	070010	01.6244	23.63	100032	01.9493	18.08	100126	01.4869	19.41	100230	01.4397	19.70
060010	01.5808	21.74	070011	01.3465	25.98	100034	01.7164	18.88	100127	01.6995	18.39	100231	01.6894	16.90
060011	01.2815	20.17	070012	01.2220	23.53	100035	01.6455	17.26	100128	02.1390	21.19	100232	01.2868	18.29
060012	01.4711	17.66	070013	01.3776	26.05	100038	01.5655	21.34	100129	01.2599	17.91	100234	01.5399	19.22
060013	01.3100	19.42	070015	01.4402	24.61	100039	01.5702	21.69	100130	01.2298	19.48	100235	01.4441	18.19
060014	01.7947	22.41	070016	01.3413	24.32	100040	01.6728	17.79	100131	01.3976	19.68	100236	01.4010	18.30
060015	01.5818	20.04	070017	01.3508	24.82	100043	01.4510	15.12	100132	01.3755	15.46	100237	02.1834	21.32
060016	01.1928	13.66	070018	01.4211	27.48	100044	01.4336	19.86	100134	01.0399	14.63	100238	01.5873	17.06
060018	01.2683	16.89	070019	01.1945	25.50	100045	01.4240	16.32	100135	01.6183	16.63	100239	01.4590	19.01
060020	01.6399	16.15	070020	01.3551	25.82	100046	01.4939	18.40	100137	01.3818	21.08	100240	00.9266	19.10
060022	01.6763	18.46	070021	01.2943	25.42	100047	01.8198	18.47	100138	00.9577	12.12	100241	00.9718	13.68
060023	01.6681	18.98	070022	01.8465	24.06	100048	00.9769	12.80	100139	01.0680	14.97	100242	01.4999	16.47
060024	01.7950	23.68	070024	01.3757	24.79	100049	01.3204	18.49	100140	01.1672	17.64	100243	01.4291	17.93
060027	01.6711	20.38	070025	01.8612	25.92	100050	01.2284	15.21	100142	01.3319	18.12	100244	01.4738	18.36
060028	01.5301	20.69	070026	01.1913	25.91	100051	01.1799	17.96	100144	01.2106	15.29	100246	01.4064	21.86
060029	00.8982	11.90	070027	01.2398	25.65	100052	01.3791	15.15	100145	01.3341	19.01	100248	01.7042	17.76
060030	01.2955	18.79	070028	01.5045	24.91	100053	01.3588	17.17	100146	01.0803	16.01	100249	01.3760	19.41
060031	01.6946	18.97	070029	01.4122	22.06	100054	01.3015	17.75	100147	01.0947	13.18	100252	01.2387	19.72
060032	01.5169	17.36	070030	01.3122	26.51	100055	01.4205	17.02	100150	01.4309	19.30	100253	01.4817	19.73
060033	01.0987	12.53	070031	01.2814	22.20	100056	01.5137	18.89	100151	01.7824	19.37	100254	01.6114	17.99
060034	01.4683	22.34	070033	01.3695	26.22	100057	01.3921	16.01	100154	01.6732	19.96	100255	01.2325	19.80
060036	01.0990	14.70	070034	01.3677	27.52	100060	01.8118	15.28	100156	01.1559	19.34	100256	01.9087	18.78
060037	01.0476	13.16	070035	01.4409	23.11	100061	01.4753	20.71	100157	01.6173	20.46	100258	01.6458	21.27
060038	01.0363	12.96	070036	01.6080	27.46	100062	01.7555	17.75	100159	00.9163	12.79	100259	01.4904	17.31
060041	00.9054	14.99	070038	00.6569	.....	100063	01.3311	16.56	100160	01.2200	18.48	100260	01.4650	20.13
060042	01.1304	16.83	070039	00.9101	.....	100067	01.4572	16.77	100161	01.7317	20.07	100262	01.4430	18.60
060043	00.9371	13.31	080001	01.6742	24.79	100068	01.3780	16.37	100162	01.4422	17.78	100263	01.4125	17.42
060044	01.2746	16.98	080002	01.2519	17.15	100069	01.3870	17.95	100165	01.1791	17.55	100264	01.3958	17.27
060046	01.0985	16.64	080003	01.3456	20.79	100070	01.4506	18.13	100166	01.5356	20.44	100265	01.3923	14.58

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
100266	01.3567	16.53	110066	01.5392	18.78	110163	01.4700	18.54	130010	00.9235	15.97	140043	01.2331	17.04
100267	01.3515	15.67	110069	01.2619	19.05	110164	01.4737	19.49	130011	01.3075	17.11	140045	01.0692	13.11
100268	01.2095	23.23	110070	01.0212	12.19	110165	01.3694	18.35	130012	01.0283	20.53	140046	01.3163	14.79
100269	01.4373	19.39	110071	01.1784	10.43	110166	01.5345	17.45	130013	01.2638	17.73	140047	01.1477	14.21
100270	00.8362	14.31	110072	01.0009	12.37	110168	01.7282	21.92	130014	01.3868	16.50	140048	01.4278	22.08
100271	01.7347	20.00	110073	01.2226	13.04	110169	01.1751	21.80	130015	00.8545	13.50	140049	01.5605	20.48
100275	01.4042	21.30	110074	01.4618	18.47	110171	01.4770	23.10	130016	00.9422	17.37	140051	01.5469	19.42
100276	01.2982	22.26	110075	01.3606	15.50	110172	01.4150	19.98	130017	01.1854	12.16	140052	01.3706	18.11
100277	01.0751	13.03	110076	01.4355	19.08	110174	00.9636	13.19	130018	01.7030	17.05	140053	01.9782	18.04
100279	01.3599	18.73	110078	01.7043	20.66	110176	01.4585	20.47	130019	01.1185	14.30	140054	01.3506	24.77
100280	01.3734	16.76	110079	01.4037	19.53	110177	01.5652	26.92	130021	01.0006	11.89	140055	01.0313	12.61
100281	01.2594	20.52	110080	01.2684	18.15	110178	01.4061	17.41	130022	01.2169	16.88	140058	01.2470	15.74
100282	01.1224	14.86	110082	02.0407	20.53	110179	01.2257	21.81	130024	01.1092	16.52	140059	01.1860	13.96
110001	01.3100	17.26	110083	01.7837	20.63	110181	00.9756	12.32	130025	01.0874	14.90	140061	01.0964	14.14
110002	01.3087	15.75	110086	01.2402	16.50	110183	01.4248	19.97	130026	01.1228	18.80	140062	01.2675	25.30
110003	01.3377	12.66	110087	01.3393	19.53	110184	01.2670	18.82	130027	00.9792	17.34	140063	01.4672	24.56
110004	01.3711	14.62	110088	00.9425	12.52	110185	01.1241	12.44	130028	01.2707	18.86	140064	01.3583	17.02
110005	01.1453	19.77	110089	01.2363	16.07	110186	01.3818	16.69	130029	01.0342	15.77	140065	01.5866	23.89
110006	01.3772	17.90	110091	01.3388	20.17	110187	01.3395	18.27	130030	01.0073	17.62	140066	01.3048	14.92
110007	01.5469	15.29	110092	01.1788	12.84	110188	01.4320	18.16	130031	01.0779	12.21	140067	01.7828	18.84
110008	01.3463	16.25	110093	00.9510	12.42	110189	01.1175	18.39	130034	00.9862	17.80	140068	01.2205	18.58
110009	00.9912	13.65	110094	01.0040	11.90	110190	01.1014	14.95	130035	01.0837	19.75	140069	01.0061	14.69
110010	02.1198	21.49	110095	01.3281	14.45	110191	01.3767	18.34	130036	01.3041	13.11	140070	01.2445	16.86
110011	01.2429	16.73	110096	01.1410	13.95	110192	01.4551	18.88	130037	01.1847	16.09	140074	00.9695	14.23
110013	01.1032	14.97	110097	01.0230	13.43	110193	01.2501	17.43	130043	01.0073	15.45	140075	01.4790	20.98
110014	01.0237	14.25	110098	01.0524	12.75	110194	01.0069	13.81	130044	01.1645	12.49	140077	01.1879	16.68
110015	01.2373	16.42	110100	01.0948	12.76	110195	01.0547	11.35	130045	01.0068	12.07	140079	01.2407	19.72
110016	01.3097	14.79	110101	01.1680	11.58	110198	01.3714	24.04	130048	01.0818	13.31	140080	01.6437	21.22
110017	00.8642	13.54	110103	00.9614	10.15	110200	01.8297	17.05	130049	01.2812	18.00	140081	01.0873	13.46
110018	01.1504	17.79	110104	01.0884	14.01	110201	01.5086	17.52	130054	00.8937	17.61	140082	01.4347	19.59
110020	01.3479	16.21	110105	01.1841	14.60	110203	00.9967	17.25	130056	00.8733	11.05	140083	01.2436	17.22
110023	01.3398	18.43	110107	01.8230	18.50	110204	00.8066	14.34	130058	00.7670	14.21	140084	01.2282	18.60
110024	01.4870	16.41	110108	00.9444	11.26	110205	01.1252	17.06	130060	01.3323	19.41	140086	01.0865	14.36
110025	01.4319	17.54	110109	01.0931	13.63	110207	01.0857	14.02	130061	00.9433	.....	140087	01.3968	16.15
110026	01.2107	14.59	110111	01.0973	16.55	110208	00.9420	16.97	130062	00.6589	.....	140088	01.6745	24.52
110027	01.0937	13.41	110112	01.0839	11.88	110209	00.7487	16.39	140001	01.2820	14.89	140089	01.2535	16.59
110028	01.6530	19.36	110113	01.0936	12.40	110211	00.8898	.....	140002	01.3159	18.78	140090	01.5327	27.83
110029	01.4107	18.29	110114	01.0737	14.35	110212	01.1691	.....	140003	01.0178	14.52	140091	01.8062	17.60
110030	01.3315	17.58	110115	01.6022	18.84	110213	00.5284	.....	140004	01.1142	16.34	140093	01.2077	17.01
110031	01.3091	19.99	110118	00.9737	13.49	120001	01.8272	25.27	140005	00.9615	09.56	140094	01.3943	19.46
110032	01.2694	12.68	110120	01.0244	12.28	120002	01.1994	21.80	140007	01.4823	21.10	140095	01.4094	20.09
110033	01.4346	19.79	110121	01.2007	12.83	120003	01.0674	22.69	140008	01.5818	19.43	140097	00.9670	12.49
110034	01.6452	17.89	110122	01.3894	16.17	120004	01.2661	21.72	140010	01.3786	22.90	140100	01.2485	18.78
110035	01.4345	20.02	110124	01.0847	15.63	120005	01.2518	18.94	140011	01.1969	16.24	140101	01.2227	18.49
110036	01.6988	18.37	110125	01.2361	15.97	120006	01.3096	24.62	140012	01.2719	18.60	140102	01.1121	14.37
110037	01.1697	11.02	110127	00.9362	18.26	120007	01.6811	20.90	140013	01.5844	15.59	140103	01.3623	16.25
110038	01.4667	15.98	110128	01.1766	19.01	120009	01.0424	20.40	140014	01.1687	16.19	140105	01.3043	20.28
110039	01.3795	18.62	110129	01.7851	15.69	120010	01.8716	22.71	140015	01.2876	14.20	140107	01.0708	11.82
110040	01.1215	15.52	110130	01.1632	11.11	120011	01.2451	31.56	140016	00.9556	11.89	140108	01.3553	21.81
110041	01.2723	15.82	110132	01.1253	12.99	120012	00.8969	20.20	140018	01.3988	19.38	140109	01.1761	13.08
110042	01.2739	14.92	110134	00.8917	12.19	120014	01.4437	22.59	140019	01.1687	12.65	140110	01.1910	17.31
110043	01.7887	16.83	110135	01.2956	14.04	120015	00.9237	22.77	140024	01.0067	13.99	140112	01.2391	13.42
110044	01.1492	14.51	110136	01.1900	17.74	120016	00.8833	24.58	140025	01.0608	16.65	140113	01.5191	17.90
110045	01.3219	21.18	110140	01.0284	16.75	120018	00.9540	20.92	140026	01.2846	15.90	140114	01.3524	19.55
110046	01.3460	17.14	110141	00.9531	12.29	120019	01.2500	19.16	140027	01.3405	16.37	140115	01.3228	19.66
110048	01.3732	13.59	110142	00.9502	11.78	120021	00.9273	18.74	140029	01.3589	21.43	140116	01.3016	20.98
110049	01.1274	14.58	110143	01.4557	20.77	120022	01.7000	20.74	140030	01.8079	21.56	140117	01.5393	20.42
110050	01.2024	13.35	110144	01.1608	17.41	120026	01.2756	24.26	140031	01.2719	13.76	140118	01.6536	23.74
110051	01.0340	16.68	110146	01.1436	15.09	120027	01.5804	23.43	140032	01.2657	16.71	140119	01.7239	23.27
110052	01.1173	10.83	110149	01.1587	16.88	120028	01.0146	.....	140033	01.2783	19.82	140120	01.4592	15.45
110054	01.3574	16.85	110150	01.3259	17.62	130001	01.0126	15.75	140034	01.1745	17.31	140121	01.5391	11.54
110056	01.1733	14.40	110152	01.1022	14.44	130002	01.4330	15.30	140035	00.9305	11.22	140122	01.6581	21.47
110059	01.3155	13.38	110153	01.0153	19.87	130003	01.3679	19.28	140036	01.2088	16.60	140124	01.2722	23.81
110061	01.0721	12.61	110154	00.8230	13.98	130005	01.5281	19.70	140037	01.1042	12.49	140125	01.3597	15.71
110062	00.8945	10.97	110155	01.0562	13.62	130006	01.8420	17.59	140038	01.1785	16.23	140127	01.3922	17.32
110063	01.1481	12.76	110156	01.0376	12.34	130007	01.6306	18.20	140040	01.2942	14.72	140128	01.1103	14.92
110064	01.3339	17.46	110161	01.3272	21.00	130008	01.0035	11.00	140041	01.3305	16.02	140129	01.2226	14.94
110065	01.0391	13.40	110162	00.8006	.....	130009	00.9620	10.74	140042	01.0137	14.16	140130	01.3646	21.74

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
140132	01.4451	19.03	140230	00.9258	10.84	150043	01.0838	21.96	150127	01.0241	13.90	160073	00.9761	12.18
140133	01.3392	21.21	140231	01.5927	20.80	150044	01.2610	18.32	150128	01.2162	19.14	160074	01.0986	14.36
140135	01.3065	14.91	140233	01.7888	18.47	150045	01.0998	15.68	150129	01.2317	22.47	160075	01.1442	13.73
140137	01.0630	14.58	140234	01.2898	16.47	150046	01.5284	15.90	150130	01.3599	16.61	160076	01.0731	15.50
140138	00.9835	12.15	140236	00.9644	13.24	150047	01.5639	22.77	150132	01.4214	19.24	160077	01.1723	10.60
140139	01.1361	14.70	140239	01.6836	18.73	150048	01.2057	16.52	150133	01.2178	14.12	160079	01.4096	16.28
140140	01.1398	13.06	140240	01.4851	20.44	150049	01.1663	13.29	150134	01.1751	17.17	160080	01.2022	16.06
140141	01.2514	13.76	140242	01.6293	21.68	150050	01.2047	14.73	150136	01.0683	18.42	160081	01.0670	14.77
140143	01.1478	16.64	140245	01.1694	14.47	150051	01.4788	18.34	150138	01.2073	17.33	160082	01.8242	17.03
140144	01.0291	17.83	140246	01.0832	12.05	150052	01.1504	14.14	150139	01.4731	14.62	160083	01.6850	18.37
140145	01.1791	15.14	140250	01.3797	21.98	150053	01.0508	18.10	160001	01.2891	17.61	160085	01.0802	11.50
140146	01.0442	16.38	140251	01.3829	19.16	150054	01.1554	12.55	160002	01.1697	13.74	160086	00.9984	13.93
140147	01.2801	16.29	140252	01.4473	23.41	150056	01.7839	22.38	160003	01.0195	12.61	160088	01.1633	12.75
140148	01.8518	17.11	140253	01.4156	17.49	150057	02.3206	18.94	160005	01.1311	13.80	160089	01.1873	14.80
140150	01.6279	25.55	140258	01.5772	20.93	150058	01.7195	19.57	160007	01.0323	12.37	160090	00.9797	15.58
140151	01.1103	16.64	140271	01.0850	13.01	150059	01.4121	19.81	160008	01.1305	14.02	160091	01.0810	10.80
140152	01.1184	22.91	140275	01.2390	16.50	150060	01.1657	14.93	160009	01.2378	13.73	160092	01.0879	13.23
140155	01.2969	16.96	140276	01.9603	21.37	150061	01.2378	15.73	160012	01.0294	13.15	160093	01.2058	13.86
140158	01.3077	21.36	140280	01.3142	17.16	150062	01.0996	16.55	160013	01.2266	15.35	160094	01.1302	14.17
140160	01.2232	15.93	140281	01.6474	20.89	150063	01.0938	17.57	160014	01.0125	12.59	160095	01.0915	12.79
140161	01.2168	17.76	140285	01.2802	15.37	150064	01.2141	15.84	160016	01.2505	16.32	160097	01.1409	13.00
140162	01.7542	17.96	140286	01.1253	17.93	150065	01.1631	18.49	160018	00.9298	13.27	160098	00.9679	14.81
140164	01.3924	17.44	140288	01.8518	23.17	150066	00.9993	15.93	160020	01.0718	12.38	160099	00.9671	11.69
140165	01.1383	12.90	140289	01.3190	15.79	150067	01.1295	15.48	160021	01.0703	13.57	160101	01.1730	18.64
140166	01.3636	17.21	140290	01.4617	21.07	150069	01.2618	16.90	160023	01.0386	12.35	160102	01.3886	17.51
140167	01.1286	14.97	140291	01.4126	22.95	150070	01.0279	14.83	160024	01.5221	18.06	160103	01.0399	13.57
140168	01.1895	15.57	140292	01.1602	20.63	150071	01.1162	13.86	160026	01.0593	14.43	160104	01.3168	17.37
140170	01.1141	12.53	140294	01.1859	16.20	150072	01.2089	15.48	160027	01.1570	13.19	160106	01.0620	14.03
140171	00.9150	13.87	140297	01.5673	27.06	150073	01.0134	19.47	160028	01.3255	17.39	160107	01.1797	14.12
140172	01.6091	18.71	140300	01.4471	18.71	150074	01.5964	18.80	160029	01.5134	18.14	160108	01.2018	14.95
140173	00.9277	13.77	150001	01.1125	17.36	150075	01.1711	14.49	160030	01.3852	17.37	160109	01.0406	12.35
140174	01.5683	18.33	150002	01.5434	18.35	150076	01.2164	20.39	160031	01.1197	13.37	160110	01.5234	17.97
140176	01.3064	21.33	150003	01.7180	19.57	150077	01.1796	16.58	160032	01.0998	15.56	160111	01.0272	11.04
140177	01.1644	16.52	150004	01.4342	19.97	150078	01.0840	15.66	160033	01.7885	16.80	160112	01.4213	15.00
140179	01.3195	20.12	150005	01.1913	18.43	150079	01.1368	13.96	160034	01.2092	14.53	160113	01.0022	12.03
140180	01.5086	21.03	150006	01.2242	17.31	150082	01.5181	17.44	160035	01.0318	12.57	160114	01.0662	14.21
140181	01.3825	19.20	150007	01.2036	17.98	150084	01.8769	22.28	160036	00.9707	14.66	160115	01.0262	14.32
140182	01.3711	20.67	150008	01.3534	20.70	150086	01.3365	16.45	160037	01.1614	15.14	160116	01.1790	15.68
140184	01.2542	14.26	150009	01.3747	17.26	150088	01.3466	17.20	160039	01.0809	15.84	160117	01.4518	15.96
140185	01.4152	16.78	150010	01.1825	15.87	150089	01.4284	18.43	160040	01.3187	16.30	160118	01.0205	13.15
140186	01.3530	17.75	150011	01.2266	17.83	150090	01.2517	18.72	160041	01.0854	13.45	160120	01.0296	10.62
140187	01.4893	16.54	150012	01.6946	21.01	150091	01.1381	15.75	160043	01.0374	13.44	160122	01.1314	16.24
140188	01.0402	10.77	150013	01.1254	13.90	150092	01.0304	15.04	160044	01.3190	13.86	160123	01.0588	13.19
140189	01.1952	16.64	150014	01.5059	20.39	150094	01.0148	16.85	160045	01.7651	17.72	160124	01.2799	15.87
140190	01.1402	15.99	150015	01.2169	18.32	150095	01.1048	17.97	160046	01.0014	12.75	160126	01.0198	13.59
140191	01.4511	21.87	150017	01.8651	17.20	150096	01.1653	17.34	160047	01.3677	15.37	160129	01.0290	13.75
140193	01.0432	13.31	150018	01.2899	18.23	150097	01.1381	17.09	160048	01.0373	11.54	160130	01.1777	13.02
140197	01.2610	16.96	150019	01.1022	15.47	150098	01.1494	13.03	160049	00.9485	12.21	160131	01.0519	13.55
140199	01.1014	15.72	150020	01.1488	12.96	150099	01.2905	17.79	160050	01.0755	14.64	160134	01.0482	11.84
140200	01.4765	21.79	150021	01.6386	18.34	150100	01.7163	17.65	160051	00.9646	13.54	160135	01.0968	13.67
140202	01.3540	19.71	150022	01.0910	16.65	150101	01.1111	14.50	160052	01.0875	14.79	160138	01.1290	14.36
140203	01.1609	19.32	150023	01.5116	18.19	150102	01.0431	14.93	160054	01.0755	12.37	160140	01.1716	14.76
140205	00.8789	13.64	150024	01.4348	15.82	150103	01.0075	15.02	160055	00.9798	12.37	160142	01.0866	13.98
140206	01.1121	20.81	150025	01.3892	17.57	150104	01.0990	15.63	160056	01.0863	13.11	160143	01.0270	14.24
140207	01.3959	20.01	150026	01.1868	18.29	150105	01.3508	16.20	160057	01.3465	16.15	160145	01.1210	14.16
140208	01.6948	24.07	150027	01.0461	15.55	150106	01.0805	16.06	160058	01.7461	19.00	160146	01.4322	14.59
140209	01.6697	15.99	150029	01.3137	20.17	150109	01.4613	16.85	160060	01.0442	13.44	160147	01.3056	16.09
140210	01.1194	14.00	150030	01.2098	16.69	150110	01.0000	17.16	160061	01.0428	14.27	160151	01.0503	13.74
140211	01.1916	20.84	150031	01.0741	15.56	150111	01.1642	14.02	160062	00.9492	12.22	160152	00.9935	13.78
140212	01.2953	22.47	150032	01.8880	19.50	150112	01.3074	17.80	160063	01.1653	15.88	160153	01.7437	17.53
140213	01.2782	22.67	150033	01.6073	21.09	150113	01.2230	17.88	160064	01.7113	17.38	170001	01.1849	16.35
140215	01.1308	13.49	150034	01.3884	21.18	150114	01.0122	14.58	160065	01.0284	14.73	170004	01.0730	13.57
140217	01.3185	21.67	150035	01.5318	18.97	150115	01.3808	17.55	160066	01.1723	14.74	170006	01.1492	15.02
140218	00.9966	13.65	150036	01.0412	17.43	150122	01.1253	17.11	160067	01.4125	17.13	170008	01.0265	14.53
140220	01.0925	15.16	150037	01.2684	18.20	150123	01.2043	12.98	160068	01.0660	13.52	170009	01.1988	16.31
140223	01.6457	28.66	150038	01.4044	17.22	150124	01.1085	15.97	160069	01.4620	16.42	170010	01.2496	15.77
140224	01.3885	22.97	150039	00.9657	16.33	150125	01.3906	18.69	160070	01.0507	14.47	170011	01.2378	15.40
140228	01.6939	18.22	150042	01.2975	16.00	150126	01.5082	20.17	160072	01.0756	11.60	170012	01.4732	16.08

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
170013	01.3228	15.33	170098	01.0500	17.00	180023	00.8812	13.12	180122	01.0903	15.01	190088	01.3480	.....
170014	01.0365	16.40	170099	01.2666	11.34	180024	01.3911	17.24	180123	01.4774	20.98	190089	01.0784	11.47
170015	01.0652	14.36	170100	00.9917	14.47	180025	01.2141	17.17	180124	01.4878	16.52	190090	01.1650	16.84
170016	01.6876	19.52	170101	00.9485	13.26	180026	01.2402	12.39	180125	00.9976	16.46	190092	01.3982	.....
170017	01.2527	15.34	170102	00.9926	13.11	180027	01.2873	15.58	180126	01.2371	12.22	190095	01.0677	14.66
170018	01.1576	13.13	170103	01.2089	15.62	180028	00.9959	16.39	180127	01.4053	17.22	190098	01.5464	18.86
170019	01.2248	15.65	170104	01.4508	19.81	180029	01.2772	15.97	180128	01.1761	16.64	190099	01.1522	17.98
170020	01.2898	14.98	170105	01.0962	15.91	180030	01.2383	13.31	180129	01.0116	14.45	190102	01.5617	17.77
170022	01.1756	14.80	170106	00.8948	12.18	180031	01.2070	12.60	180130	01.4718	17.91	190103	00.8823	09.75
170023	01.4656	16.42	170109	01.0364	14.50	180032	00.9250	15.83	180132	01.2950	15.20	190106	01.1721	17.69
170024	01.1515	12.84	170110	00.9577	13.67	180033	01.1365	12.86	180133	01.3505	24.67	190109	01.2153	13.50
170025	01.2269	15.81	170112	00.9853	13.90	180034	01.2655	14.14	180134	01.0389	13.87	190110	00.9437	12.43
170026	01.0417	12.83	170113	01.1475	14.95	180035	01.5526	18.73	180136	01.6029	16.47	190111	01.5997	18.33
170027	01.3447	15.50	170114	01.0128	13.80	180036	01.2050	17.11	180137	01.8119	18.38	190112	01.5901	19.46
170030	01.0153	13.99	170115	01.0238	11.34	180037	01.3414	19.79	180138	01.2091	17.99	190113	01.3584	18.49
170031	00.9092	12.62	170116	01.0473	15.74	180038	01.4104	15.04	180139	01.1543	18.64	190114	01.0182	12.20
170032	01.1647	14.89	170117	00.9415	13.50	180040	02.0226	19.20	180140	00.8743	.....	190115	01.2236	18.33
170033	01.3701	14.59	170119	00.9812	12.09	180041	01.1036	13.42	180141	01.8022	.....	190116	01.1871	.....
170034	00.9962	14.61	170120	01.2988	16.06	180042	01.1987	13.59	190001	00.8702	17.98	190118	01.0964	12.38
170035	00.8580	14.82	170122	01.7447	19.93	180043	01.0028	15.84	190002	01.6861	18.15	190120	01.0003	13.75
170036	00.9007	13.19	170123	01.7667	19.02	180044	01.1644	16.29	190003	01.3867	17.41	190122	01.2265	15.70
170037	01.2485	16.31	170124	01.0109	14.25	180045	01.2627	16.79	190004	01.4153	15.24	190124	01.6508	20.23
170038	00.9237	11.46	170126	00.9445	11.50	180046	01.2348	16.65	190005	01.6473	17.60	190125	01.5592	17.99
170039	01.1505	13.62	170128	00.9794	14.42	180047	01.0286	13.80	190006	01.2974	14.32	190128	01.0852	18.56
170040	01.6026	18.83	170131	01.2140	09.38	180048	01.2851	16.17	190007	01.0081	13.52	190130	01.0318	12.09
170041	00.9985	11.29	170133	01.1285	14.20	180049	01.3320	15.45	190008	01.6674	17.72	190131	01.2019	16.12
170043	01.0095	13.49	170134	00.9462	12.48	180050	01.2528	16.12	190009	01.1614	13.79	190133	00.9749	12.08
170044	01.1045	14.42	170137	01.1888	17.30	180051	01.4299	14.78	190010	01.0337	16.62	190134	01.0188	14.79
170045	01.0555	10.72	170139	01.0392	11.82	180053	01.0895	14.30	190011	01.1664	14.41	190135	01.4616	22.58
170049	01.2898	18.28	170142	01.3501	16.49	180054	01.1107	13.76	190013	01.3986	15.95	190136	01.2005	11.22
170051	00.9202	13.66	170143	01.1128	13.82	180055	01.1648	14.00	190014	01.1133	15.35	190138	00.8846	17.51
170052	01.0589	12.60	170144	01.6127	14.73	180056	01.0761	16.38	190015	01.2521	17.78	190140	01.0146	12.16
170053	00.9478	15.39	170145	01.1395	14.83	180058	00.9870	12.63	190017	01.4478	16.02	190142	00.9041	12.39
170054	01.0865	13.19	170146	01.5244	19.54	180059	00.9160	12.59	190018	01.1910	15.92	190144	01.3101	15.22
170055	01.0974	14.55	170147	01.2724	20.70	180060	01.0317	10.17	190019	01.6081	18.39	190145	00.9987	13.66
170056	00.9193	13.72	170148	01.4120	17.64	180063	00.9916	10.79	190020	01.1829	15.85	190146	01.6349	19.61
170057	01.0283	13.90	170150	01.0938	13.41	180064	01.3317	14.03	190025	01.3560	13.62	190147	01.0237	13.69
170058	01.1682	15.80	170151	01.0380	11.66	180065	01.0472	10.82	190026	01.4931	16.17	190148	00.9081	12.77
170060	01.0543	13.41	170152	00.9840	12.99	180066	01.1561	18.09	190027	01.5790	16.49	190149	01.0591	11.47
170061	01.1320	12.90	170160	00.9790	11.17	180067	01.8053	16.40	190029	01.1538	15.40	190151	01.2260	11.73
170063	00.8933	10.92	170164	00.9859	14.42	180069	01.0138	15.33	190033	00.9378	09.66	190152	01.5161	21.27
170064	01.0420	12.09	170166	01.2016	13.65	180070	01.1195	14.66	190034	01.2429	.....	190155	01.0392	12.29
170066	00.9793	12.58	170168	00.9222	09.33	180072	01.0649	13.91	190035	01.3660	.....	190156	00.8732	11.99
170067	01.1302	11.76	170171	01.0731	11.22	180075	01.0012	14.13	190036	01.6990	19.10	190158	01.1877	21.59
170068	01.3080	15.24	170175	01.3540	17.53	180078	01.1591	17.57	190037	00.8934	10.84	190160	01.3255	17.03
170069	00.8338	14.01	170176	01.6200	19.83	180079	01.3352	13.03	190039	01.4034	17.21	190161	01.1212	12.65
170070	01.0108	12.56	170182	01.2299	19.43	180080	01.0543	15.57	190040	01.4397	19.32	190162	01.0388	18.47
170073	01.0663	14.67	170183	02.0361	.....	180085	02.2480	17.70	190041	01.5692	19.72	190164	01.2269	16.05
170074	01.2456	14.34	170184	01.1905	.....	180087	01.1722	13.74	190043	01.0383	11.79	190166	00.9327	14.04
170075	00.9439	10.67	180001	01.2323	17.03	180088	01.5598	19.99	190044	01.1678	17.11	190167	01.2338	18.49
170076	01.0546	11.60	180002	01.0634	16.78	180092	01.2627	15.25	190045	01.4070	20.17	190170	00.9454	13.08
170077	00.9418	12.07	180004	01.1027	14.47	180093	01.3756	16.05	190046	01.4636	17.58	190173	01.4730	20.12
170079	01.0260	12.66	180005	01.1767	18.54	180094	01.0358	11.51	190048	01.2833	13.72	190175	01.3200	20.26
170080	00.9806	10.65	180006	00.9857	08.51	180095	01.2459	12.94	190049	00.9962	15.70	190176	01.7427	19.11
170081	01.0204	10.44	180007	01.5365	16.29	180099	01.3192	12.31	190050	01.0311	14.58	190177	01.6579	22.84
170082	01.0284	10.80	180009	01.4058	19.11	180101	01.3237	18.01	190053	01.0753	12.11	190178	00.9581	10.87
170084	00.9539	10.93	180010	01.8565	18.19	180102	01.4761	16.43	190054	01.3375	14.09	190182	00.9681	20.02
170085	00.9648	12.69	180011	01.2791	15.29	180103	02.1571	17.93	190059	00.9187	13.44	190183	01.1238	14.79
170086	01.7259	18.50	180012	01.4064	17.51	180104	01.5751	18.07	190060	01.4553	15.43	190184	01.0796	13.09
170087	16.1090	18.78	180013	01.4569	16.63	180105	01.0042	12.82	190064	01.6010	18.33	190185	01.3600	18.53
170088	00.9759	10.80	180014	01.7118	19.99	180106	00.8943	12.27	190065	01.4987	14.71	190186	00.9457	13.16
170089	00.9506	15.53	180015	01.3127	15.02	180108	00.8561	13.54	190071	00.8980	12.15	190189	01.0752	13.17
170090	01.0397	09.80	180016	01.3243	14.50	180115	01.0271	15.07	190077	00.9526	13.65	190190	00.9250	12.66
170092	00.8270	11.80	180017	01.3423	13.87	180116	01.4484	15.66	190078	01.1690	11.60	190191	01.3301	17.54
170093	00.9986	11.76	180018	01.2533	14.59	180117	01.1145	17.03	190079	01.2555	16.98	190196	00.8663	16.29
170094	00.9536	15.42	180019	01.3260	16.70	180118	01.0362	12.03	190081	00.9078	10.23	190197	01.2380	18.98
170095	01.1349	13.69	180020	01.0728	15.86	180120	01.0568	13.12	190083	01.0600	15.02	190199	01.1999	16.26
170097	01.0695	13.17	180021	01.1131	13.69	180121	01.2249	13.68	190086	01.4128	15.47	190200	01.5575	21.70

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
190201	01.2734	18.93	210015	01.2807	18.58	220051	01.2093	20.56	230019	01.5032	22.60	230118	01.2187	16.37
190202	01.4760	17.85	210016	01.7192	23.30	220052	01.3214	23.88	230020	01.7231	22.21	230119	01.3042	22.31
190203	01.5075	20.83	210017	01.2275	14.51	220053	01.2594	19.48	230021	01.6150	17.90	230120	01.1809	17.47
190204	01.5863	20.85	210018	01.2493	21.26	220055	01.3462	23.52	230022	01.3615	18.27	230121	01.2510	19.69
190205	01.9236	17.90	210019	01.4990	18.17	220057	01.4076	21.39	230024	01.4369	23.71	230122	01.4028	19.20
190206	01.5515	21.53	210022	01.4499	20.79	220058	01.0836	16.26	230027	01.1510	15.73	230124	01.1633	16.89
190207	01.2969	16.42	210023	01.3678	20.78	220060	01.3041	25.32	230029	01.5797	20.36	230125	01.2952	14.51
190208	00.8122	11.17	210024	01.5604	19.73	220062	00.5838	18.49	230030	01.2204	16.47	230128	01.3852	21.24
190218	01.1988	15.33	210025	01.4143	18.21	220063	01.2285	19.40	230031	01.4361	19.72	230129	01.7824	19.92
190223	00.4249	16.58	210026	01.3749	19.52	220064	01.2338	20.51	230032	01.7412	19.08	230130	01.6730	23.74
190227	00.8255	10.56	210027	01.3029	18.58	220065	01.2265	19.58	230034	01.2288	17.99	230132	01.4154	23.25
190231	01.3079	16.00	210028	01.2217	17.19	220066	01.3350	20.73	230035	01.1178	16.17	230133	01.2207	15.07
190233	02.1157	.....	210029	01.3174	17.99	220067	01.2868	22.58	230036	01.2775	18.79	230134	01.1074	17.91
190234	01.0506	.....	210030	01.1539	19.44	220068	00.5263	16.67	230037	01.1284	17.40	230135	01.2642	20.25
190235	01.2869	.....	210031	01.5487	16.42	220070	01.2498	18.77	230038	01.7083	21.21	230137	01.1949	18.51
190236	01.2668	.....	210032	01.1789	17.90	220071	01.9236	21.67	230040	01.2243	20.53	230141	01.6822	22.44
200001	01.3804	16.92	210033	01.2620	18.58	220073	01.4101	24.14	230041	01.2174	20.75	230142	01.2188	18.90
200002	01.0723	17.70	210034	01.3689	20.34	220074	01.1894	22.82	230042	01.2231	19.32	230143	01.3145	16.58
200003	01.0974	16.02	210035	01.2687	18.11	220075	01.2619	19.51	230046	01.8844	25.32	230144	01.2250	21.19
200006	01.0590	14.97	210037	01.2433	17.38	220076	01.1859	25.46	230047	01.3420	20.37	230145	01.1856	15.96
200007	01.1251	17.01	210038	01.3320	21.63	220077	01.7917	22.92	230053	01.6445	24.16	230146	01.3105	19.56
200008	01.2258	20.19	210039	01.1897	17.55	220079	01.1692	21.68	230054	01.8208	21.45	230147	01.4445	19.70
200009	01.8129	19.95	210040	01.3323	21.01	220080	01.2719	19.58	230055	01.1628	18.26	230149	01.1767	15.51
200012	01.1117	16.55	210043	01.3063	21.32	220081	01.0044	24.81	230056	00.9866	14.55	230151	01.3931	22.02
200013	01.1261	15.69	210044	01.2665	19.38	220082	01.3096	23.04	230058	01.1539	18.69	230153	01.1329	19.70
200015	01.2305	17.41	210045	01.0746	11.42	220083	01.1972	20.43	230059	01.4456	19.01	230154	00.9371	12.43
200016	01.0109	15.76	210048	01.2050	23.30	220084	01.3134	23.23	230060	01.3047	17.97	230155	00.9383	16.62
200017	01.2501	17.94	210049	01.1551	17.77	220086	01.6491	26.01	230062	01.0249	14.41	230156	01.7141	22.91
200018	01.1961	15.20	210051	01.4237	20.03	220088	01.6090	22.68	230063	01.3178	19.15	230157	01.2020	20.15
200019	01.2392	18.59	210054	01.3311	21.05	220089	01.3337	22.69	230065	01.3391	19.44	230159	01.5106	19.64
200020	01.1405	20.96	210055	01.2655	24.26	220090	01.2575	20.95	230066	01.3879	20.58	230162	01.0467	15.60
200021	01.1723	17.78	210056	01.3809	17.67	220092	01.2336	20.66	230068	01.4483	22.15	230165	01.8519	21.91
200023	00.9047	16.15	210057	01.4140	25.76	220094	01.4156	19.82	230069	01.1621	21.95	230167	01.7996	19.23
200024	01.3279	19.84	210058	01.5351	18.09	220095	01.2483	19.06	230070	01.5713	19.57	230169	01.3465	20.88
200025	01.0790	19.51	210059	01.2620	21.44	220098	01.2576	19.71	230071	01.1340	22.00	230171	01.0260	14.42
200026	01.0265	15.97	210060	01.1836	23.61	220100	01.2637	23.69	230072	01.2305	19.32	230172	01.2797	18.87
200027	01.1183	17.27	210061	01.1780	17.65	220101	01.4392	23.41	230075	01.4720	19.41	230174	01.2978	19.50
200028	00.9729	16.24	220001	01.2880	21.80	220104	01.3000	24.79	230076	01.3501	22.67	230175	03.1496	11.15
200031	01.2812	15.26	220002	01.5420	23.02	220105	01.2698	22.16	230077	02.0635	18.62	230176	01.2352	20.69
200032	01.3456	18.90	220003	01.0746	16.71	220106	01.2620	22.14	230078	01.1336	15.79	230178	01.0050	17.92
200033	01.7912	20.16	220004	01.1627	18.66	220107	01.1929	19.21	230080	01.2285	20.74	230180	01.1057	15.79
200034	01.2381	18.05	220006	01.4307	21.04	220108	01.1992	21.13	230081	01.2949	16.73	230184	01.1534	17.45
200037	01.1963	16.09	220008	01.2955	20.45	220110	02.0108	31.74	230082	01.2055	15.97	230186	01.2243	17.37
200038	01.1101	18.23	220010	01.3125	21.44	220111	01.2703	21.76	230085	01.1164	17.76	230188	01.1813	16.01
200039	01.2718	19.03	220011	01.1494	27.00	220116	02.0069	24.40	230086	01.0061	14.88	230189	00.9246	14.93
200040	01.1080	17.37	220012	01.3759	30.46	220118	02.0709	27.44	230087	01.0463	17.12	230190	01.0342	20.21
200041	01.0933	16.19	220015	01.2323	20.94	220119	01.3231	24.27	230089	01.2842	21.86	230191	00.9118	16.65
200043	00.5276	16.46	220016	01.3819	20.87	220123	01.0394	22.86	230092	01.3128	18.29	230193	01.2127	16.97
200050	01.1870	17.84	220017	01.3926	23.16	220126	01.3385	20.63	230093	01.2211	18.91	230194	01.1254	15.94
200051	00.9682	18.29	220019	01.1521	17.57	220128	01.2038	22.97	230095	01.1969	16.51	230195	01.3147	21.44
200052	00.9788	14.12	220020	01.2411	18.68	220133	00.8368	29.15	230096	01.1728	20.60	230197	01.3474	21.41
200055	01.1748	15.29	220021	01.3635	23.88	220135	01.2397	24.67	230097	01.5928	19.03	230199	01.1846	16.61
200062	00.9125	15.03	220023	01.1724	19.92	220153	00.9842	19.37	230099	01.1191	18.90	230201	01.1826	14.03
200063	01.2548	18.27	220024	01.2011	20.61	220154	01.0025	20.72	230100	01.2050	14.82	230204	01.3955	20.13
200066	01.2157	15.65	220025	01.2146	19.07	220162	01.1174	.....	230101	01.0781	17.28	230205	01.0457	13.00
210001	01.4359	19.45	220028	01.4903	21.29	220163	02.0494	24.21	230103	01.0526	17.37	230207	01.2669	21.19
210002	02.0301	16.46	220029	01.1504	23.54	220171	01.6465	21.72	230104	01.6096	21.24	230208	01.2412	18.18
210003	01.5454	22.78	220030	01.1142	17.02	230001	01.1916	18.72	230105	01.6864	19.47	230211	00.9096	14.11
210004	01.3604	21.20	220031	02.0045	29.21	230002	01.2641	18.80	230106	01.3011	18.64	230212	01.0720	22.89
210005	01.2337	18.52	220033	01.3844	19.62	230003	01.1456	18.79	230107	00.9245	11.54	230213	01.0473	13.19
210006	01.0987	17.09	220035	01.3148	19.49	230004	01.6847	24.03	230108	01.2350	18.02	230216	01.6086	19.50
210007	01.6811	20.55	220036	01.5951	22.33	230005	01.2549	18.69	230110	01.3936	17.31	230217	01.2395	19.60
210008	01.3385	19.03	220038	01.2902	21.60	230006	01.1078	15.91	230111	00.9900	17.97	230219	00.9318	16.58
210009	01.8256	19.93	220041	01.2145	21.02	230007	01.0590	17.82	230113	00.9699	18.07	230221	01.1033	17.78
210010	01.1897	16.40	220042	01.2037	25.43	230012	00.9618	11.92	230114	00.6644	25.66	230222	01.3910	18.46
210011	01.2790	21.24	220046	01.3759	23.55	230013	01.3026	20.55	230115	01.0034	15.79	230223	01.3134	21.86
210012	01.6303	21.50	220049	01.3204	21.16	230015	01.1338	19.54	230116	00.9514	14.84	230227	01.4686	22.63
210013	01.2454	18.65	220050	01.0930	18.78	230017	01.5755	20.51	230117	01.9294	25.77	230230	01.6739	21.30

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
230232	00.9775	18.31	240065	01.0639	10.79	240152	01.0432	18.30	250057	01.2901	14.84	260012	01.1120	12.21
230235	01.0780	14.12	240066	01.4080	18.87	240153	01.0196	15.01	250058	01.1584	13.20	260013	01.1128	13.85
230236	01.3039	21.82	240069	01.2138	18.58	240154	01.0483	14.45	250059	01.0879	14.15	260014	01.7531	18.62
230239	01.1599	16.38	240071	01.1332	17.67	240155	00.9544	16.25	250060	00.7832	10.79	260015	01.3476	12.13
230241	01.1124	17.56	240072	01.0874	17.53	240157	01.1163	11.54	250061	00.8589	09.59	260017	01.2927	14.90
230244	01.3635	21.20	240073	00.9506	15.03	240160	00.9811	15.61	250063	00.8529	12.96	260018	00.9297	10.14
230253	00.9665	18.09	240075	01.1877	19.26	240161	00.9741	14.77	250065	00.9859	11.60	260019	01.0453	12.50
230254	01.2864	21.85	240076	01.1076	20.82	240162	00.9992	15.08	250066	00.9305	14.05	260020	01.6738	20.95
230257	00.8638	18.77	240077	00.9344	12.01	240163	00.9475	14.68	250067	01.1461	15.22	260021	01.5109	18.46
230259	01.1898	19.63	240078	01.5036	21.81	240166	01.0721	15.70	250068	00.8507	09.05	260022	01.2923	16.51
230264	01.0486	19.01	240079	01.0478	13.53	240169	00.9590	15.46	250069	01.4098	13.92	260023	01.3274	16.81
230269	01.3682	22.82	240080	01.4004	21.73	240170	01.1711	14.40	250071	00.9012	10.90	260024	00.9475	12.58
230270	01.2231	20.42	240082	01.0933	15.87	240171	01.0599	14.30	250072	01.3508	16.19	260025	01.2408	14.22
230273	01.5791	21.61	240083	01.3701	16.80	240172	01.0622	14.86	250076	01.5698	08.95	260027	01.5512	20.66
230275	00.5037	16.62	240084	01.3013	17.76	240173	00.9750	14.79	250077	00.9415	11.54	260029	01.1498	16.88
230276	00.6974	17.39	240085	00.9624	15.55	240179	01.0875	15.05	250078	01.4511	14.35	260030	01.1773	10.28
230277	01.2458	21.07	240086	01.0731	15.22	240184	01.0888	11.77	250079	00.8988	13.59	260031	01.5415	18.47
230278	01.8501	21.54	240087	01.1736	15.74	240187	01.1716	18.89	250081	01.3350	15.13	260032	01.6162	18.24
230279	00.6949	15.06	240088	01.4370	18.72	240193	01.0850	15.54	250082	01.2696	12.99	260034	01.0286	15.30
230280	01.0876	14.88	240089	00.9741	15.79	240196	00.6148	22.86	250083	01.0209	10.67	260035	01.0432	11.67
240001	01.5822	22.07	240090	01.0671	13.53	240200	00.9038	13.54	250084	01.1159	15.95	260036	01.0354	18.28
240002	01.7315	20.58	240093	01.3382	16.86	240205	01.0346	.....	250085	00.9834	12.43	260037	01.4487	15.56
240004	01.5268	21.05	240094	00.9928	17.38	240206	00.9570	.....	250088	00.9081	14.66	260039	01.1663	12.17
240005	01.0266	15.07	240096	00.9783	14.74	240207	01.2804	22.23	250089	01.1680	13.27	260040	01.6549	15.94
240006	01.1154	20.02	240097	01.1033	18.17	240210	01.2460	22.69	250093	01.1083	12.75	260042	01.2618	16.78
240007	01.0769	15.81	240098	00.9425	16.39	240211	01.0014	11.52	250094	01.2614	14.92	260044	01.0934	14.86
240008	01.0662	16.32	240099	01.0621	10.76	250001	01.4559	16.92	250095	01.0168	14.72	260047	01.4644	15.90
240009	01.0015	14.35	240100	01.2967	18.25	250002	00.8370	14.44	250096	01.2783	15.77	260048	01.2365	19.25
240010	01.9744	21.16	240101	01.1792	17.70	250003	01.0137	15.14	250097	01.3211	13.86	260050	01.0968	14.63
240011	01.1601	15.71	240102	00.9227	12.87	250004	01.4726	16.68	250098	00.8662	14.72	260052	01.3373	16.89
240013	01.3128	16.96	240103	01.0701	13.76	250005	01.0613	10.43	250099	01.3168	12.67	260053	01.1651	10.83
240014	01.0839	19.10	240104	01.1850	21.72	250006	00.9608	14.73	250100	01.2729	14.27	260054	01.3178	14.83
240016	01.3772	16.31	240105	01.0170	12.35	250007	01.2974	18.24	250101	00.8766	09.75	260055	01.0236	08.93
240017	01.2008	15.66	240106	01.3884	23.85	250008	00.9270	11.91	250102	01.6510	14.56	260057	01.1559	14.12
240018	01.3331	17.17	240107	00.9699	14.74	250009	01.1951	15.81	250104	01.4468	16.31	260059	01.2358	11.75
240019	01.1997	20.69	240108	00.9753	12.35	250010	01.0272	11.88	250105	00.9242	11.52	260061	01.1323	11.91
240020	01.1545	20.05	240109	00.9763	12.06	250012	00.9493	13.18	250107	00.8879	14.99	260062	01.2004	17.75
240021	01.0040	13.13	240110	00.9880	14.66	250015	01.1025	10.43	250109	00.9619	12.97	260063	01.1235	15.61
240022	01.1171	18.13	240111	01.0264	15.65	250017	00.9743	14.92	250112	00.9503	14.95	260064	01.3135	15.06
240023	01.1030	16.17	240112	01.0120	14.22	250018	01.0885	11.21	250117	01.0158	13.39	260065	01.7978	16.07
240025	01.1265	14.54	240114	00.8971	13.21	250019	01.4948	16.51	250119	01.1128	11.94	260066	01.0288	15.31
240027	01.0280	15.50	240115	01.6575	21.53	250020	00.9503	11.47	250120	01.0898	13.47	260067	00.9511	10.89
240028	01.1803	18.14	240116	00.9560	12.54	250021	00.9206	08.33	250122	01.2659	.....	260068	01.6925	19.07
240029	01.2190	17.00	240117	01.1415	17.40	250023	00.8554	.....	250123	01.3245	18.31	260070	01.0637	12.16
240030	01.2864	17.33	240119	00.8838	17.45	250024	00.9613	08.37	250124	00.9107	11.28	260073	01.0411	11.87
240031	00.9918	13.83	240121	00.9377	17.85	250025	01.1325	15.43	250125	01.3265	18.00	260074	01.3241	17.22
240036	01.5677	19.89	240122	01.0774	16.25	250027	01.0193	11.14	250126	00.9963	13.81	260077	01.7094	16.86
240037	01.0459	17.05	240123	01.0887	13.80	250029	00.8793	11.91	250127	00.7981	10.67	260078	01.2180	14.84
240038	01.4768	24.33	240124	00.9980	16.84	250030	00.9894	11.26	250128	01.1054	11.86	260079	01.0338	11.96
240040	01.1838	19.00	240125	00.9119	12.16	250031	01.3401	17.65	250131	00.9853	10.41	260080	01.0487	10.85
240041	01.2688	15.42	240127	01.0956	12.16	250032	01.2651	15.27	250134	00.9847	15.67	260081	01.5242	18.50
240043	01.2180	17.60	240128	01.1103	14.99	250033	01.1179	12.63	250136	00.9293	15.06	260082	01.1931	13.85
240044	01.1777	16.75	240129	01.0683	13.13	250034	01.6275	13.70	250138	01.2493	16.52	260085	01.5683	18.89
240045	01.1170	18.25	240130	01.0694	15.14	250035	00.8775	13.38	250141	01.2384	16.11	260086	00.9991	13.83
240047	01.5112	19.66	240132	01.2511	21.26	250036	01.0177	10.97	250145	00.9805	.....	260089	01.0806	12.16
240048	01.2509	21.83	240133	01.1407	16.89	250037	00.8394	09.52	250146	01.0293	12.44	260091	01.6447	20.21
240049	01.7860	21.16	240135	00.9022	11.98	250038	00.9491	12.49	250148	01.1361	14.14	260094	01.2142	17.53
240050	01.1382	22.26	240137	01.2280	15.99	250039	01.0330	12.23	250149	00.9158	12.56	260095	01.4130	15.92
240051	00.9385	14.60	240138	00.9613	12.39	250040	01.3378	16.36	260001	01.6347	16.79	260096	01.5959	23.01
240052	01.2651	18.14	240139	00.9705	14.07	250042	01.2431	13.72	260002	01.4563	20.60	260097	01.1569	16.79
240053	01.5135	19.37	240141	01.1692	18.92	250043	01.0021	11.48	260003	00.9752	13.10	260100	01.0555	13.31
240056	01.2694	21.66	240142	01.1055	15.56	250044	00.9974	14.17	260004	01.0307	12.81	260102	01.0467	17.58
240057	01.7845	21.08	240143	01.1220	11.76	250045	01.1352	17.75	260005	01.6959	20.17	260103	01.3939	16.96
240058	00.9705	08.83	240144	01.0129	13.66	250047	00.9859	11.39	260006	01.4637	16.81	260104	01.7038	18.80
240059	01.1096	19.63	240145	00.9274	12.01	250048	01.5334	14.39	260007	01.6391	14.42	260105	01.8450	21.41
240061	01.7813	21.05	240146	00.9883	18.68	250049	00.9044	11.19	260008	01.2715	16.18	260107	01.4336	19.39
240063	01.5152	22.26	240148	01.0915	08.84	250050	01.2911	12.79	260009	01.2277	15.64	260108	01.8662	18.57
240064	01.2556	20.39	240150	00.8854	12.16	250051	00.8720	08.88	260011	01.6403	17.12	260109	00.9885	11.86

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
260110	01.5703	14.92	270035	01.0128	16.94	280050	00.9679	13.74	290021	01.6450	19.51	310041	01.3388	21.96
260113	01.0828	14.31	270036	00.9373	09.94	280051	01.2066	13.85	290022	01.6828	20.47	310042	01.2149	22.13
260115	01.2400	14.59	270039	01.0684	12.96	280052	00.9828	12.52	290027	00.9732	15.03	310043	01.2896	19.99
260116	01.1030	13.89	270040	01.0918	19.79	280054	01.2703	16.10	290029	00.8983	.....	310044	01.3360	20.03
260119	01.1917	13.28	270041	01.0796	11.52	280055	00.9249	12.19	290032	01.4471	18.24	310045	01.4249	27.62
260120	01.2217	14.60	270044	01.1485	14.40	280056	01.0135	13.28	290036	01.0870	13.90	310047	01.3531	24.05
260122	01.1474	13.40	270046	00.9270	13.70	280057	00.9801	15.61	290038	00.9351	17.61	310048	01.2560	21.34
260123	01.0221	12.27	270048	01.0968	14.13	280058	01.3647	14.36	290039	01.3412	.....	310049	01.3224	23.91
260127	00.9860	13.88	270049	01.8343	19.33	280060	01.5785	18.24	300001	01.3841	21.03	310050	01.2281	21.48
260128	01.0214	09.22	270050	01.0747	17.43	280061	01.4895	15.95	300003	01.8856	21.59	310051	01.3357	23.27
260129	01.2018	13.53	270051	01.3399	19.12	280062	01.1451	12.55	300005	01.2741	19.13	310052	01.2886	21.19
260131	01.4057	15.91	270052	01.0912	12.73	280064	01.0800	13.94	300006	01.1402	17.36	310054	01.3056	23.97
260134	01.1561	14.28	270053	00.9396	09.78	280065	01.2745	17.49	300007	01.1618	17.04	310056	01.3867	20.63
260137	01.5544	14.25	270057	01.2164	18.21	280066	01.0357	11.48	300008	01.2110	18.30	310057	01.2922	23.67
260138	01.8949	21.17	270058	00.9476	11.51	280068	01.0870	09.89	300009	01.1504	18.16	310058	01.0906	26.79
260141	01.9549	17.43	270059	00.8656	15.65	280070	01.0149	11.63	300010	01.2297	17.88	310060	01.2000	18.73
260142	01.2382	13.99	270060	00.9067	13.00	280073	01.0115	13.94	300011	01.3613	22.07	310061	01.2538	20.23
260143	00.9915	11.96	270063	00.9363	14.23	280074	01.1316	13.76	300012	01.3381	21.42	310062	01.2965	24.98
260147	01.0190	12.74	270068	00.9009	15.59	280075	01.2322	13.10	300013	01.1476	17.06	310063	01.3660	21.28
260148	00.9522	09.30	270072	00.7740	11.39	280076	01.0519	12.93	300014	01.2209	19.36	310064	01.2783	22.29
260158	01.1057	11.77	270073	01.1623	11.16	280077	01.3421	17.26	300015	01.1797	18.08	310067	01.3279	23.76
260159	01.0850	19.81	270074	00.8787	.....	280079	01.2143	10.42	300016	01.2009	15.73	310069	01.2838	20.03
260160	01.0947	11.84	270075	00.9757	.....	280080	01.0583	12.11	300017	01.2344	21.96	310070	01.4058	22.98
260162	01.5751	19.55	270076	00.7949	.....	280081	01.6898	18.79	300018	01.2172	19.62	310072	01.2874	20.57
260163	01.3342	15.35	270079	00.9165	13.66	280082	01.0127	13.48	300019	01.2814	18.78	310073	01.6854	23.77
260164	00.9984	12.17	270080	01.2060	15.54	280083	01.1020	14.54	300020	01.2710	20.72	310074	01.4715	22.61
260166	01.2345	21.39	270081	01.0741	12.39	280084	01.0433	11.01	300021	01.1849	15.34	310075	01.3895	23.13
260172	00.9976	12.72	270082	01.0736	14.48	280088	01.7915	17.98	300022	01.1134	17.22	310076	01.4399	28.74
260173	01.0104	11.78	270083	01.0503	16.28	280089	01.0285	14.37	300023	01.2978	19.78	310077	01.5635	23.51
260175	01.1633	14.99	270084	00.9318	14.12	280090	00.9935	13.49	300024	01.1828	16.74	310078	01.3027	24.59
260176	01.7313	18.43	280001	01.1150	12.98	280091	01.2088	14.18	300028	01.2388	16.75	310081	01.2885	21.29
260177	01.3273	20.42	280003	02.0371	19.15	280092	00.8942	12.18	300029	01.3275	22.39	310083	01.2987	22.33
260178	01.4928	18.91	280005	01.4351	17.19	280094	01.0535	14.07	300033	01.1132	13.69	310084	01.3541	21.20
260179	01.6451	18.70	280009	01.7538	17.25	280097	01.0852	12.27	300034	02.0364	23.29	310086	01.2266	21.30
260180	01.7006	20.07	280011	00.8644	11.91	280098	00.9677	10.40	310001	01.7992	26.40	310087	01.2818	19.26
260183	01.5643	16.14	280012	01.3040	15.43	280101	01.0917	13.18	310002	01.7327	26.31	310088	01.2278	20.64
260186	01.2995	15.97	280013	01.8405	20.57	280102	01.1442	12.76	310003	01.2627	24.08	310090	01.2294	25.46
260188	01.2526	18.64	280014	00.9583	13.39	280104	00.9763	10.84	310005	01.2319	20.54	310091	01.3343	20.80
260189	00.8480	11.26	280015	01.0124	15.19	280105	01.3758	17.28	310006	01.2052	19.62	310092	01.3108	20.70
260190	01.2528	18.90	280017	01.1012	13.94	280106	00.9288	13.93	310008	01.3806	22.73	310093	01.1706	19.79
260191	01.2514	17.92	280018	01.0931	13.35	280107	01.0876	11.13	310009	01.2807	22.80	310096	01.8668	23.17
260193	01.2323	18.75	280020	01.6154	18.93	280108	01.2167	13.96	310010	01.2537	20.92	310105	01.2442	23.63
260195	01.1679	14.49	280021	01.3263	15.49	280109	00.9153	09.80	310011	01.2873	21.55	310108	01.4315	21.85
260197	01.1444	20.98	280022	01.0087	12.52	280110	01.0169	11.19	310012	01.5915	24.33	310110	01.2368	20.38
260198	01.3378	15.86	280023	01.4093	15.69	280111	01.2161	15.63	310013	01.2770	21.84	310111	01.3068	20.46
260200	01.3613	19.10	280024	00.9413	13.05	280114	00.9765	12.99	310014	01.7131	24.26	310112	01.3241	21.02
270002	01.2856	15.06	280025	00.9422	12.14	280115	00.9474	14.77	310015	01.9529	24.97	310113	01.2395	20.60
270003	01.2214	19.98	280026	01.0265	15.28	280117	01.1921	14.47	310016	01.2564	22.34	310115	01.2923	19.31
270004	01.7045	19.96	280028	01.0549	14.53	280118	00.9889	15.17	310017	01.3661	23.40	310116	01.2370	21.96
270006	01.0898	14.78	280029	01.2195	14.02	280119	00.8659	.....	310018	01.1268	20.55	310118	01.2551	22.53
270007	00.9224	13.18	280030	01.7278	24.40	280123	00.9506	15.63	310019	01.6124	23.53	310119	01.6198	30.37
270009	01.0810	15.34	280031	01.0191	13.10	290001	01.6662	21.85	310020	01.2521	21.55	310120	01.0709	17.44
270011	01.0719	15.52	280032	01.3303	15.57	290002	00.9831	17.79	310021	01.3931	22.03	310121	01.1650	20.34
270012	01.6741	17.63	280033	01.0971	14.24	290003	01.6600	20.74	310022	01.2806	21.47	320001	01.4682	17.14
270013	01.4138	17.77	280034	01.3131	13.86	290005	01.4915	19.03	310024	01.3560	22.85	320002	01.3511	20.74
270014	01.7987	16.83	280035	00.9238	11.81	290006	01.1731	16.15	310025	01.2619	22.27	320003	01.1841	15.65
270016	00.9321	13.23	280037	01.0168	14.28	290007	01.9114	27.06	310026	01.2312	22.67	320004	01.2645	17.19
270017	01.3064	18.66	280038	01.0809	14.53	290008	01.1790	18.73	310027	01.3355	20.94	320005	01.3203	18.87
270019	01.0378	14.02	280039	01.1314	13.99	290009	01.5603	22.25	310028	01.1787	21.21	320006	01.3638	15.96
270021	01.1545	16.23	280040	01.6214	18.67	290010	01.1286	11.93	310029	01.9766	22.49	320009	01.5899	16.52
270023	01.3584	20.28	280041	00.9179	11.80	290011	01.0396	14.67	310031	02.8736	24.35	320011	01.0253	17.06
270024	00.9913	13.05	280042	01.1032	13.11	290012	01.3984	20.71	310032	01.3445	21.17	320012	00.9834	16.21
270026	00.9309	12.95	280043	01.0605	14.76	290013	01.0682	15.39	310034	01.2696	21.26	320013	01.1618	19.19
270027	01.0785	11.91	280045	01.2844	13.63	290014	01.0288	16.38	310036	01.1474	19.86	320014	01.1042	13.79
270028	01.0841	15.37	280046	01.1494	11.04	290015	01.0036	15.04	310037	01.3407	26.92	320016	01.1839	13.77
270029	00.9507	16.24	280047	01.0939	15.54	290016	01.2251	19.81	310038	02.0204	24.49	320017	01.1548	16.85
270032	01.1189	15.80	280048	01.1833	12.06	290019	01.3517	19.06	310039	01.2885	21.42	320018	01.5098	17.37
270033	00.8853	12.22	280049	01.0480	13.94	290020	01.0868	17.08	310040	01.2597	24.06	320019	01.5443	22.95

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
320021	01.7533	17.31	330057	01.6977	16.97	330167	01.7092	28.82	330265	01.3607	16.53	340021	01.2689	16.22
320022	01.2423	16.07	330058	01.3103	15.76	330169	01.4110	32.57	330267	01.2246	23.35	340022	01.0375	14.98
320023	00.9909	16.72	330059	01.5940	29.90	330171	01.3203	21.95	330268	01.0334	14.44	340023	01.4060	17.97
320030	01.0487	18.27	330061	01.3131	23.60	330175	01.1554	14.35	330270	01.9732	32.47	340024	01.1772	15.07
320031	00.9027	12.36	330062	01.1628	15.58	330177	01.0005	13.74	330273	01.3707	23.35	340025	01.1840	14.99
320032	00.9301	15.10	330064	01.4496	29.63	330179	00.8725	14.38	330275	01.3082	18.58	340027	01.1891	15.59
320033	01.1267	20.90	330065	01.1872	17.24	330180	01.1898	16.40	330276	01.1936	17.02	340028	01.5458	17.32
320035	00.9731	14.58	330066	01.3095	17.55	330181	01.3087	30.46	330277	01.1398	16.32	340030	02.0708	20.58
320037	01.2157	15.59	330067	01.3397	20.60	330182	02.4691	28.41	330279	01.3457	18.52	340031	01.0081	11.97
320038	01.2291	13.85	330072	01.3517	27.84	330183	01.5101	18.74	330285	01.7862	22.52	340032	01.3860	18.60
320046	01.2573	18.15	330073	01.1565	14.87	330184	01.3734	26.85	330286	01.3224	24.25	340035	01.1828	15.73
320048	01.3064	17.40	330074	01.2166	18.14	330185	01.3291	25.44	330290	01.7785	29.90	340036	01.2472	17.33
320056	00.9777	.....	330075	01.0853	17.25	330186	00.8858	19.79	330293	01.1588	13.48	340037	01.1215	15.85
320057	00.9860	.....	330078	01.3888	17.05	330188	01.2089	18.28	330304	01.2571	27.34	340038	01.0707	15.42
320058	00.8563	.....	330079	01.2315	17.05	330189	01.4328	16.85	330306	01.4672	27.44	340039	01.2910	19.52
320059	01.1562	.....	330080	01.4550	27.21	330191	01.3345	17.14	330307	01.2474	19.43	340040	01.7921	18.22
320060	00.9435	.....	330084	01.0610	16.46	330193	01.3182	27.97	330308	01.2507	29.68	340041	01.2364	17.24
320061	01.1137	.....	330085	01.3273	18.64	330194	01.8320	29.32	330309	01.2698	24.10	340042	01.1970	14.01
320062	00.9094	.....	330086	01.2423	24.99	330195	01.6507	29.85	330314	01.4593	22.18	340044	01.0253	13.44
320063	01.2911	16.46	330088	01.0571	24.62	330196	01.3114	00.34	330315	16.1090	25.23	340045	00.9968	09.61
320065	01.3721	17.00	330090	01.5514	16.76	330197	01.0574	14.99	330316	01.2635	21.85	340047	01.8734	18.38
320067	00.8637	17.64	330091	01.3268	18.50	330198	01.4037	22.87	330327	00.9920	16.17	340048	00.8186	14.02
320068	00.8763	15.36	330092	01.1180	14.07	330199	01.4010	25.87	330331	01.2269	29.77	340049	00.6961	13.94
320069	00.9960	10.67	330094	01.1768	16.51	330201	01.6465	27.62	330332	01.2958	26.61	340050	01.1941	17.37
320070	00.9059	.....	330095	01.2330	17.55	330202	01.6534	28.76	330333	01.2526	23.81	340051	01.3394	16.08
320074	01.0785	17.04	330096	01.0917	15.45	330203	01.3909	19.06	330336	01.3450	28.99	340052	01.0093	18.41
320079	01.1533	17.22	330097	01.2483	15.36	330204	01.4006	30.31	330338	01.2358	23.09	340053	01.6663	19.08
330001	01.1757	25.49	330100	00.7182	26.07	330205	01.1539	20.29	330339	00.8847	18.73	340054	01.1083	13.09
330002	01.4142	25.22	330101	01.7684	33.56	330208	01.2513	24.55	330340	01.1880	21.17	340055	01.1907	17.40
330003	01.3152	17.67	330102	01.3513	17.47	330209	01.2154	23.11	330350	01.8015	28.27	340060	01.1491	16.69
330004	01.3320	19.08	330103	01.2733	16.46	330211	01.1993	17.23	330353	01.3368	30.33	340061	01.7040	19.91
330005	01.7984	20.49	330104	01.3905	26.74	330212	01.1041	21.12	330354	01.5264	.....	340063	01.0417	13.08
330006	01.2710	23.92	330106	01.5962	34.42	330213	01.1771	16.58	330357	01.3809	33.49	340064	01.2144	17.12
330007	01.3464	17.71	330107	01.3262	25.92	330214	01.7550	29.72	330359	00.9243	19.54	340065	01.3430	14.39
330008	01.2061	15.62	330108	01.2139	16.28	330215	01.2276	15.66	330372	01.2018	24.47	340067	01.2792	15.88
330009	01.3815	30.32	330111	01.0633	14.81	330218	01.1335	17.94	330381	01.1971	28.03	340068	01.2351	14.77
330010	01.2801	15.07	330114	00.9802	16.13	330219	01.6778	19.13	330385	01.1776	-2.89	340069	01.7382	19.47
330011	01.3290	17.81	330115	01.2248	15.23	330221	01.3386	27.53	330386	01.2009	22.53	340070	01.3823	17.57
330012	01.7038	31.01	330116	00.9813	14.21	330222	01.2772	17.64	330387	01.0268	23.95	340071	01.0851	15.08
330013	02.0608	17.36	330118	01.6299	18.94	330223	01.0642	15.37	330389	01.7489	29.43	340072	01.0654	15.20
330014	01.3788	30.31	330119	01.7640	33.48	330224	01.2453	20.32	330390	01.2900	30.36	340073	01.5496	20.23
330016	01.0547	15.47	330121	01.0392	16.10	330225	01.1722	24.43	330393	01.7141	27.22	340075	01.2024	16.26
330019	01.2902	25.33	330122	01.0867	21.84	330226	01.2740	17.05	330394	01.5390	17.96	340080	01.0607	12.72
330020	01.0620	15.26	330125	01.8729	19.78	330229	01.3074	15.73	330395	01.3045	30.64	340084	01.0587	15.61
330023	01.2479	23.30	330126	01.1881	22.34	330230	01.4285	28.69	330396	01.3520	24.91	340085	01.1720	15.65
330024	01.8143	30.17	330127	01.3437	24.82	330231	01.0938	30.02	330397	01.2858	25.47	340087	01.1024	16.01
330025	01.1813	18.51	330128	01.3917	28.29	330232	01.2394	16.42	330398	01.2749	26.92	340088	01.1388	16.42
330027	01.4780	30.17	330132	01.0770	14.60	330233	01.5512	29.70	330399	01.2737	29.65	340089	01.0348	12.85
330028	01.4234	24.95	330133	01.3665	30.50	330234	02.2563	29.60	340001	01.5504	19.47	340090	01.1542	17.15
330029	01.0148	19.09	330135	01.1572	18.28	330235	01.1452	18.33	340002	01.8974	18.38	340091	01.7238	19.42
330030	01.2083	14.75	330136	01.2992	16.54	330236	01.4044	27.87	340003	01.1484	17.08	340093	01.0733	12.10
330033	01.2824	13.81	330140	01.7638	17.79	330238	01.2306	14.19	340004	01.4886	17.16	340094	01.4431	17.65
330034	00.7369	32.72	330141	01.3548	24.27	330239	01.1936	15.39	340005	01.1591	13.24	340096	01.1673	17.33
330036	01.2231	22.66	330144	00.9791	13.70	330240	01.3305	28.41	340006	01.0881	14.60	340097	01.1830	16.61
330037	01.1592	14.92	330148	01.0830	14.58	330241	01.9102	22.54	340007	01.1617	16.20	340098	01.7209	19.46
330038	01.2065	14.81	330151	01.0751	14.55	330242	01.3802	23.99	340008	01.1475	16.97	340099	01.1578	12.70
330039	00.8432	14.25	330152	01.4444	28.88	330245	01.3022	17.51	340009	01.4763	19.70	340101	01.1697	11.80
330041	01.3306	30.19	330153	01.7128	17.15	330246	01.3541	25.33	340010	01.3236	16.97	340104	00.8600	12.36
330043	01.3108	26.60	330154	01.6429	.....	330247	00.7659	29.15	340011	01.1355	14.36	340105	01.3859	17.94
330044	01.2722	17.63	330157	01.3608	19.48	330249	01.1711	15.98	340012	01.3193	15.92	340106	01.2109	18.52
330045	01.4075	26.13	330158	01.4129	23.06	330250	01.3086	16.89	340013	01.2557	15.63	340107	01.4165	16.65
330046	01.4956	29.75	330159	01.3177	17.67	330252	00.8785	15.72	340014	01.5864	22.01	340109	01.3485	16.84
330047	01.2551	16.37	330160	01.4457	29.16	330254	01.1651	15.21	340015	01.3037	17.05	340111	01.1783	13.75
330048	01.2230	16.94	330161	00.7222	16.75	330258	01.3696	26.99	340016	01.2047	15.58	340112	01.0683	13.87
330049	01.3252	17.74	330162	01.2585	26.51	330259	01.5046	22.78	340017	01.2671	16.06	340113	02.0121	21.03
330053	01.1943	15.15	330163	01.2523	18.88	330261	01.2906	25.24	340018	01.1777	15.29	340114	01.5618	19.74
330055	01.4882	31.04	330164	01.3928	19.40	330263	01.0194	18.52	340019	01.0467	13.86	340115	01.5417	18.15
330056	01.3144	27.86	330166	01.0011	15.11	330264	01.2443	23.18	340020	01.2083	17.65	340116	01.8211	20.54

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
340119	01.2911	16.28	350041	00.9769	14.99	360062	01.5165	19.27	360143	01.3986	18.13	370012	00.8913	09.07
340120	01.0917	12.31	350042	01.0876	11.16	360063	01.1515	18.08	360144	01.3179	20.90	370013	01.7919	19.41
340121	01.1182	15.36	350043	01.7067	16.69	360064	01.6063	21.61	360145	01.6494	17.67	370014	01.2905	18.49
340123	01.1194	16.92	350044	00.8710	10.29	360065	01.2762	17.59	360147	01.2388	15.85	370015	01.2695	14.88
340124	01.0603	13.70	350047	01.1747	16.78	360066	01.4343	18.88	360148	01.1249	17.65	370016	01.4272	15.52
340125	01.4926	18.36	350049	01.2578	10.74	360067	01.2705	12.77	360149	01.2285	17.72	370017	01.0956	11.48
340126	01.4258	16.47	350050	00.9330	10.74	360068	01.7423	22.41	360150	01.2490	19.17	370018	01.3350	16.66
340127	01.2939	15.72	350051	00.9947	15.46	360069	01.1370	16.74	360151	01.3513	17.46	370019	01.2757	13.17
340129	01.2939	17.50	350053	01.0948	10.34	360070	01.7333	17.18	360152	01.4715	17.88	370020	01.3047	12.51
340130	01.4419	17.78	350055	00.8596	12.12	360071	01.3523	16.78	360153	01.1796	14.12	370021	00.8951	09.76
340131	01.5338	17.10	350056	00.9765	12.81	360072	01.2124	16.99	360154	01.0368	12.79	370022	01.2941	16.91
340132	01.4383	13.48	350058	00.8563	12.32	360074	01.3725	19.42	360155	01.3327	19.43	370023	01.3248	15.36
340133	01.0956	14.59	350060	00.7725	07.81	360075	01.4496	20.74	360156	01.3468	17.17	370025	01.3637	16.03
340137	01.1410	16.93	350061	01.0745	14.05	360076	01.3490	17.88	360159	01.2231	19.63	370026	01.4154	16.34
340138	01.0567	14.77	350063	00.8461	.....	360077	01.5389	19.34	360161	01.2521	19.38	370028	01.9042	19.01
340141	01.6716	19.46	350064	00.9598	.....	360078	01.3080	20.54	360162	01.2452	18.42	370029	01.2199	13.67
340142	01.2340	14.52	350066	00.4249	.....	360079	01.8681	21.00	360163	01.8349	19.83	370030	01.2212	15.66
340143	01.4482	17.07	360001	01.3384	16.97	360080	01.1083	15.47	360164	00.9007	14.82	370032	01.5792	15.46
340144	01.3645	18.62	360002	01.2162	16.93	360081	01.3841	19.32	360165	01.1742	14.70	370033	01.0221	11.30
340145	01.4125	16.83	360003	01.7712	21.00	360082	01.3414	20.33	360166	01.2030	14.95	370034	01.2616	13.35
340146	01.0456	12.52	360006	01.7607	20.88	360083	01.2828	16.28	360170	01.3775	17.38	370035	01.6378	16.49
340147	01.3150	18.57	360007	01.0849	16.02	360084	01.6067	19.41	360172	01.3901	16.51	370036	01.1174	10.48
340148	01.5007	18.58	360008	01.2525	17.40	360085	01.7980	20.40	360174	01.3088	17.57	370037	01.7461	17.69
340151	01.2148	15.08	360009	01.3939	17.80	360086	01.4480	18.21	360175	01.2520	18.78	370038	00.9834	11.67
340153	01.8980	19.07	360010	01.1941	16.42	360087	01.4085	17.90	360176	01.1680	14.85	370039	01.4126	14.24
340155	01.4119	20.03	360011	01.3105	18.17	360088	01.2530	16.38	360177	01.2971	16.97	370040	01.0732	12.21
340156	00.8453	.....	360012	01.2907	19.29	360089	01.1458	17.82	360178	01.1892	16.88	370041	01.0325	14.17
340158	01.2122	16.64	360013	01.1167	17.72	360090	01.2435	19.06	360179	01.2990	19.34	370042	00.8601	12.67
340159	01.1730	17.58	360014	01.1749	17.98	360091	01.2344	19.17	360180	02.1407	22.61	370043	00.9385	13.83
340160	01.1167	13.34	360016	01.5907	17.92	360092	01.1738	18.70	360184	00.4826	16.57	370045	01.0062	10.45
340162	01.1881	17.44	360017	01.8253	20.42	360093	01.2307	16.69	360185	01.2327	17.09	370046	01.0062	11.67
340164	01.5860	18.61	360018	01.6307	19.25	360094	01.3184	19.51	360186	01.1293	14.23	370047	01.3674	15.46
340166	01.3553	19.31	360019	01.2457	19.11	360095	01.2967	17.00	360187	01.3884	16.45	370048	01.2342	14.10
340168	00.5173	14.86	360020	01.4476	19.77	360096	01.1102	16.11	360188	00.9743	15.83	370049	01.3882	15.65
340171	01.1321	20.34	360021	01.2174	17.75	360098	01.3556	17.96	360189	01.0811	16.02	370051	00.9683	12.64
340173	01.2798	.....	360024	01.4071	18.60	360099	01.0454	15.01	360192	01.3259	20.42	370054	01.4885	15.15
350001	01.0123	11.96	360025	01.2808	18.44	360100	01.2628	16.54	360193	01.3581	16.93	370056	01.5839	18.24
350002	01.7471	15.76	360026	01.3129	15.99	360101	01.5606	19.00	360194	01.2097	16.98	370057	01.1540	13.78
350003	01.1860	16.16	360027	01.5042	19.53	360102	01.3166	20.31	360195	01.1428	18.15	370059	01.1079	17.59
350004	01.9396	17.55	360028	01.4059	16.15	360103	01.3796	19.64	360197	01.2406	18.15	370060	01.0892	12.84
350005	01.1759	12.94	360029	01.1959	17.00	360106	01.0886	14.96	360200	01.0117	14.16	370063	01.0280	13.43
350006	01.4658	15.92	360030	01.3039	16.35	360107	01.2908	17.73	360203	01.1555	15.13	370064	01.0078	10.63
350007	00.9387	11.95	360031	01.3375	18.56	360108	01.0396	15.34	360204	01.1930	17.97	370065	00.9975	15.50
350008	00.9673	15.65	360032	01.0924	18.26	360109	01.0923	17.32	360210	01.1623	19.78	370071	01.0650	11.99
350009	01.2044	15.95	360034	01.2896	13.90	360112	01.8045	22.51	360211	01.2500	18.78	370072	00.9083	12.83
350010	01.1975	12.15	360035	01.5988	20.13	360113	01.3367	19.20	360212	01.3950	19.17	370076	01.2782	12.00
350011	01.9030	17.35	360036	01.3855	17.71	360114	01.0906	17.10	360213	01.1504	17.17	370077	01.1968	16.27
350012	01.2136	11.99	360037	02.0437	20.51	360115	01.2874	17.65	360218	01.3232	16.46	370078	01.6803	14.49
350013	01.0734	15.32	360038	01.5766	18.07	360116	01.1189	16.64	360230	01.5121	19.37	370079	00.9507	12.41
350014	01.0049	15.46	360039	01.3052	16.07	360118	01.3818	18.32	360231	01.0866	12.11	370080	00.9633	11.68
350015	01.6959	15.63	360040	01.4268	17.31	360121	01.2342	17.90	360234	01.3527	18.54	370082	00.8647	13.46
350016	01.0278	10.92	360041	01.3556	18.33	360123	01.1997	18.37	360236	01.2897	17.59	370083	00.9410	11.35
350017	01.4347	15.24	360042	01.1551	17.62	360125	01.0747	17.38	360239	01.3234	19.51	370084	01.1272	11.02
350018	01.0690	11.21	360044	01.1741	15.64	360126	01.2090	20.09	360241	00.5799	18.86	370085	00.8936	14.52
350019	01.6318	18.43	360045	01.5348	20.90	360127	01.2236	16.48	360242	01.6800	.....	370086	01.1242	07.79
350020	01.7038	20.24	360046	01.1457	17.85	360128	01.2053	14.73	360243	00.7547	15.52	370089	01.2565	13.16
350021	01.0657	11.41	360047	01.1558	13.65	360129	01.0204	14.59	360244	00.6212	15.74	370091	01.7693	17.18
350023	00.9056	12.86	360048	01.7911	21.55	360130	01.1377	15.59	360245	00.7563	14.33	370092	01.0486	14.38
350024	01.0901	15.40	360049	01.2049	18.18	360131	01.3624	17.38	360247	00.4249	.....	370093	01.8714	18.71
350025	01.0197	13.34	360050	01.1543	12.37	360132	01.3101	18.78	360248	01.7716	.....	370094	01.4088	17.00
350027	00.9438	12.32	360051	01.6080	21.90	360133	01.4858	18.44	370001	01.7032	18.73	370095	00.9450	11.66
350029	00.8818	13.02	360052	01.7565	18.41	360134	01.7139	19.43	370002	01.2588	13.98	370097	01.4520	18.02
350030	00.9794	15.93	360054	01.2912	15.83	360135	01.1809	16.82	370004	01.3080	15.35	370099	01.1924	12.65
350033	00.9672	14.33	360055	01.2726	19.12	360136	01.0773	15.96	370005	01.0106	13.12	370100	00.9622	13.45
350034	00.9622	18.05	360056	01.4296	16.47	360137	01.6206	18.82	370006	01.2229	15.45	370103	00.9375	15.07
350035	00.8570	09.95	360057	01.1168	13.87	360140	01.0258	16.19	370007	01.2061	13.82	370105	01.9923	16.23
350038	01.0479	14.07	360058	01.3461	16.66	360141	01.4692	21.06	370008	01.4030	16.68	370106	01.5356	16.46
350039	01.0484	13.84	360059	01.5754	20.39	360142	00.9969	15.98	370011	01.0547	12.95	370108	01.0528	11.73

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
370112	01.0771	13.21	380029	01.1586	18.45	390032	01.2762	18.10	390115	01.3809	22.31	390205	01.4138	20.63
370113	01.2416	16.23	380031	01.0219	18.48	390035	01.2570	17.79	390116	01.2586	21.78	390206	01.4057	20.14
370114	01.6787	15.49	380033	01.7402	24.13	390036	01.4202	18.06	390117	01.1972	15.62	390209	01.0481	15.09
370121	01.1451	17.38	380035	01.3725	19.01	390037	01.3360	18.93	390118	01.2115	16.26	390211	01.2749	16.99
370122	01.1357	07.58	380036	01.0566	20.26	390039	01.1244	15.66	390119	01.3748	17.59	390213	01.0016	16.41
370123	01.2119	12.32	380037	01.1645	19.53	390040	00.9686	13.13	390121	01.3448	17.47	390215	01.2812	21.06
370125	01.0097	13.37	380038	01.3393	22.64	390041	01.3187	17.07	390122	01.0693	17.57	390217	01.2357	18.51
370126	00.9543	15.34	380039	01.3779	29.30	390042	01.5624	21.73	390123	01.3537	20.71	390219	01.3287	19.67
370131	01.0012	12.88	380040	01.2637	19.96	390043	01.1719	14.85	390125	01.2284	15.61	390220	01.1983	19.08
370133	01.1472	10.09	380042	01.1612	20.57	390044	01.6556	19.63	390126	01.2945	21.03	390222	01.3122	20.33
370138	01.1325	15.23	380047	01.7067	22.12	390045	01.7661	18.05	390127	01.2538	20.96	390223	01.5528	23.17
370139	01.1354	12.56	380048	01.0410	14.68	390046	01.6117	19.79	390128	01.2119	18.14	390224	00.9223	13.35
370140	00.9528	10.99	380050	01.3901	17.45	390047	01.7852	28.26	390130	01.1560	17.20	390225	01.2083	17.19
370141	01.3715	17.30	380051	01.5648	20.05	390048	01.1647	16.60	390131	01.2907	16.30	390226	01.7768	24.15
370146	01.0085	10.73	380052	01.1918	16.61	390049	01.6474	20.69	390132	01.3448	15.42	390228	01.2582	19.38
370148	01.5151	18.46	380055	01.1757	24.14	390050	02.1314	22.39	390133	01.8281	21.71	390231	01.3348	25.11
370149	01.2706	15.35	380056	01.0666	17.36	390051	02.2272	25.28	390135	01.3066	21.05	390233	01.3161	17.22
370153	01.1557	14.05	380060	01.4373	21.98	390052	01.2179	19.41	390136	01.1980	15.39	390235	01.6702	24.38
370154	00.9897	13.05	380061	01.5351	22.07	390054	01.2347	16.08	390137	01.5015	16.35	390236	01.2217	15.88
370156	01.0800	12.49	380062	01.1543	14.40	390055	01.8450	21.81	390138	01.3173	17.93	390237	01.5935	20.36
370158	00.9865	11.75	380063	01.2864	19.01	390056	01.1639	16.81	390139	01.5607	23.54	390238	01.4213	16.51
370159	01.2594	15.59	380064	01.3688	21.25	390057	01.2716	18.70	390142	01.6526	23.18	390242	01.2889	18.48
370163	00.8591	12.16	380065	01.0800	22.49	390058	01.3370	18.67	390145	01.3905	19.48	390244	00.8920	09.83
370165	01.2006	12.46	380066	01.4293	18.58	390060	01.1510	16.92	390146	01.2882	16.44	390245	01.3803	24.05
370166	01.1406	16.32	380068	01.0516	19.05	390061	01.4893	19.08	390147	01.2376	19.08	390246	01.2473	17.25
370169	01.1037	11.25	380069	01.1438	18.59	390062	01.2096	16.01	390150	01.1109	18.10	390247	01.0371	18.26
370170	01.0855	.	380070	01.3961	21.24	390063	01.7640	19.24	390151	01.2813	18.58	390249	00.9800	12.06
370171	01.0678	.....	380071	01.3440	20.07	390065	01.2780	19.30	390152	01.0750	18.81	390256	01.8586	23.45
370172	00.9962	.....	380072	00.9537	14.66	390066	01.3186	17.77	390153	01.2419	22.46	390258	01.2671	20.08
370173	01.1933	.....	380075	01.4047	19.72	390067	01.7794	18.91	390154	01.2332	16.67	390260	01.2216	21.17
370174	01.1211	.....	380078	01.1150	17.41	390068	01.2742	17.23	390155	01.2835	19.44	390262	02.1059	17.77
370176	01.1972	15.29	380081	01.0847	18.84	390069	01.2051	17.75	390156	01.4396	21.37	390263	01.4786	19.16
370177	01.0146	10.09	380082	01.3405	22.96	390070	01.2858	20.39	390157	01.3451	17.99	390265	01.2976	18.82
370178	01.0055	10.96	380083	01.2349	20.06	390071	01.1351	13.68	390158	01.5819	18.96	390266	01.1930	16.81
370179	00.8169	17.33	380084	01.3216	21.43	390072	01.0913	15.91	390160	01.2468	18.50	390267	01.2771	19.80
370180	00.9740	.....	380087	01.0052	15.38	390073	01.6266	19.03	390161	01.1266	14.43	390268	01.3964	20.44
370183	01.0165	12.06	380088	01.0315	16.16	390074	01.3127	16.05	390162	01.4556	19.59	390270	01.3202	16.67
370186	01.0206	13.15	380089	01.3738	22.25	390075	01.3025	16.41	390163	01.2420	15.99	390272	00.5074	.....
370189	00.9532	07.82	380090	01.3211	25.71	390076	01.3566	21.07	390164	02.1542	20.37	390277	00.4880	22.55
370190	01.5794	15.31	380091	01.2631	25.13	390078	01.0424	16.88	390166	01.1022	18.31	390278	00.6661	18.42
370192	01.3093	17.57	390001	01.3373	18.25	390079	01.7564	16.81	390167	01.3544	21.30	390279	01.0584	15.32
370194	01.8180	.....	390002	01.3644	18.62	390080	01.3323	19.14	390168	01.2625	18.43	390281	02.6697	.....
370195	01.7401	.....	390003	01.2554	15.88	390081	01.3776	22.88	390169	01.2856	18.72	390282	02.9409	.....
370196	01.1671	.....	390004	01.4319	18.12	390083	01.1662	22.01	390170	01.9087	21.25	400001	01.3065	08.65
370197	01.0898	.....	390005	01.0806	14.24	390084	01.1944	15.57	390173	01.1949	16.79	400002	01.6129	11.34
380001	01.3616	21.21	390006	01.7592	18.17	390086	01.2005	15.86	390174	01.7675	25.41	400003	01.2768	08.61
380002	01.1954	19.35	390007	01.1638	21.90	390088	01.3124	22.62	390176	01.1748	18.14	400004	01.1628	08.18
380003	01.2096	20.71	390008	01.1579	15.47	390090	01.8633	18.97	390178	01.2993	18.44	400005	01.0828	06.61
380004	01.7682	23.34	390009	01.6174	17.81	390091	01.1348	17.40	390179	01.3019	22.12	400006	01.1998	07.59
380005	01.2457	21.15	390010	01.1940	17.10	390093	01.1530	14.99	390180	01.5552	23.40	400007	01.2160	07.46
380006	01.3673	19.26	390011	01.2706	16.82	390095	01.1941	14.46	390181	01.0669	18.59	400009	01.0124	07.71
380007	01.5837	23.43	390012	01.2607	19.75	390096	01.3470	17.00	390183	01.2194	18.03	400010	00.9370	08.53
380008	01.0565	17.83	390013	01.2410	16.90	390097	01.3270	21.56	390184	01.1453	18.07	400011	00.9932	08.12
380009	01.8640	23.30	390015	01.1668	13.12	390098	01.7998	20.75	390185	01.2099	16.34	400012	01.2679	07.40
380010	01.1177	20.67	390016	01.2448	16.40	390100	01.6693	20.03	390189	01.0930	16.73	400013	01.2504	07.44
380011	01.0880	20.97	390017	01.1347	15.43	390101	01.2430	16.62	390191	01.1775	14.33	400014	01.3895	08.92
380013	01.2741	17.76	390018	01.3507	20.05	390102	01.3992	20.51	390192	01.1868	16.36	400015	01.2239	09.83
380014	01.5560	20.77	390019	01.1182	15.59	390103	01.1030	18.00	390193	01.2146	16.13	400016	01.3497	10.89
380017	01.8253	23.17	390022	01.3276	21.40	390104	01.0899	14.99	390194	01.1010	18.91	400017	01.2425	07.70
380018	01.7644	21.22	390023	01.3010	18.98	390106	01.0768	15.15	390195	01.8873	22.93	400018	01.2993	09.67
380019	01.3170	19.33	390024	00.9898	23.26	390107	01.2972	19.04	390196	01.4406	.....	400019	01.8030	09.34
380020	01.4406	21.43	390025	00.6308	15.97	390108	01.3512	20.08	390197	01.3014	18.49	400021	01.4988	08.78
380021	01.2983	19.44	390026	01.2830	20.94	390109	01.1606	14.14	390198	01.2247	15.75	400022	01.3222	10.01
380022	01.2344	21.01	390027	01.8940	25.88	390110	01.5989	18.05	390199	01.3118	15.40	400024	00.9975	07.79
380023	01.2476	17.43	390028	01.9133	17.78	390111	01.8414	27.88	390200	01.0929	14.88	400026	00.9746	05.66
380025	01.2534	22.55	390029	01.9558	18.83	390112	01.1966	12.26	390201	01.2589	19.26	400027	01.1943	09.06
380026	01.1657	17.54	390030	01.2417	17.37	390113	01.2118	16.25	390203	01.3873	20.96	400028	01.0387	07.89
380027	01.3334	23.09	390031	01.1640	17.15	390114	01.2644	22.27	390204	01.2800	18.56	400029	01.1383	.....

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400031	01.1913	08.38	420053	01.2774	14.99	430056	00.8741	09.56	440068	01.2254	17.28	440205	01.1096	15.47
400032	01.1933	08.21	420054	01.2603	17.08	430057	00.9229	10.73	440070	01.1011	14.28	440206	01.0829	13.80
400044	01.2118	09.14	420055	01.0222	14.59	430060	00.9262	08.64	440071	01.3979	16.32	440208	01.9916	.....
400048	01.2251	.....	420056	01.1518	13.66	430062	00.8090	10.50	440072	01.4186	14.81	440209	01.7802	.....
400061	01.5945	13.14	420057	01.1676	15.20	430064	01.1664	12.48	440073	01.3463	18.39	440211	00.7914	.....
400079	01.2989	08.37	420059	00.9864	13.80	430065	01.0035	10.34	440078	01.0317	13.14	450002	01.5261	18.75
400087	01.4162	08.10	420061	01.1701	16.99	430066	00.9891	11.87	440081	01.1820	15.86	450004	01.2254	12.21
400094	01.1058	09.07	420062	01.3804	16.51	430073	01.0158	13.25	440082	02.0430	21.47	450005	01.2221	14.82
400098	01.2338	07.55	420064	01.1545	14.32	430076	00.9849	10.30	440083	01.1480	12.16	450007	01.2626	13.51
400102	01.2188	07.59	420065	01.3538	17.37	430077	01.6495	16.77	440084	01.1833	12.89	450008	01.3661	14.74
400103	01.4253	09.13	420066	00.9250	15.38	430079	00.9968	11.63	440090	00.8532	11.62	450010	01.4024	15.12
400104	01.4137	09.01	420067	01.2687	16.48	430081	00.9338	.....	440091	01.6477	16.91	450011	01.5959	17.67
400105	01.3250	09.05	420068	01.3430	17.25	430082	00.9221	.....	440100	01.0678	13.60	450014	01.0411	14.53
400106	01.2027	07.87	420069	01.0606	14.29	430083	00.7736	.....	440102	01.0777	12.64	450015	01.5299	15.25
400109	01.4914	09.67	420070	01.2890	15.76	430084	00.9792	.....	440103	01.2605	16.57	450016	01.6408	17.49
400110	01.1463	08.39	420071	01.3340	17.29	430085	00.9069	.....	440104	01.6987	18.53	450018	01.5929	21.98
400111	01.1311	08.52	420072	01.0354	11.94	430087	00.9333	08.64	440105	01.0989	16.52	450020	01.0246	16.23
400112	01.2492	08.03	420073	01.3185	18.17	430089	00.8346	.....	440109	01.1123	12.71	450021	01.8352	21.68
400113	01.2692	07.41	420074	00.9857	11.49	440001	01.1456	12.99	440110	00.9587	16.41	450023	01.4560	16.45
400114	01.0613	07.55	420075	00.9638	14.51	440002	01.6285	16.75	440111	01.4009	18.75	450024	01.3308	16.74
400115	01.0254	07.86	420078	01.8003	19.92	440003	01.1383	15.46	440114	01.0824	12.28	450025	01.5918	15.72
400117	01.1717	09.01	420079	01.5954	18.15	440006	01.4804	18.40	440115	01.0713	15.34	450028	01.5626	18.19
400118	01.2078	09.52	420080	01.3386	21.29	440007	00.9713	11.94	440120	01.5429	18.26	450029	01.4570	14.12
400120	01.3175	09.23	420081	01.2360	19.59	440008	01.0206	12.34	440125	01.4791	18.20	450031	01.5193	19.54
400121	01.0939	06.53	420082	01.4171	19.00	440009	01.2679	14.38	440130	01.2138	13.33	450032	01.2471	12.89
400122	01.0230	06.66	420083	01.2856	17.31	440010	00.9448	10.15	440131	01.1302	13.71	450033	01.6126	17.70
400123	01.1446	09.36	420085	01.5083	17.52	440011	01.3301	16.51	440132	01.1419	14.75	450034	01.7095	18.08
400124	02.3583	11.31	420086	01.3750	16.96	440012	01.5155	18.04	440133	01.5684	18.67	450035	01.5326	19.16
410001	01.3371	22.95	420087	01.6990	16.86	440014	01.1200	09.84	440135	01.2866	17.25	450037	01.6270	18.03
410004	01.3139	21.15	420088	01.1999	15.27	440015	01.7323	18.12	440137	01.0171	13.14	450039	01.3288	17.37
410005	01.3535	22.61	420089	01.2336	20.60	440016	00.9970	12.59	440141	01.0474	14.12	450040	01.5635	17.73
410006	01.3134	20.75	420091	01.2895	18.32	440017	01.6425	20.72	440142	01.0235	11.05	450042	01.7513	15.78
410007	01.7033	21.60	420093	01.0290	.....	440018	01.4087	17.06	440143	01.1029	16.45	450044	01.6323	19.72
410008	01.2207	21.52	420094	01.0142	.....	440019	01.7245	17.21	440144	01.2377	18.01	450046	01.3332	15.81
410009	01.3152	21.03	430004	01.1098	15.06	440020	01.2198	15.78	440145	00.9917	14.42	450047	01.1063	13.46
410010	01.0663	25.32	430005	01.3635	14.44	440022	01.1220	14.01	440147	01.5380	23.56	450050	01.0051	14.35
410011	01.2322	23.54	430007	01.0876	12.77	440023	01.0845	13.04	440148	01.1478	15.54	450051	01.6238	18.53
410012	01.8243	20.26	430008	01.1139	13.56	440024	01.3163	16.88	440149	01.1533	15.28	450052	01.0402	13.01
410013	01.3321	27.36	430010	01.1619	11.70	440025	01.1310	13.54	440150	01.2975	19.97	450053	01.0950	13.82
420002	01.3781	20.19	430011	01.2805	14.49	440029	01.2898	16.88	440151	01.3044	16.20	450054	01.6713	21.71
420004	01.8270	18.16	430012	01.2848	15.08	440030	01.2286	12.15	440152	01.8133	17.68	450055	01.1386	13.89
420005	01.2076	14.51	430013	01.2924	15.39	440031	01.0158	13.14	440153	01.2942	15.19	450056	01.6924	17.92
420006	01.1694	17.19	430014	01.3101	17.03	440032	01.0561	14.47	440156	01.5826	19.18	450058	01.5836	16.46
420007	01.4966	16.92	430015	01.2209	15.17	440033	01.1140	14.61	440157	01.0397	13.83	450059	01.2884	13.85
420009	01.2382	16.92	430016	01.8665	17.78	440034	01.5576	17.68	440159	01.3156	14.02	450063	00.9369	10.66
420010	01.1211	15.13	430018	00.9509	13.13	440035	01.3309	16.53	440161	01.8754	20.06	450064	01.4910	15.57
420011	01.1251	15.28	430022	00.9348	11.95	440039	01.6969	17.44	440166	01.5786	18.25	450065	01.1163	14.73
420014	01.0959	14.36	430023	00.9495	10.34	440040	01.0122	10.81	440168	01.0442	12.43	450068	01.8865	21.36
420015	01.3676	16.84	430024	00.9521	12.07	440041	01.0586	12.23	440173	01.5485	17.50	450072	01.2275	18.67
420016	01.0741	14.21	430026	01.0086	11.24	440046	01.2850	15.30	440174	01.0180	12.74	450073	01.1003	12.06
420018	01.8145	20.00	430027	01.7854	17.63	440047	00.9397	14.52	440175	01.1775	18.60	450076	01.6678	.....
420019	01.1995	14.70	430028	01.1346	13.29	440048	01.8500	17.82	440176	01.4502	19.17	450078	00.9703	11.75
420020	01.3498	16.94	430029	00.9654	13.84	440049	01.6746	16.37	440178	01.2514	17.07	450079	01.4563	21.93
420023	01.4485	18.50	430031	00.9226	11.58	440050	01.3461	16.28	440180	01.2307	16.96	450080	01.2802	15.99
420026	01.8750	18.16	430033	01.0529	13.10	440051	00.9678	13.82	440181	01.0352	12.37	450081	01.0888	14.50
420027	01.3572	16.82	430034	01.1129	11.59	440052	01.1948	14.76	440182	01.0190	12.53	450082	01.0035	14.70
420030	01.2764	17.28	430036	01.0216	11.83	440053	01.3459	16.28	440183	01.5114	19.69	450083	01.7818	19.58
420031	00.9784	11.88	430037	00.9883	13.15	440054	01.2016	14.55	440184	01.3997	18.96	450085	01.0862	17.24
420033	01.1614	18.91	430038	01.0476	10.83	440056	01.1017	13.57	440185	01.2202	17.48	450087	01.4647	19.68
420036	01.3499	16.42	430040	01.0233	12.64	440057	01.0237	12.15	440186	01.0746	15.77	450090	01.2180	13.26
420037	01.2802	20.66	430041	00.9677	12.47	440058	01.2495	16.30	440187	01.1420	14.58	450092	01.2103	14.59
420038	01.2725	14.80	430043	01.2163	11.82	440059	01.3842	14.85	440189	01.5092	19.13	450094	01.3336	17.87
420039	01.1654	15.64	430044	00.8361	14.07	440060	01.3027	14.20	440192	01.1999	15.37	450096	01.5711	17.19
420042	01.1386	14.05	430047	01.0845	11.92	440061	01.1956	15.89	440193	01.2971	18.60	450097	01.4826	18.51
420043	01.2699	19.12	430048	01.2958	15.48	440063	01.6377	17.90	440194	01.2212	17.13	450098	01.1761	15.10
420048	01.1477	15.56	430049	00.9275	12.70	440064	01.1174	14.56	440197	01.3749	19.23	450099	01.3103	14.66
420049	01.2069	15.89	430051	00.9280	13.84	440065	01.2888	17.78	440200	01.0979	15.64	450101	01.4893	15.44
420051	01.6352	18.06	430054	01.0393	12.79	440067	01.2835	14.99	440203	00.9109	13.09	450102	01.7046	17.87

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
450104	01.2431	14.23	450219	01.1560	14.78	450379	01.5227	21.62	450591	01.1493	18.92	450713	01.4979	20.85
450107	01.6232	22.05	450221	01.1643	14.40	450381	00.9920	12.86	450596	01.3891	17.15	450715	01.3738	18.59
450108	00.9827	12.48	450222	01.6034	18.35	450388	01.8109	17.12	450597	01.0350	14.53	450716	01.2943	19.56
450109	00.9150	14.72	450224	01.3620	20.66	450389	01.3265	17.71	450603	00.7116	16.81	450717	01.2538	23.86
450110	01.2792	19.30	450229	01.5626	15.41	450393	01.3164	19.70	450604	01.4372	14.00	450718	01.2333	19.03
450111	01.2174	18.93	450231	01.6412	18.25	450395	01.0473	16.49	450605	01.3880	17.67	450723	01.3871	18.22
450112	01.3183	14.31	450234	00.9989	13.07	450399	01.0599	15.59	450609	00.9188	11.77	450724	01.3696	17.44
450113	01.3022	17.93	450235	01.0302	13.46	450400	01.1885	11.76	450610	01.5475	17.21	450725	00.9390	17.49
450118	01.5826	20.36	450236	01.2206	15.28	450403	01.3015	21.22	450614	01.0086	12.53	450727	01.1724	10.80
450119	01.3813	17.13	450237	01.6258	16.83	450411	00.9144	12.20	450615	01.0918	12.80	450728	00.9311	12.62
450121	01.5556	19.99	450239	01.0605	13.70	450417	01.0947	19.31	450617	01.3521	20.12	450730	01.3241	21.46
450123	01.0933	15.98	450241	00.9279	12.67	450418	01.4996	21.43	450620	01.1348	12.16	450733	01.3628	16.88
450124	01.7210	19.68	450243	00.7767	11.59	450419	01.2762	20.34	450623	01.1891	16.71	450735	01.0637	12.02
450126	01.3625	16.01	450246	00.9464	17.09	450422	00.8249	24.65	450626	01.0634	16.57	450742	01.2932	19.47
450128	01.1955	15.37	450249	00.9676	09.95	450423	01.5850	21.56	450628	00.9320	12.34	450743	01.4228	17.79
450130	01.4846	16.93	450250	00.9480	11.36	450424	01.2492	17.77	450630	01.6658	23.25	450746	01.0195	13.81
450131	01.4057	18.24	450253	01.3024	11.92	450429	01.1208	12.87	450631	01.7515	20.15	450747	01.3610	17.04
450132	01.7205	16.46	450258	01.1072	10.85	450431	01.6315	18.76	450632	00.9769	11.39	450749	01.0118	14.63
450133	01.6057	17.90	450259	01.1636	18.29	450438	01.2603	13.51	450633	01.6399	20.20	450750	01.0231	12.20
450135	01.6757	23.54	450264	00.8806	13.08	450446	00.6453	12.67	450634	01.6147	23.56	450751	01.3418	15.58
450137	01.4998	22.19	450269	01.0765	13.96	450447	01.3882	18.07	450638	01.5883	22.00	450754	00.9546	13.49
450140	00.9941	17.44	450270	01.2477	10.42	450451	01.1574	16.96	450639	01.4387	22.12	450755	01.1688	15.54
450142	01.4544	20.28	450271	01.2655	14.84	450457	01.7817	17.61	450641	01.0408	13.24	450757	00.9466	13.62
450143	01.0340	11.10	450272	01.3466	15.38	450460	01.0539	12.46	450643	01.2270	17.43	450758	02.0193	21.92
450144	01.0933	15.29	450276	01.0101	12.63	450462	01.7722	20.49	450644	01.5090	19.07	450760	01.2573	18.35
450145	00.8163	13.36	450278	00.9870	13.64	450464	01.0035	15.14	450646	01.6539	31.36	450761	01.1320	09.57
450146	00.9883	20.32	450280	01.5303	23.09	450465	01.3391	17.10	450647	01.9577	23.27	450763	01.0156	16.60
450147	01.4189	17.72	450283	01.1089	12.43	450467	00.9711	14.01	450648	00.9835	09.48	450766	02.0719	20.76
450148	01.2604	20.21	450286	01.0057	16.36	450469	01.3759	17.25	450649	01.0406	14.06	450769	00.9957	13.40
450149	01.4207	19.76	450288	01.2705	13.67	450473	00.9937	15.03	450651	01.7505	22.80	450770	01.0417	14.57
450150	00.9250	13.75	450289	01.4339	19.14	450475	01.1405	14.96	450652	00.8637	13.96	450771	01.7803	22.32
450151	01.1248	14.16	450292	01.2470	21.03	450484	01.4469	18.14	450653	01.2233	15.20	450774	01.0767	21.24
450152	01.2600	15.74	450293	00.9767	12.41	450488	01.3234	16.08	450654	00.9499	12.28	450775	01.2796	17.09
450153	01.6196	18.44	450296	01.3759	18.76	450489	01.0173	12.72	450656	01.5367	17.19	450776	00.9194	11.18
450154	01.1960	13.12	450299	01.3431	16.01	450497	01.1693	12.88	450658	00.9719	12.32	450777	01.0464	16.60
450155	01.0291	14.09	450303	00.9927	11.50	450498	01.0512	13.15	450659	01.5366	20.23	450779	01.2621	21.36
450157	00.9708	13.25	450306	01.2219	12.82	450508	01.4218	16.12	450661	01.2306	18.51	450780	01.4049	16.91
450160	00.9428	21.47	450307	00.7803	14.25	450514	01.1886	18.47	450662	01.6164	17.38	450781	01.5749	11.01
450162	01.2530	18.76	450309	01.0613	14.17	450517	00.9025	11.11	450665	00.9129	12.95	450785	01.0228	16.39
450163	01.1402	16.82	450315	01.0420	18.63	450518	01.5700	16.38	450666	01.3361	19.17	450788	01.4500	19.31
450164	01.1323	12.83	450320	01.3553	18.45	450523	01.5823	19.45	450668	01.5988	19.60	450794	01.4278	16.20
450165	01.0215	14.19	450321	01.0170	13.51	450530	01.3726	14.27	450669	01.3407	19.26	450795	00.8686	20.22
450166	01.0279	13.06	450322	00.8184	16.61	450534	01.0374	18.02	450670	01.3131	17.24	450797	00.7374	16.67
450169	01.0085	13.79	450324	01.7039	15.66	450535	01.2951	21.25	450672	01.6229	20.69	450798	00.8393	08.88
450170	00.9944	12.46	450325	00.9022	11.47	450537	01.3071	19.69	450673	01.0518	12.14	450801	01.4832	.....
450176	01.2956	15.32	450327	01.0130	12.60	450538	01.2091	20.77	450674	00.9801	19.88	450802	01.2272	.....
450177	01.2760	13.52	450330	01.1514	15.62	450539	01.4094	14.67	450675	01.5223	20.99	450803	00.8612	.....
450178	01.0251	15.84	450334	01.0501	12.11	450544	01.3519	19.25	450677	01.4273	23.91	450804	01.5602	.....
450181	01.0644	14.13	450337	01.1588	14.10	450545	01.2665	20.93	450678	01.5041	20.85	450807	00.9215	.....
450184	01.5239	17.20	450340	01.3279	14.68	450547	01.1549	15.13	450683	01.3412	20.91	450808	01.2870	.....
450185	01.0771	08.69	450341	01.0487	15.87	450550	01.0679	18.37	450684	01.3022	21.41	450809	01.6785	.....
450187	01.2404	16.51	450346	01.4354	16.05	450551	01.2276	13.01	450686	01.6066	14.14	450810	01.1663	.....
450188	01.0902	12.80	450347	01.1515	16.68	450558	01.7260	20.85	450688	01.3635	19.63	450811	02.1655	.....
450190	01.1702	.....	450348	00.9841	11.20	450559	00.9350	12.26	450690	01.4068	21.41	450812	01.5923	.....
450191	01.0843	15.87	450351	01.1952	17.71	450561	01.6864	17.18	450691	00.9630	.....	460001	01.8027	20.73
450192	01.2918	17.51	450352	01.1041	16.53	450563	01.2755	23.92	450694	01.1412	18.16	460003	01.6975	17.86
450193	02.0470	21.80	450353	01.2638	16.98	450565	01.2685	16.10	450696	01.9768	22.02	460004	01.7352	21.45
450194	01.2664	17.65	450355	01.1492	13.03	450570	01.0784	15.39	450697	01.4936	13.82	460005	01.6823	18.56
450196	01.4866	17.04	450358	02.0820	21.20	450571	01.4774	15.53	450698	00.9737	11.65	460006	01.4506	19.40
450200	01.4247	17.40	450362	01.1670	13.83	450573	01.0633	14.35	450700	00.9478	13.15	460007	01.3572	20.40
450201	01.0028	15.45	450369	01.0555	13.10	450574	00.9359	11.73	450702	01.5794	19.02	460008	01.3920	15.91
450203	01.2237	17.46	450370	01.2731	12.87	450575	01.0769	16.62	450703	01.5445	18.46	460009	01.8544	19.39
450209	01.5068	21.78	450371	01.1668	12.16	450578	00.9338	12.99	450704	01.4195	18.02	460010	02.0179	20.86
450210	01.1673	12.30	450372	01.3120	21.02	450580	01.1396	13.29	450705	00.9145	18.50	460011	01.4594	16.34
450211	01.4145	16.70	450373	01.1592	13.38	450583	00.9779	13.04	450706	01.2505	22.63	460013	01.5172	16.74
450213	01.6568	18.26	450374	00.9104	11.66	450584	01.1828	13.02	450709	01.3415	19.78	460014	01.1366	15.12
450214	01.4227	19.51	450376	01.4817	17.78	450586	01.0491	11.16	450711	01.5989	18.18	460015	01.2168	20.40
450217	01.0015	11.56	450378	01.1022	19.87	450587	01.2528	16.14	450712	00.7871	13.25	460016	00.9547	12.50

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460017	01.5589	16.40	490032	01.7716	19.42	490127	01.0048	14.52	500094	00.9101	15.30	510068	01.1159	14.34
460018	01.0027	15.45	490033	01.2338	16.00	490129	01.1961	19.20	500096	00.9886	19.50	510070	01.3303	15.86
460019	01.1127	14.45	490035	01.1321	13.02	490130	01.3038	15.07	500097	01.2189	17.46	510071	01.3254	15.64
460020	01.0418	16.33	490037	01.2365	14.06	490131	00.9879	14.74	500098	01.0355	15.44	510072	01.0592	14.37
460021	01.3866	19.46	490038	01.2628	13.62	490132	01.0313	.....	500101	01.0064	15.92	510077	01.1916	15.36
460022	00.9383	19.23	490040	01.4798	21.72	500001	01.3669	21.66	500102	01.0209	19.46	510080	01.2132	11.53
460023	01.2243	21.08	490041	01.2703	16.22	500002	01.4343	19.10	500104	01.3276	19.88	510081	01.1592	12.97
460024	01.0133	14.78	490042	01.3532	15.75	500003	01.3891	25.32	500106	00.9016	20.08	510082	01.2166	12.89
460025	00.8149	13.73	490043	01.4482	24.19	500005	01.8255	21.58	500107	01.1533	15.79	510084	00.9560	13.24
460026	00.9812	17.03	490044	01.3527	17.15	500007	01.3881	21.79	500108	01.7163	21.74	510085	01.3533	17.90
460027	00.9409	19.08	490045	01.2333	19.25	500008	01.9493	23.18	500110	01.2349	19.44	510086	01.0754	15.08
460029	01.0389	18.60	490046	01.4948	17.80	500011	01.4304	22.64	500118	01.1761	21.92	520002	01.2174	18.84
460030	01.1784	17.32	490047	01.0934	16.50	500012	01.4822	21.18	500119	01.3376	20.39	520003	01.1191	15.41
460032	01.0291	21.16	490048	01.6100	17.44	500014	01.4987	20.92	500122	01.2814	21.99	520004	01.1859	16.78
460033	00.9787	17.97	490050	01.4629	21.02	500015	01.3772	21.85	500123	00.8526	18.56	520006	01.0231	18.17
460035	00.9265	12.17	490052	01.6086	15.45	500016	01.4764	23.26	500124	01.3158	22.83	520007	01.2287	14.55
460036	01.0267	20.05	490053	01.2701	14.77	500019	01.3370	21.38	500125	01.0071	11.61	520008	01.5786	22.49
460037	00.9886	17.48	490054	01.0984	14.36	500021	01.5616	21.91	500129	01.7389	23.35	520009	01.6559	17.31
460039	01.0874	20.37	490057	01.5488	17.69	500023	01.2117	19.53	500132	00.9561	18.51	520010	01.1793	19.33
460041	01.2644	20.90	490059	01.6184	19.41	500024	01.6823	22.23	500134	00.6989	15.59	520011	01.2164	16.85
460042	01.4809	17.04	490060	01.0834	17.79	500025	01.8739	23.44	500138	04.3602	.....	520013	01.3851	18.80
460043	01.2702	21.71	490063	01.7059	23.01	500026	01.4032	23.85	500139	01.5089	21.71	520014	01.1387	16.08
460044	01.1922	19.83	490066	01.3652	18.00	500027	01.5357	25.23	500141	01.3249	22.22	520015	01.1912	16.72
460046	00.9068	12.27	490067	01.2287	15.82	500028	01.1235	14.69	500143	00.7297	15.20	520016	01.1027	13.21
460047	01.7394	19.82	490069	01.4526	14.96	500029	00.9578	13.71	500146	01.2100	26.11	520017	01.1523	17.45
460049	01.9737	17.85	490071	01.5023	17.40	500030	01.5287	22.55	510001	01.8263	17.35	520018	01.1219	16.17
460050	01.2736	21.99	490073	01.4717	17.55	500031	01.3434	20.58	510002	01.2917	14.18	520019	01.3048	16.63
460051	01.2890	32.89	490074	01.3704	16.77	500033	01.2738	18.41	510004	01.1211	13.65	520021	01.3120	19.90
470001	01.1596	18.73	490075	01.3998	16.37	500036	01.3200	19.95	510005	00.9588	14.19	520024	01.0460	13.11
470003	01.7896	20.83	490077	01.2583	17.87	500037	01.1678	18.70	510006	01.2972	17.42	520025	01.1099	18.58
470004	01.1094	15.85	490079	01.3234	15.15	500039	01.3890	22.10	510007	01.4902	17.98	520026	01.0837	17.49
470005	01.2726	20.26	490083	00.7754	15.02	500041	01.2884	23.23	510008	01.1461	15.55	520027	01.2448	19.27
470006	01.2455	17.83	490084	01.3006	15.43	500042	01.3514	22.37	510012	01.1013	14.37	520028	01.3020	17.76
470008	01.1896	16.76	490085	01.2407	13.39	500043	01.1913	17.16	510013	01.1685	15.80	520029	00.9692	16.94
470010	01.1226	19.03	490088	01.1873	14.44	500044	01.9855	20.99	510015	00.9465	12.51	520030	01.6462	21.19
470011	01.1940	19.82	490089	01.1298	16.18	500045	01.1331	20.81	510016	00.9182	12.66	520031	01.1241	15.24
470012	01.2425	17.88	490090	01.2038	15.17	500048	00.9599	16.46	510018	01.1815	15.26	520032	01.2406	15.25
470015	01.2207	16.67	490091	01.2790	18.78	500049	01.5178	19.24	510020	01.1178	10.56	520033	01.1692	16.22
470018	01.2215	20.53	490092	01.2061	15.13	500050	01.4336	20.96	510022	01.8968	19.16	520034	01.1969	17.64
470020	00.9818	15.18	490093	01.3619	15.83	500051	01.6724	23.18	510023	01.2001	16.62	520035	01.3383	15.87
470023	01.2839	19.08	490094	01.1741	14.52	500052	01.3139	.....	510024	01.4367	18.43	520037	01.6525	19.06
470024	01.1460	18.26	90095	01.4744	16.79	500053	01.3079	20.42	510026	01.0247	12.33	520038	01.3145	16.45
490001	01.2421	19.51	490097	01.1556	14.52	500054	01.8795	21.08	510027	00.9512	14.62	520039	00.9955	16.33
490002	01.0970	14.56	490098	01.2294	11.89	500055	01.1303	20.13	510028	01.0802	18.99	520040	01.4720	19.34
490003	00.5817	17.38	490099	00.9524	16.51	500057	01.3033	17.22	510029	01.2896	16.78	520041	01.1755	14.93
490004	01.2321	16.97	490100	01.4519	17.21	500058	01.5239	20.32	510030	01.0520	14.39	520042	01.0959	16.42
490005	01.5901	16.31	490101	01.2184	23.01	500059	01.1465	20.76	510031	01.4816	15.97	520044	01.4077	16.15
490006	01.1325	13.82	490104	00.8468	16.07	500060	01.4066	23.27	510033	01.3557	15.30	520045	01.7375	18.68
490007	02.0908	17.16	490105	00.6278	18.83	500061	01.0337	18.19	510035	01.3544	16.81	520047	00.9924	15.41
490009	01.8662	18.25	490106	00.8531	16.48	500062	01.1280	18.80	510036	01.0700	11.64	520048	01.4686	18.11
490010	01.1620	17.32	490107	01.3316	22.98	500064	01.5976	22.08	510038	01.1634	13.36	520049	02.0343	18.52
490011	01.4246	17.33	490108	00.9024	15.63	500065	01.2132	18.72	510039	01.3333	15.48	520051	01.7979	20.21
490012	01.2241	15.30	490109	00.9343	17.44	500068	01.0323	18.40	510043	00.9309	11.52	520053	01.1225	15.45
490013	01.2162	16.87	490110	01.4172	15.07	500069	01.2241	19.76	510046	01.2754	15.91	520054	01.0821	17.03
490014	01.4751	22.42	490111	01.2461	15.83	500071	01.2885	19.80	510047	01.2479	18.06	520056	01.7830	18.87
490015	01.4306	18.76	490112	01.6008	18.51	500072	01.2068	22.83	510048	01.0995	18.22	520057	01.1240	16.59
490017	01.3604	16.73	490113	01.3485	21.59	500073	01.0538	16.74	510050	01.5736	16.11	520058	01.1053	18.17
490018	01.2979	17.15	490114	01.1423	15.47	500074	01.1566	15.67	510053	01.0292	14.12	520059	01.4116	18.74
490019	01.1915	16.46	490115	01.2238	15.28	500077	01.3828	21.68	510055	01.2750	19.68	520060	01.4316	15.26
490020	01.2068	15.76	490116	01.3302	15.48	500079	01.3693	21.40	510058	01.1979	17.03	520062	01.3513	16.73
490021	01.2417	17.33	490117	01.1816	12.41	500080	00.8662	11.72	510059	01.4663	14.25	520063	01.1984	17.63
490022	01.4384	19.33	490118	01.7802	21.05	500084	01.1803	20.78	510060	01.1522	15.55	520064	01.7055	20.15
490023	01.2952	18.01	490119	01.3722	16.80	500085	01.0712	19.55	510061	01.0354	13.37	520066	01.5293	18.82
490024	01.8236	16.47	490120	01.3270	17.49	500086	01.3028	20.03	510062	01.1776	15.77	520068	00.9933	16.85
490027	01.1664	13.62	490122	01.4656	21.27	500088	01.3456	23.37	510063	00.9557	16.84	520069	01.1907	17.13
490028	01.3111	20.18	490123	01.1882	15.29	500089	01.0257	15.05	510065	01.0484	11.49	520070	01.6330	17.38
490030	01.1733	10.83	490124	01.2019	17.12	500090	00.9484	13.67	510066	01.1361	11.93	520071	01.1630	17.53
490031	01.1165	13.00	490126	01.4239	14.85	500092	01.0566	17.86	510067	01.2728	17.97	520074	01.0679	15.42

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
520075	01.4659	18.02	520178	01.0937	15.23									
520076	01.1585	15.11	530002	01.1955	19.16									
520077	00.8551	14.03	530003	01.0202	12.47									
520078	01.6233	18.63	530004	00.9991	14.18									
520082	01.2821	16.43	530005	01.0060	13.47									
520083	01.6785	21.60	530006	01.1364	16.52									
520084	01.0951	16.87	530007	01.0868	12.98									
520087	01.6994	18.12	530008	01.3367	16.82									
520088	01.3078	17.98	530009	01.0070	16.77									
520089	01.5203	19.50	530010	01.4089	16.12									
520090	01.2399	16.18	530011	01.1090	16.94									
520091	01.3644	18.13	530012	01.5439	18.11									
520092	01.1184	15.74	530014	01.4219	15.18									
520094	00.7907	16.12	530015	01.2693	18.00									
520095	01.3677	17.93	530016	01.2968	14.93									
520096	01.4350	18.94	530017	00.8748	16.97									
520097	01.3153	18.65	530018	01.0355	18.67									
520098	01.8227	20.17	530019	01.0131	15.32									
520100	01.2523	16.72	530022	01.0905	16.71									
520101	01.1235	16.09	530023	00.8558	18.57									
520102	01.2023	19.37	530025	01.2400	18.76									
520103	01.3272	17.94	530026	01.0951	15.48									
520107	01.3034	17.50	530027	00.9181	10.62									
520109	01.0055	17.63	530029	01.0278	13.46									
520110	01.1560	17.94	530031	00.8952	11.67									
520111	00.9540	16.01	530032	01.0887	18.13									
520112	01.1157	16.89												
520113	01.2035	19.18												
520114	01.0837	13.27												
520115	01.2596	16.02												
520116	01.2507	18.13												
520117	01.0605	15.78												
520118	00.9421	10.53												
520120	00.8814	12.70												
520121	00.9486	15.67												
520122	00.9718	14.73												
520123	01.0916	16.93												
520124	01.1417	14.93												
520130	01.0461	13.47												
520131	01.0271	16.78												
520132	01.1689	14.48												
520134	01.0798	15.97												
520135	00.9421	17.28												
520136	01.5062	19.05												
520138	01.8573	19.44												
520139	01.2790	19.89												
520140	01.6111	21.15												
520141	01.0486	15.86												
520142	00.8690	13.20												
520144	01.0297	16.42												
520145	00.9171	16.59												
520146	01.0863	13.94												
520148	01.0827	15.34												
520149	00.9713	13.44												
520151	01.0919	15.42												
520152	01.1594	17.07												
520153	00.9221	13.81												
520154	01.0972	17.71												
520156	01.1062	16.69												
520157	01.0427	13.77												
520159	00.9343	16.85												
520160	01.7979	19.07												
520161	01.0019	15.94												
520170	01.2386	19.95												
520171	00.9327	13.23												
520173	01.1538	18.34												
520174	01.3545	21.51												
520177	01.5931	20.16												

Note: Case mix indexes do not include discharges from PPS-exempt units.
Case mix indexes include cases received in HCFA central office through December 1996.

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

Urban Area (Constituent Counties)	Wage index	GAF
0040 Abilene, TX	0.8287	0.8793
Taylor, TX		
0060 [2] Aguadilla, PR	0.4224	0.5542
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9728	0.9813
Portage, OH		
Summit, OH		
0120 Albany, GA	0.7914	0.8520
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8480	0.8932
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9329	0.9535
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8269	0.8780
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0086	1.0059
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9137	0.9401
Blair, PA		
0320 Amarillo,.		
TX Potter, TX	0.9425	0.9603
Randall, TX		
0380 Anchorage, AK	1.2998	1.1967
Anchorage, AK		
0440 Ann Arbor, MI	1.1785	1.1190
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8266	0.8777
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8996	0.9301
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 [2] Arecibo, PR	0.4224	0.5542
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9072	0.9355
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9087	0.9365
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	0.9823	0.9878
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, 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-Cape May, NJ	1.0724	1.0490
Atlantic, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA–SC	0.9333	0.9538
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9133	0.9398
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA	1.0014	1.0010
Kern, CA		
0720 [1] Baltimore, MD	0.9689	0.9786
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9478	0.9640
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.4291	1.2770
Barnstable, MA		
0760 Baton Rouge, LA	0.8382	0.8862
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8593	0.9014
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1221	1.0821
Whatcom, WA		
0870 [2] Benton Harbor, MI	0.8923	0.9249
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1570	1.1050
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9783	0.9851
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8415	0.8885
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8914	0.9243
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9005	0.9307
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7859	0.8479
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.9128	0.9394
Monroe, IN		
1040 Bloomington-Normal, IL	0.8733	0.9114
McLean, IL		
1080 Boise City, ID	0.8887	0.9224
Ada, ID		
Canyon, ID		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1436	1.0962
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	1.0015	1.0010
Boulder, CO		
1145 Brazoria, TX	0.9129	0.9395
Brazoria, TX		
1150 Bremerton, WA	1.0999	1.0674
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8740	0.9119
Cameron, TX		
1260 Bryan-College Station, TX	0.8571	0.8998
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9272	0.9496
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0142	1.0097
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4508	0.5795
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8961	0.9276

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

Urban Area (Constituent Counties)	Wage index	GAF
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9013	0.9313
Natrona, WY		
1360 Cedar Rapids, IA	0.8529	0.8968
Linn, IA		
1400 Champaign-Urbana, IL	0.8824	0.9179
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8807	0.9167
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9142	0.9404
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC–SC	0.9710	0.9800
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	0.9051	0.9340
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.8658	0.9060
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.8247	0.8764
Laramie, WY		
1600[1] Chicago, IL	1.0860	1.0581
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0429	1.0292
Butte, CA		
1640[1] Cincinnati, OH–KY–IN	0.9521	0.9669
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	0.7852	0.8474
Christian, KY		
Montgomery, TN		
1680[1] Cleveland-Lorain-Elyria, OH	0.9804	0.9865
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9316	0.9526
El Paso, CO		
1740 Columbia, MO	0.9001	0.9305
Boone, MO		
1760 Columbia, SC	0.9192	0.9439
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.8288	0.8793
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840[1] Columbus, OH	0.9793	0.9858
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8945	0.9265
Nueces, TX		
San Patricio, TX		
1900 Cumberland, MD–WV	0.8822	0.9178
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9674	0.9776
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8146	0.8690
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8405	0.8878
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9279	0.9500
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 [2] Daytona Beach, FL	0.8838	0.9189
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8286	0.8792
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.7915	0.8520
Macon, IL		
2080 [1] Denver, CO	1.0386	1.0263
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8837	0.9188
Dallas, IA		
Polk, IA		
Warren, IA		
2160[1] Detroit, MI	1.0840	1.0568
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.8070	0.8634
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9303	0.9517
Kent, DE		
2200 Dubuque, IA	0.8088	0.8647
Dubuque, IA		
2240 Duluth-Superior, MN–WI	0.9779	0.9848
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0632	1.0429
Dutchess, NY		
2290 Eau Claire, WI	0.8764	0.9136
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	1.0123	1.0084
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9081	0.9361
Elkhart, IN		
2335 [2] Elmira, NY	0.8401	0.8875
Chemung, NY		
2340 Enid, OK	0.7962	0.8555
Garfield, OK		
2360 Erie, PA	0.8862	0.9206
Erie, PA		
2400 Eugene-Springfield, OR	1.1659	1.1108
Lane, OR		
2440 Evansville-Henderson, IN–KY	0.8641	0.9048
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.8837	0.9188

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

Urban Area (Constituent Counties)	Wage index	GAF
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8734	0.9115
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7461	0.8183
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	0.9115	0.9385
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1171	1.0788
Genesee, MI		
2650 Florence, AL	0.7716	0.8373
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8711	0.9098
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0248	1.0169
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0487	1.0331
Broward, FL		
2700 [2] Fort Myers-Cape Coral, FL	0.8838	0.9189
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0257	1.0175
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7769	0.8412
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 [2] Fort Walton Beach, FL	0.8838	0.9189
Okaloosa, FL		
2760 Fort Wayne, IN	0.8901	0.9234
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9997	0.9998
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0607	1.0412
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8815	0.9173
Etowah, AL		
2900 Gainesville, FL	0.9616	0.9735
Alachua, FL		
2920 Galveston-Texas City, TX	1.0564	1.0383
Galveston, TX		
2960 Gary, IN	0.9270	0.9494
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8401	0.8875
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8443	0.8906
Wayne, NC		
2985 Grand Forks, ND–MN	0.8815	0.9173
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9491	0.9649
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0147	1.0100
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9306	0.9519
Cascade, MT		
3060 Greeley, CO	1.0097	1.0066
Weld, CO		
3080 Green Bay, WI	0.9585	0.9714
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9351	0.9551
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NCGuilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9064	0.9349
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9059	0.9346
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9681	0.9780
Washington, MD		
3200 Hamilton-Middletown, OH	0.8767	0.9138
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	1.0187	1.0128
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1,2] Hartford, CT	1.2617	1.1726
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS	0.7192	0.7979
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.8285	0.8791
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1817	1.1211
Honolulu, HI		
3350 Houma, LA	0.7854	0.8475
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9855	0.9900
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9160	0.9417
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8485	0.8936
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9848	0.9896
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9401	0.9586
Johnson, IA		
3520 Jackson, MI	0.9052	0.9341
Jackson, MI		
3560 Jackson, MS	0.7790	0.8428
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8522	0.8963
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.8969	0.9282
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.7939	0.8538
Onslow, NC		
3610 [2] Jamestown, NY	0.8401	0.8875
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.8824	0.9179
Rock, WI		
3640 Jersey City, NJ	1.1412	1.0947
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN–VA	0.9114	0.9384
Carter, TN		
Hawkins, TN		
Sullivan, TN		

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

Urban Area (Constituent Counties)	Wage index	GAF
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8421	0.8890
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7443	0.8169
Craighead, AR		
3710 Joplin, MO	0.7541	0.8243
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0668	1.0453
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.8653	0.9057
Kankakee, IL		
3760 [1] Kansas City, KS–MO	0.9564	0.9699
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	0.9196	0.9442
Kenosha, WI		
3810 Killeen-Temple, TX	1.0252	1.0172
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8831	0.9184
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8416	0.8886
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.8749	0.9125
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8227	0.8749
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.9174	0.9427
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.7776	0.8418
Calcasieu, LA		
3980 [2] Lakeland-Winter Haven, FL	0.8838	0.9189
Polk, FL		
4000 Lancaster, PA	0.9481	0.9642
Lancaster, PA		
4040 Lansing-East Lansing, MI	1.0088	1.0060
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 [2] Laredo, TX	0.7404	0.8140
Webb, TX		
4100 Las Cruces, NM	0.8658	0.9060
Dona Ana, NM		
4120 [1] Las Vegas, NV–AZ	1.0592	1.0402
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8608	0.9024
Douglas, KS		
4200 Lawton, OK	0.9045	0.9336
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9536	0.9680
Androscoggin, ME		
4280 Lexington, KY	0.8416	0.8886
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9185	0.9434
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9231	0.9467
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8490	0.8940
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8613	0.9028
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480[1] Los Angeles-Long Beach, CA	1.2268	1.1503
Los Angeles, CA		
4520 Louisville, KY–IN	0.9507	0.9660
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8400	0.8875
Lubbock, TX		
4640 Lynchburg, VA	0.8228	0.8750
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.9227	0.9464
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0055	1.0038
Dane, WI		
4800 Mansfield, OH	0.8639	0.9047
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4475	0.5766
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8371	0.8854
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0354	1.0241
Jackson, OR		
4900[2] Melbourne-Titusville-Palm Bay, FL	0.8838	0.9189
Brevard, FL		
4920 [1] Memphis, TN–AR–MS	0.8589	0.9011
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0947	1.0639
Merced, CA		
5000 [1] Miami, FL	0.9859	0.9903
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.0875	1.0591
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9819	0.9876
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN–WI	1.0733	1.0496
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	0.8455	0.8914
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0377	1.0257

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

Urban Area (Constituent Counties)	Wage index	GAF
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.0934	1.0631
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8414	0.8885
Ouachita, LA		
5240 Montgomery, AL	0.7813	0.8445
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9173	0.9426
Delaware, IN		
5330 Myrtle Beach, SC	0.8072	0.8636
Horry, SC		
5345 Naples, FL	1.0109	1.0075
Collier, FL		
5360 [1] Nashville, TN	0.9182	0.9432
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3807	1.2472
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2619	1.1727
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2617	1.1726
New London, CT		
5560 [1] New Orleans, LA	0.9566	0.9701
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.3982	1.2580
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.1111	1.0748
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.1283	1.0862
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA–NC	0.8316	0.8814
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 [1] Oakland, CA	1.5158	1.3295
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9032	0.9327
Marion, FL		
5800 Odessa-Midland, TX	0.8660	0.9062
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8481	0.8933
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0901	1.0609
Thurston, WA		
5920 Omaha, NE–IA	0.9421	0.9600
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1532	1.1025
Orange, CA		
5960 [1] Orlando, FL	0.9397	0.9583
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 [2] Owensboro, KY	0.7772	0.8415
Daviess, KY		
6015 [2] Panama City, FL	0.8838	0.9189
Bay, FL		
6020 [2] Parkersburg-Marietta, WV–OH (West Virginia Hospitals)	0.8046	0.8617
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV–OH (Ohio Hospitals)	0.8434	0.8899
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8838	0.9189
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8586	0.9009
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA–NJ	1.1379	1.0925
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9606	0.9728
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7826	0.8455
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9725	0.9811
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA	1.0960	1.0648
Berkshire, MA		
6340 Pocatello, ID	0.9586	0.9715
Bannock, ID		
6360 Ponce, PR	0.4589	0.5866
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9627	0.9743
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR–WA	1.1344	1.0902
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.1049	1.0707
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	1.0073	1.0050
Utah, UT		
6560 Pueblo, CO	0.8450	0.8911
Pueblo, CO		

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

Urban Area (Constituent Counties)	Wage index	GAF
6580[2] Punta Gorda, FL	0.8838	0.9189
Charlotte, FL		
6600 Racine, WI	0.8934	0.9257
Racine, WI		
6640[1] Raleigh-Durham-Chapel Hill, NC	0.9818	0.9875
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8345	0.8835
Pennington, SD		
6680 Reading, PA	0.9516	0.9666
Berks, PA		
6690 Redding, CA	1.1790	1.1194
Shasta, CA		
6720 Reno, NV	1.0768	1.0520
Washoe, NV		
6740[2] Richland-Kennewick-Pasco, WA	1.0221	1.0151
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9152	0.9411
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 [1] Riverside-San Bernardino, CA	1.1145	1.0771
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8402	0.8876
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.0502	1.0341
Olmsted, MN		
6840 [1] Rochester, NY	0.9524	0.9672
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9081	0.9361
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9029	0.9324
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.2202	1.1460
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9564	0.9699
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9544	0.9685
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8366	0.8850
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO–IL	0.9130	0.9396
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 [2] Salem, OR	0.9976	0.9984
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4513	1.2905
Monterey, CA		
7160[1] Salt Lake City-Ogden, UT	0.9862	0.9905
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7780	0.8421
Tom Green, TX		
7240 [1] San Antonio, TX	0.8499	0.8946
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.2225	1.1475
San Diego, CA		
7360 [1] San Francisco, CA	1.4091	1.2647
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4332	1.2795
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4618	0.5891
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		
Morovis, PR		
Naguabo, 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	1.1374	1.0922
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0688	1.0466
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.4187	1.2706
Santa Cruz, CA		
7490 Santa Fe, NM	1.0332	1.0226
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2267	1.1502
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9757	0.9833
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.8638	0.9046
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8539	0.8975
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1375	1.0922
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA	0.8783	0.9150
Mercer, PA		
7620 [2] Sheboygan, WI	0.8471	0.8926
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8499	0.8946
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9381	0.9572

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

Urban Area (Constituent Counties)	Wage index	GAF
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8031	0.8606
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8712	0.9099
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9880	0.9918
St. Joseph, IN		
7840 Spokane, WA	1.0486	1.0330
Spokane, WA		
7880 Springfield, IL	0.8713	0.9100
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8036	0.8609
Christian, MO		
Greene, MO		
Webster, MO		
8003 [2] Springfield, MA	1.0718	1.0486
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9635	0.9749
Centre, PA		
8080 Steubenville-Weirton, OH–WV	0.8645	0.9051
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.1518	1.1016
San Joaquin, CA		
8140 [2] Sumter, SC	0.7921	0.8525
Sumter, SC		
8160 Syracuse, NY	0.9480	0.9641
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1016	1.0685
Pierce, WA		
8240 [2] Tallahassee, FL	0.8838	0.9189
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9196	0.9442
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8614	0.9029
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8699	0.9090
Miller, AR		
Bowie, TX		
8400 Toledo, OH	1.0140	1.0096
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9438	0.9612
Shawnee, KS		
8480 Trenton, NJ	1.0380	1.0259
Mercer, NJ		
8520 Tucson, AZ	0.9180	0.9431
Pima, AZ		
8560 Tulsa, OK	0.8074	0.8637
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8187	0.8720
Tuscaloosa, AL		
8640 Tyler, TX	0.9567	0.9701
Smith, TX		
8680 [2] Utica-Rome, NY	0.8401	0.8875
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3528	1.2299
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0544	1.0369
Ventura, CA		
8750 Victoria, TX	0.8474	0.8928
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0110	1.0075
Cumberland, NJ		
8780 [2] Visalia-Tulare-Porterville, CA	0.9977	0.9984
Tulare, CA		
8800 Waco, TX	0.7696	0.8358
McLennan, TX		
8840 [1] Washington, DC–MD–VA–WV	1.0780	1.0528
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpeper, 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	1.0545	1.0370
Marathon, WI		
8960 West Palm Beach-Boca Raton, FL	1.0309	1.0211
Palm Beach, FL		
9000 [2] Wheeling, OH–WV (West Virginia Hospitals)	0.7966	0.8558
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, OH–WV (Ohio Hospitals)	0.8434	0.8899
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9403	0.9587
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7646	0.8321
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8548	0.8981
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1538	1.1029
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9322	0.9531
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0221	1.0151
Yakima, WA		
9270 Yolo, CA	1.1431	1.0959
Yolo, CA		
9280 York, PA	0.9415	0.9596
York, PA		
9320 Youngstown-Warren, OH	0.9937	0.9957
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0324	1.0221
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9732	0.9816
Yuma, AZ		

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1998.

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

Nonurban area	Wage index	GAF
Alabama	0.7260	0.8031
Alaska	1.2302	1.1524
Arizona	0.7989	0.8575
Arkansas	0.6995	0.7829

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

Nonurban area	Wage index	GAF
California	0.9977	0.9984
Colorado	0.8129	0.8677
Connecticut	1.2617	1.1726
Delaware	0.8925	0.9251
Florida	0.8838	0.9189
Georgia	0.7761	0.8407
Hawaii	1.0229	1.0156
Idaho	0.8221	0.8745
Illinois	0.7644	0.8320
Indiana	0.8161	0.8701
Iowa	0.7391	0.8130
Kansas	0.7203	0.7988
Kentucky	0.7772	0.8415
Louisiana	0.7383	0.8124
Maine	0.8468	0.8924
Maryland	0.8617	0.9031
Massachusetts	1.0718	1.0486
Michigan	0.8923	0.9249
Minnesota	0.8180	0.8715
Mississippi	0.6911	0.7765
Missouri	0.7207	0.7991
Montana	0.8302	0.8804
Nebraska	0.7401	0.8137
Nevada	0.8914	0.9243
New Hampshire	0.9724	0.9810
New Jersey [1]	.....	.....
New Mexico	0.8110	0.8664
New York	0.8401	0.8875
North Carolina	0.7939	0.8538
North Dakota	0.7360	0.8107
Ohio	0.8434	0.8899
Oklahoma	0.7072	0.7888
Oregon	0.9976	0.9984
Pennsylvania	0.8421	0.8890
Puerto Rico	0.4224	0.5542
Rhode Island [1]	.....	.....
South Carolina	0.7921	0.8525
South Dakota	0.6983	0.7820
Tennessee	0.7353	0.8101
Texas	0.7404	0.8140
Utah	0.8926	0.9251
Vermont	0.9314	0.9525
Virginia	0.7782	0.8422
Washington	1.0221	1.0151
West Virginia	0.7966	0.8558
Wisconsin	0.8471	0.8926
Wyoming	0.8247	0.8764

[1] All counties within the State are classified as urban.

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

Urban area	Wage index	GAF
Abilene, TX	0.8287	0.8793
Albuquerque, NM	0.9329	0.9535
Alexandria, LA	0.8269	0.8780
Amarillo, TX	0.9277	0.9499
Anchorage, AK	1.2998	1.1967
Asheville, NC	0.9072	0.9355
Athens, GA	0.9087	0.9365
Atlanta, GA	0.9823	0.9878

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

Urban area	Wage index	GAF
Austin-San Marcos, TX	0.9133	0.9398
Bangor, ME	0.9478	0.9640
Barnstable-Yarmouth, MA	1.3827	1.2484
Baton Rouge, LA	0.8382	0.8862
Benton Harbor, MI	0.8923	0.9249
Bergen-Passaic, NJ	1.1570	1.1050
Billings, MT	0.9609	0.9731
Birmingham, AL	0.9005	0.9307
Bismarck, ND	0.7859	0.8479
Boise City, ID	0.8887	0.9224
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1436	1.0962
Caguas, PR	0.4508	0.5795
Casper, WY	0.9013	0.9313
Champaign-Urbana, IL	0.8706	0.9095
Charlotte-Gastonia-Rock Hill, NC–SC	0.9710	0.9800
Charlottesville, VA	0.8885	0.9222
Chattanooga, TN-GA	0.8658	0.9060
Chicago, IL	1.0759	1.0514
Cincinnati, OH–KY–IN	0.9521	0.9669
Cleveland-Lorain-Elyria, OH	0.9804	0.9865
Columbia, MO	0.8759	0.9133
Columbus, OH	0.9793	0.9858
Dallas, TX	0.9674	0.9776
Davenport-Moline-Rock Island, IA–IL	0.8405	0.8878
Denver, CO	1.0386	1.0263
Des Moines, IA	0.8837	0.9188
Detroit, MI	1.0840	1.0568
Duluth-Superior, MN–WI	0.9779	0.9848
Dutchess County, NY	1.0364	1.0248
Eugene-Springfield, OR	1.1659	1.1108
Fargo-Moorhead, ND–MN	0.8729	0.9111
Fayetteville, NC	0.8491	0.8940
Flint, MI	1.1171	1.0788
Florence, AL	0.7716	0.8373
Florence, SC	0.8711	0.9098
Ft. Lauderdale, FL	1.0487	1.0331
Fort Pierce-Port St. Lucie, FL	1.0008	1.0005
Fort Walton Beach, FL	0.8653	0.9057
Forth Worth-Arlington, TX	0.9997	0.9998
Gadsden, AL	0.8815	0.9173
Gainesville, FL	0.9616	0.9735
Gary, IN	0.9114	0.9384
Grand Forks, ND–MN	0.8815	0.9173
Grand Junction, CO	0.9491	0.9649
Great Falls, MT	0.9306	0.9519
Greeley, CO	0.9791	0.9856
Green Bay, WI	0.9585	0.9714
Greensboro-Winston-Salem-High Point, NC	0.9351	0.9551
Harrisburg-Lebanon-Carlisle, PA	1.0076	1.0052
Honolulu, HI	1.1817	1.1211
Houma, LA	0.7854	0.8475
Houston, TX	0.9855	0.9900
Huntington-Ashland, WV–KY–OH	0.9160	0.9417
Huntsville, AL	0.8485	0.8936

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

Urban area	Wage index	GAF
Indianapolis, IN	0.9848	0.9896
Iowa City, IA	0.9198	0.9444
Jackson, MS	0.7790	0.8428
Johnson City-Kingsport-Bristol, TN–VA	0.9114	0.9384
Jonesboro, AR	0.7443	0.8169
Joplin, MO	0.7541	0.8243
Kalamazoo-Battlecreek, MI	1.0668	1.0453
Kansas City, KS–MO	0.9564	0.9699
Knoxville, TN	0.8831	0.9184
Lafayette, LA	0.8227	0.8749
Lafayette, IN	0.9174	0.9427
Lansing-East Lansing, MI	1.0088	1.0060
Las Cruces, NM	0.8658	0.9060
Las Vegas, NV–AZ	1.0592	1.0402
Lexington, KY	0.8416	0.8886
Lima, OH	0.9185	0.9434
Lincoln, NE	0.9035	0.9329
Little Rock-North Little Rock, AR	0.8490	0.8940
Longview-Marshall, TX	0.8509	0.8953
Los Angeles-Long Beach, CA	1.2268	1.1503
Louisville, KY–IN	0.9507	0.9660
Macon, GA	0.9227	0.9464
Madison, WI	1.0055	1.0038
Mansfield, OH	0.8639	0.9047
Medford-Ashland, OR	1.0354	1.0241
Memphis, TN–AR–MS	0.8589	0.9011
Milwaukee-Waukesha, WI	0.9819	0.9876
Minneapolis-St. Paul, MN–WI	1.0733	1.0496
Monroe, LA	0.8414	0.8885
Montgomery, AL	0.7813	0.8445
Nashville, TN	0.9182	0.9432
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2619	1.1727
New London-Norwich, CT	1.2258	1.1496
New Orleans, LA	0.9566	0.9701
New York, NY	1.3982	1.2580
Newark, NJ	1.1111	1.0748
Newburgh, NY–PA	1.1283	1.0862
Oakland, CA	1.5158	1.3295
Odessa-Midland, TX	0.8516	0.8958
Oklahoma City, OK	0.8481	0.8933
Omaha, NE–IA	0.9421	0.9600
Orange County, CA	1.1532	1.1025
Peoria-Pekin, IL	0.8586	0.9009
Philadelphia, PA–NJ	1.1379	1.0925
Pittsburgh, PA	0.9583	0.9713
Pocatello, ID	0.9000	0.9304
Portland, ME	0.9627	0.9743
Portland-Vancouver, OR–WA	1.1344	1.0902
Provo-Orem, UT	1.0073	1.0050
Raleigh-Durham-Chapel Hill, NC	0.9818	0.9875
Rapid City, SD	0.8345	0.8835
Rochester, MN	1.0502	1.0341
Rockford, IL	0.9081	0.9361
Sacramento, CA	1.2202	1.1460

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

Urban area	Wage index	GAF
Saginaw-Bay City-Midland, MI	0.9564	0.9699
St. Cloud, MN	0.9544	0.9685
St. Louis, MO–IL	0.9130	0.9396
Salinas, CA	1.4299	1.2775
Salt Lake City-Ogden, UT	0.9862	0.9905
San Diego, CA	1.2225	1.1475
San Francisco, CA	1.4091	1.2647
Santa Fe, NM	1.0007	1.0005
Santa Rosa, CA	1.2146	1.1424
Seattle-Bellevue-Everett, WA	1.1375	1.0922
Sherman-Denison, TX	0.8324	0.8819
Sioux City, IA–NE	0.8031	0.8606
Sioux Falls, SD	0.8607	0.9024
South Bend, IN	0.9880	0.9918
Spokane, WA	1.0311	1.0212
Springfield, IL	0.8610	0.9026
Springfield, MO	0.8036	0.8609
Stockton-Lodi, CA	1.1518	1.1016
Syracuse, NY	0.9480	0.9641
Tampa-St. Petersburg-Clearwater, FL	0.9196	0.9442
Texarkana, AR-Texarkana, TX	0.8699	0.9090
Topeka, KS	0.9310	0.9522
Tucson, AZ	0.9180	0.9431
Tulsa, OK	0.8074	0.8637
Tyler, TX	0.9421	0.9600
Vallejo-Fairfield-Napa, CA	1.3528	1.2299
Washington, DC–MD–VA–WV	1.0780	1.0528
Waterloo-Cedar Falls, IA	0.8643	0.9050
Wausau, WI	0.9845	0.9894
Wichita, KS	0.9157	0.9415
Wichita Falls, TX	0.7646	0.8321
Rural Florida	0.8838	0.9189
Rural Louisiana	0.7383	0.8124
Rural Minnesota	0.8180	0.8715
Rural Missouri	0.7207	0.7991
Rural New Hampshire	0.9724	0.9810
Rural New Mexico	0.8110	0.8664
Rural North Carolina	0.7939	0.8538
Rural Oregon	0.9976	0.9984
Rural Washington	1.0221	1.0151
Rural West Virginia	0.7966	0.8558
Rural Wyoming	0.8247	0.8764

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	16.6537
Aguadilla, PR	8.4161
Akron, OH	19.6368
Albany, GA	15.9028
Albany-Schenectady-Troy, NY	17.0398
Albuquerque, NM	18.7069
Alexandria, LA	16.4017
Allentown-Bethlehem-Easton, PA	20.2671

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Altoona, PA	18.3612
Amarillo, TX	18.9399
Anchorage, AK	25.8065
Ann Arbor, MI	23.6829
Anniston, AL	16.6112
Appleton-Oshkosh-Neenah, WI	18.0782
Arecibo, PR	8.4753
Asheville, NC	18.2293
Athens, GA	18.2596
Atlanta, GA	19.7400
Atlantic-Cape May, NJ	22.4152
Augusta-Aiken, GA–SC	18.7555
Austin-San Marcos, TX	18.3520
Bakersfield, CA	20.1222
Baltimore, MD	19.4693
Bangor, ME	19.0461
Barnstable-Yarmouth, MA	28.7181
Baton Rouge, LA	16.8431
Beaumont-Port Arthur, TX	17.2676
Bellingham, WA	22.5492
Benton Harbor, MI	17.3503
Bergen-Passaic, NJ	24.4277
Billings, MT	19.6586
Biloxi-Gulfport-Pascagoula, MS	16.9110
Binghamton, NY	17.9128
Birmingham, AL	18.0953
Bismarck, ND	15.4640
Bloomington, IN	18.3421
Bloomington-Normal, IL	17.5497
Boise City, ID	17.7955
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	22.9992
Boulder-Longmont, CO	20.1260
Brazoria, TX	18.7704
Bremerton, WA	22.1033
Brownsville-Harlingen-San Benito, TX	17.5624
Bryan-College Station, TX	17.2226
Buffalo-Niagara Falls, NY	18.6331
Burlington, VT	20.3813
Caguas, PR	8.9610
Canton-Massillon, OH	18.0078
Casper, WY	18.1110
Cedar Rapids, IA	17.1383
Champaign-Urbana, IL	17.7326
Charleston-North Charleston, SC	17.6972
Charleston, WV	18.3703
Charlotte-Gastonia-Rock Hill, NC–SC	19.5119
Charlottesville, VA	18.1882
Chattanooga, TN–GA	17.3976
Cheyenne, WY	15.1808
Chicago, IL	21.8239
Chico-Paradise, CA	20.9567
Cincinnati, OH–KY–IN	19.0379
Clarksville-Hopkinsville, TN–KY	15.7785
Cleveland-Lorain-Elyria, OH	19.7003
Colorado Springs, CO	18.7205
Columbia, MO	18.0868
Columbia, SC	18.4707
Columbus, GA–AL	16.6542
Columbus, OH	19.6781
Corpus Christi, TX	17.9745
Cumberland, MD–WV	17.7280
Dallas, TX	19.4990
Danville, VA	16.3692
Davenport-Moline-Rock Island, IA–IL	16.8903
Dayton-Springfield, OH	19.2596

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Daytona Beach, FL	16.8298
Decatur, AL	16.6503
Decatur, IL	15.9047
Denver, CO	20.8698
Des Moines, IA	17.7579
Detroit, MI	21.7532
Dothan, AL	16.2160
Dover, DE	18.6953
Dubuque, IA	16.2530
Duluth-Superior, MN–WI	19.6500
Dutchess County, NY	21.3657
Eau Claire, WI	17.6122
El Paso, TX	20.3430
Elkhart-Goshen, IN	18.2474
Elmira, NY	16.5714
Enid, OK	16.0002
Erie, PA	17.8087
Eugene-Springfield, OR	22.9777
Evansville, Henderson, IN–KY	17.3648
Fargo-Moorhead, ND–MN	17.7585
Fayetteville, NC	17.5510
Fayetteville-Springdale-Rogers, AR	14.9924
Flagstaff, AZ–UT	18.3168
Flint, MI	22.4472
Florence, AL	15.1732
Florence, SC	17.5055
Fort Collins-Loveland, CO	20.5933
Fort Lauderdale, FL	20.9943
Fort Myers-Cape Coral, FL	17.6604
Fort Pierce-Port St. Lucie, FL	20.6112
Fort Smith, AR–OK	15.6127
Fort Walton Beach, FL	17.6128
Fort Wayne, IN	17.8865
Fort Worth-Arlington, TX	20.0524
Fresno, CA	21.3156
Gadsden, AL	17.7134
Gainesville, FL	19.3227
Galveston-Texas City, TX	21.2286
Gary, IN	19.3581
Glens Falls, NY	16.8524
Goldsboro, NC	16.9659
Grand Forks, ND–MN	17.5737
Grand Junction, CO	18.2668
Grand Rapids-Muskegon-Holland, MI	20.3894
Great Falls, MT	17.6888
Greeley, CO	20.2891
Green Bay, WI	18.2802
Greensboro-Winston-Salem-High Point, NC	18.7911
Greenville, NC	18.2150
Greenville-Spartanburg-Anderson, SC	18.2047
Hagerstown, MD	19.4546
Hamilton-Middletown, OH	17.6176
Harrisburg-Lebanon-Carlisle, PA	20.4715
Hartford, CT	25.2442
Hattiesburg, MS	14.4517
Hickory-Morganton-Lenoir, NC	17.4555
Honolulu, HI	23.7434
Houma, LA	15.7820
Houston, TX	19.8028
Huntington-Ashland, WV–KY–OH	18.4061
Huntsville, AL	17.0504
Indianapolis, IN	19.7891
Iowa City, IA	18.8914
Jackson, MI	18.1893
Jackson, MS	15.5941

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Jackson, TN	17.1259
Jacksonville, FL	18.0231
Jacksonville, NC	14.0121
Jamestown, NY	15.1763
Janesville-Beloit, WI	17.7327
Jersey City, NJ	22.9317
Johnson City-Kingsport-Bristol, TN–VA	18.3137
Johnstown, PA	16.8349
Jonesboro, AR	14.9575
Joplin, MO	15.0911
Kalamazoo-Battlecreek, MI	21.4383
Kankakee, IL	17.3875
Kansas City, KS–MO	19.2182
Kenosha, WI	18.4799
Killeen-Temple, TX	20.6010
Knoxville, TN	17.7457
Kokomo, IN	16.9123
La Crosse, WI–MN	17.5812
Lafayette, LA	16.4896
Lafayette, IN	18.4349
Lake Charles, LA	15.6250
Lakeland-Winter Haven, FL	17.6957
Lancaster, PA	19.0528
Lansing-East Lansing, MI	20.2720
Laredo, TX	14.7188
Las Cruces, NM	17.3739
Las Vegas, NV–AZ	21.2843
Lawrence, KS	17.2986
Lawton, OK	18.1767
Lewiston-Auburn, ME	19.1630
Lexington, KY	16.8604
Lima, OH	18.4571
Lincoln, NE	18.5501
Little Rock-North Little Rock, AR	17.0606
Longview-Marshall, TX	17.3073
Los Angeles-Long Beach, CA	24.5811
Louisville, KY–IN	19.1041
Lubbock, TX	16.8801
Lynchburg, VA	16.5342
Macon, GA	18.5414
Madison, WI	20.2048
Mansfield, OH	17.3603
Mayaguez, PR	8.9928
McAllen-Edinburg-Mission, TX	16.8206
Medford-Ashland, OR	20.8059
Melbourne-Titusville-Palm Bay, FL	17.7216
Memphis, TN–AR–MS	17.2589
Merced, CA	21.9978
Miami, FL	19.8109
Middlesex-Somerset-Hunterdon, NJ	22.2234
Milwaukee-Waukesha, WI	19.7306
Minneapolis-St. Paul, MN–WI	21.5680
Mobile, AL	16.9905
Modesto, CA	21.6914
Monmouth-Ocean, NJ	21.9716
Monroe, LA	16.9075
Montgomery, AL	15.4155
Muncie, IN	18.4325
Myrtle Beach, SC	16.2206
Naples, FL	20.3132
Nashville, TN	18.4503
Nassau-Suffolk, NY	27.7455
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	25.3561
New London-Norwich, CT	24.1396
New Orleans, LA	19.2230
New York, NY	28.1700
Newark, NJ	24.0742
Newburgh, NY–PA	22.6737
Norfolk-Virginia Beach-Newport News, VA–NC	16.7115
Oakland, CA	30.2802
Ocala, FL	18.1497
Odessa-Midland, TX	17.4016
Oklahoma City, OK	17.0417
Olympia, WA	21.9051
Omaha, NE–IA	18.9312
Orange County, CA	23.3199
Orlando, FL	18.8833
Owensboro, KY	15.0313
Panama City, FL	16.7539
Parkersburg-Marietta, WV–OH	16.1677
Pensacola, FL	16.4635
Peoria-Pekin, IL	17.2543
Philadelphia, PA–NJ	22.8669
Phoenix-Mesa, AZ	19.3025
Pine Bluff, AR	15.7267
Pittsburgh, PA	19.5430
Pittsfield, MA	22.0237
Pocatello, ID	19.2628
Ponce, PR	9.2209
Portland, ME	19.3456
Portland-Vancouver, OR–WA	22.7959
Providence-Warwick, RI	22.2031
Provo-Orem, UT	20.2420
Pueblo, CO	16.9797
Punta Gorda, FL	17.5323
Racine, WI	17.9536
Raleigh-Durham-Chapel Hill, NC	19.7297
Rapid City, SD	16.7698
Reading, PA	19.1233
Redding, CA	23.6924
Reno, NV	21.6378
Richland-Kennewick-Pasco, WA	19.9294
Richmond-Petersburg, VA	18.3907
Riverside-San Bernardino, CA	22.7212
Roanoke, VA	16.8848
Rochester, MN	21.1030
Rochester, NY	19.1384
Rockford, IL	18.2476
Rocky Mount, NC	18.1440
Sacramento, CA	24.5203
Saginaw-Bay City-Midland, MI	19.2180
St. Cloud, MN	19.1778
St. Joseph, MO	16.8108
St. Louis, MO–IL	18.3475
Salem, OR	19.9649
Salinas, CA	29.1634
Salt Lake City-Ogden, UT	19.8077
San Angelo, TX	15.6340
San Antonio, TX	17.0791
San Diego, CA	24.5018
San Francisco, CA	28.4956
San Jose, CA	28.8011
San Juan-Bayamon, PR	9.2790
San Luis Obispo-Atascadero-Paso Robles, CA	22.8552
Santa Barbara-Santa Maria-Lompoc, CA	21.4774
Santa Cruz-Watsonville, CA	28.5090
Santa Fe, NM	20.7615
Santa Rosa, CA	25.7526
Sarasota-Bradenton, FL	19.6072
Savannah, GA	17.3582
Scranton-Wilkes Barre-Hazleton, PA	17.1601
Seattle-Bellevue-Everett, WA	22.7858
Sharon, PA	17.6500
Sheboygan, WI	15.7984
Sherman-Denison, TX	17.0784
Shreveport-Bossier City, LA	18.8520
Sioux City, IA–NE	16.1387
Sioux Falls, SD	17.5067
South Bend, IN	19.8290
Spokane, WA	21.0721
Springfield, IL	17.5080
Springfield, MO	16.0540
Springfield, MA	21.4074
State College, PA	19.3613
Steubenville-Weirton, OH–WV	17.3728
Stockton-Lodi, CA	23.1020
Sumter, SC	15.7585
Syracuse, NY	19.0186
Tacoma, WA	22.1357
Tallahassee, FL	16.7434
Tampa-St. Petersburg-Clearwater, FL	18.2926
Terre Haute, IN	17.3093
Texarkana, AR-Texarkana, TX	17.4104
Toledo, OH	20.8792
Topeka, KS	18.9662
Trenton, NJ	20.8592
Tucson, AZ	18.4477
Tulsa, OK	16.2252
Tuscaloosa, AL	16.4520
Tyler, TX	19.2259
Utica-Rome, NY	16.8763
Vallejo-Fairfield-Napa, CA	27.6380
Ventura, CA	21.9959
Victoria, TX	17.0294
Vineland-Millville-Bridgeton, NJ	20.3170
Visalia-Tulare-Porterville, CA	19.9417
Waco, TX	15.4645
Washington, DC–MD–VA–WV	21.6632
Waterloo-Cedar Falls, IA	17.3631
Wausau, WI	21.1907
West Palm Beach-Boca Raton, FL	20.8423
Wheeling, OH–WV	15.4868
Wichita, KS	18.8949
Wichita Falls, TX	15.3642
Williamsport, PA	17.1768
Wilmington-Newark, DE–MD	23.1858
Wilmington, NC	18.7325
Yakima, WA	20.2994
Yolo, CA	22.9704
York, PA	18.9189
Youngstown-Warren, OH	19.9688
Yuba City, CA	20.7466
Yuma, AZ	19.5572

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	14.5882
Alaska	24.7201
Arizona	16.0545
Arkansas	14.0570
California	20.0484
Colorado	16.3349
Connecticut	25.3532

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Delaware	17.9354
Florida	17.7600
Georgia	15.5949
Hawaii	20.5550
Idaho	16.5193
Illinois	15.3604
Indiana	16.3993
Iowa	14.8515
Kansas	14.4750
Kentucky	15.6180
Louisiana	14.8369
Maine	17.0166
Maryland	17.3152
Massachusetts	21.5382
Michigan	17.9306
Minnesota	16.4358
Mississippi	13.8878
Missouri	14.4791
Montana	16.6820
Nebraska	14.8733
Nevada	17.9119
New Hampshire	19.5257
New Jersey [1]	.....
New Mexico	16.2165
New York	16.8824
North Carolina	15.9493
North Dakota	14.7904
Ohio	16.9480
Oklahoma	14.2120
Oregon	20.0438
Pennsylvania	16.9213
Puerto Rico	8.4891
Rhode Island [1]	.....
South Carolina	15.9167
South Dakota	14.0318
Tennessee	14.7759
Texas	14.8782
Utah	17.9362
Vermont	18.7155
Virginia	15.6378
Washington	20.5396
West Virginia	15.9511
Wisconsin	17.0229
Wyoming	16.5729

[1] All counties within the State are classified as urban.

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclass. hospitals	GAF—reclass. hospitals
Aguadilla, PR [1]	0.9291	0.9509	.....	.....
Arecibo, PR [1]	0.9291	0.9509	.....	.....
Caguas, PR	0.9914	0.9941	0.9914	0.9941
Mayaguez, PR	0.9843	0.9892	.....	.....
Ponce, PR	1.0093	1.0064	.....	.....
San Juan-Bayamon, PR	1.0156	1.0107	.....	.....
Rural Puerto Rico	0.9291	0.9509	.....	.....

[1] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1998.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0907	7.2	10.3
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0511	7.9	10.6
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9484	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.3858	5.5	8.5
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5041	2.9	3.9
6	01	SURG	CARPAL TUNNEL RELEASE	.7582	2.2	3.3
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.4717	7.3	11.4
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.2142	2.2	3.2
9	01	MED	SPINAL DISORDERS & INJURIES	1.2646	5.1	7.2
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2184	5.3	7.4
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.7879	3.2	4.3
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9370	5.0	6.8
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7832	4.7	5.8
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1889	5.1	6.8
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7241	3.2	4.1
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0452	4.6	6.1
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6161	2.8	3.7
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9399	4.5	5.9
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6293	3.2	4.1
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.5786	8.0	10.8
21	01	MED	VIRAL MENINGITIS	1.4866	5.4	7.1
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.8594	3.7	4.8
23	01	MED	NONTRAUMATIC STUPOR & COMA	.7777	3.3	4.6
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9578	3.9	5.3
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5821	2.8	3.6
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.9601	3.6	4.9
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.2670	3.4	5.5
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.1707	4.4	6.4
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.6383	2.8	3.7

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	.3295	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8369	3.4	4.8
32	01	MED	CONCUSSION AGE >17 W/O CC	.5109	2.2	3.1
33	01	MED	*CONCUSSION AGE 0–17	.2071	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0385	4.2	5.8
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5941	3.0	3.9
36	02	SURG	RETINAL PROCEDURES	.6265	1.3	1.5
37	02	SURG	ORBITAL PROCEDURES	.9725	2.6	3.9
38	02	SURG	PRIMARY IRIS PROCEDURES	.4826	1.9	2.7
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5406	1.5	2.0
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.7341	2.2	3.3
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3354	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.5676	1.5	2.0
43	02	MED	HYPHEMA	.4119	2.9	4.0
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6072	4.3	5.3
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6730	2.9	3.6
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7234	3.7	4.9
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4623	2.7	3.6
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2955	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.8074	3.9	5.3
50	03	SURG	SIALOADENECTOMY	.8143	1.7	2.1
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.8367	1.9	2.9
52	03	SURG	CLEFT LIP & PALATE REPAIR	1.2768	2.2	3.2
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.0682	2.3	3.6
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4790	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.8366	2.0	2.9
56	03	SURG	RHINOPLASTY	.8830	2.1	2.8
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0182	2.7	4.0
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2720	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8238	2.3	3.3
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	.2072	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.1181	2.8	4.5
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2933	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.2444	3.1	4.6
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1568	4.4	6.7
65	03	MED	DYSEQUILIBRIUM	.5177	2.5	3.2
66	03	MED	EPISTAXIS	.5605	2.8	3.5
67	03	MED	EPIGLOTTITIS	.7866	3.1	3.8
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6831	3.5	4.3
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5160	2.9	3.5
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3892	2.7	3.3
71	03	MED	LARYNGOTRACHEITIS	.6688	3.0	3.9
72	03	MED	NASAL TRAUMA & DEFORMITY	.6364	2.7	3.5
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7660	3.4	4.7
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	.3332	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1958	8.3	10.6
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.6427	8.7	11.7
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1150	3.5	5.1
78	04	MED	PULMONARY EMBOLISM	1.4264	6.6	7.7
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6258	6.8	8.7
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC ...	.9121	4.9	6.1
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5091	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3329	5.4	7.4
83	04	MED	MAJOR CHEST TRAUMA W CC	.9716	4.6	5.9
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5260	2.8	3.5
85	04	MED	PLEURAL EFFUSION W CC	1.2212	5.3	6.9
86	04	MED	PLEURAL EFFUSION W/O CC	.6715	3.1	4.1
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3639	4.9	6.5
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9705	4.6	5.7

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.1006	5.4	6.6
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6773	4.0	4.7
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.7940	3.7	4.4
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1947	5.3	6.7
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7423	3.7	4.7
94	04	MED	PNEUMOTHORAX W CC	1.1857	5.1	6.7
95	04	MED	PNEUMOTHORAX W/O CC	.5974	3.2	4.0
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.8005	4.2	5.1
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5887	3.3	4.0
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.6298	2.3	3.8
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6710	2.4	3.2
100 ...	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5109	1.8	2.2
101 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8518	3.5	4.7
102 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5295	2.3	2.9
103 ...	05	SURG	HEART TRANSPLANT	16.5746	32.1	48.2
104 ...	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.3563	10.8	13.3
105 ...	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.7109	8.3	10.2
106 ...	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.5843	9.8	11.1
107 ...	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.0812	7.3	8.3
108 ...	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	6.1282	9.4	12.1
109 ...	.....		NO LONGER VALID	.0000	.0	.0
110 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1964	7.7	10.2
111 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2409	5.4	6.2
112 ...	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	2.0025	3.1	4.2
113 ...	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.6579	9.7	13.2
114 ...	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.5363	6.4	8.8
115 ...	05	SURG	PERM PACE IMPLNT W AMI, HRT FAIL OR SHOCK OR AICD LEAD OR GEN PROC.	3.5476	6.7	9.2
116 ...	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR PTCA W CORONARY ART STENT.	2.5321	3.5	4.7
117 ...	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.1950	2.7	4.0
118 ...	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5889	2.0	3.0
119 ...	05	SURG	VEIN LIGATION & STRIPPING	1.1997	3.1	5.1
120 ...	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9158	5.0	8.5
121 ...	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP DISCH ALIVE	1.6537	6.0	7.3
122 ...	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP DISCH ALIVE	1.1446	3.9	4.7
123 ...	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4695	2.7	4.5
124 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.3565	3.6	4.6
125 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	.9738	2.3	2.9
126 ...	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.4879	10.0	13.1
127 ...	05	MED	HEART FAILURE & SHOCK	1.0199	4.5	5.8
128 ...	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7807	5.6	6.4
129 ...	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1414	1.9	3.2
130 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9410	5.1	6.3
131 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6040	4.1	4.9
132 ...	05	MED	ATHEROSCLEROSIS W CC	.6749	2.7	3.3
133 ...	05	MED	ATHEROSCLEROSIS W/O CC	.5360	2.1	2.7
134 ...	05	MED	HYPERTENSION	.5760	2.8	3.6
135 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	.8336	3.4	4.5
136 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	.5709	2.4	3.1
137 ...	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8131	3.3	3.3
138 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.7962	3.2	4.2
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.4982	2.2	2.7
140 ...	05	MED	ANGINA PECTORIS	.5993	2.6	3.2
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7005	3.1	4.1
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5231	2.3	2.9
143 ...	05	MED	CHEST PAIN	.5200	1.9	2.4
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0904	3.9	5.4
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6401	2.3	3.0
146 ...	06	SURG	RECTAL RESECTION W CC	2.7356	9.3	10.5
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.5885	6.3	6.9
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3883	10.6	12.6
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5495	6.5	7.1
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.7109	9.1	11.1
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2645	4.9	6.1
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9139	7.2	8.5
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1634	5.2	5.8

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1851	10.8	14.1
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3350	3.9	5.0
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	.8374	6.0	6.0
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.1824	4.0	5.6
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6272	2.2	2.8
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.2548	3.8	5.1
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7177	2.3	2.8
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.0573	3.0	4.2
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.5856	1.7	2.1
163 ...	06	SURG	HERNIA PROCEDURES AGE 0–17	.8660	3.1	4.7
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3412	7.5	8.7
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2270	4.7	5.4
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4582	4.3	5.4
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8373	2.5	3.0
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.1187	3.2	4.7
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.6903	2.0	2.6
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7587	8.1	11.8
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1146	3.7	5.1
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.2867	5.3	7.4
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6744	2.9	4.0
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9925	4.1	5.2
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5366	2.7	3.2
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.1011	4.5	5.8
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8556	3.8	4.7
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6241	2.8	3.3
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.1100	5.2	6.7
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9153	4.4	5.7
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5204	3.1	3.7
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7664	3.5	4.6
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5496	2.6	3.2
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	.5930	2.7	3.6
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8424	3.5	4.8
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3192	2.9	2.9
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7049	3.0	4.0
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0727	4.3	5.8
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5488	2.5	3.4
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.8786	3.3	4.9
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3490	11.1	14.9
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7057	5.6	7.1
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.2666	10.6	13.0
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6688	5.9	7.5
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.7112	8.2	9.8
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6075	5.5	6.3
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.3085	7.2	8.7
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1693	4.1	4.7
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3523	7.9	10.7
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.0210	7.5	11.3
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.4752	11.1	15.2
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3255	5.3	7.2
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.2605	5.2	7.2
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2117	4.9	6.4
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.2144	5.0	6.8
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	.6543	3.2	4.2
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0507	4.1	5.3
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6039	2.4	3.0
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.2337	5.3	5.9
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8265	6.5	7.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2541	5.0	5.6
212 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.1311	3.9	5.2
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.6513	6.4	8.8
214 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
215 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
216 ...	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1082	7.4	10.3
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.8033	9.2	13.8
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4576	4.4	5.6
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	.9631	2.9	3.4
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5800	5.3	5.3
221 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
222 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
223 ...	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.9007	2.1	2.7
224 ...	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.7466	1.8	2.1
225 ...	08	SURG	FOOT PROCEDURES	1.0124	3.1	4.6
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4095	4.1	6.3
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.7729	2.2	2.9
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	.9542	2.3	3.5
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.6706	1.8	2.4
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.1296	3.3	5.0
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.2727	3.1	4.8
232 ...	08	SURG	ARTHROSCOPY	1.0629	2.5	4.2
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0329	5.7	8.3
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1126	2.9	3.9
235 ...	08	MED	FRACTURES OF FEMUR	.7710	4.2	5.9
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7338	4.3	5.7
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5952	3.2	4.2
238 ...	08	MED	OSTEOMYELITIS	1.3250	7.0	9.5
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	.9865	5.3	7.0
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2098	5.1	7.0
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5862	3.3	4.2
242 ...	08	MED	SEPTIC ARTHRITIS	1.0501	5.5	7.2
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7158	4.0	5.1
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7199	4.0	5.4
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5002	3.0	4.0
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5713	3.3	4.2
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5587	2.8	3.7
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7428	3.7	5.0
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.6559	2.7	4.0
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	.6995	3.4	4.7
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4517	2.3	3.0
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	.2520	1.8	1.8
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7265	3.9	5.3
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4350	2.8	3.5
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	.2934	2.9	2.9
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7826	4.0	5.7
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9276	2.6	3.2
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7162	2.0	2.3
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8874	2.1	3.2
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6092	1.4	1.7
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.8961	1.8	2.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.7820	2.6	4.0
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0221	8.9	12.6
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.0773	5.4	7.3
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5166	4.6	7.3
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.7909	2.6	3.6
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.8424	2.7	4.1
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.0090	2.4	3.5
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5733	5.9	8.5
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7061	2.2	3.2
271 ...	09	MED	SKIN ULCERS	1.0259	6.0	7.8
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	.9950	5.1	6.7
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6618	4.0	5.4
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1229	5.0	7.2
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5882	2.5	3.9
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6122	3.8	4.7
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8322	5.1	6.2
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5574	4.0	4.8
279 ...	09	MED	*CELLULITIS AGE 0–17	.7309	4.2	4.2
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6757	3.4	4.7
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4558	2.5	3.4
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2551	2.2	2.2
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.6936	3.8	5.0
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4371	2.7	3.6
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.1556	8.8	12.1
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2671	5.8	7.3
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8727	8.6	12.1
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0255	4.9	6.2
289 ...	10	SURG	PARATHYROID PROCEDURES	.9827	2.4	3.5
290 ...	10	SURG	THYROID PROCEDURES	.8970	2.0	2.6
291 ...	10	SURG	THYROGLOSSAL PROCEDURES	.7372	1.7	2.2
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.5483	7.6	11.2
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2297	3.8	5.6
294 ...	10	MED	DIABETES AGE >35	.7546	4.0	5.3
295 ...	10	MED	DIABETES AGE 0–35	.7359	3.2	4.1
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8657	4.3	5.8
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5188	3.0	3.9
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.4207	2.0	2.5
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.8716	3.9	5.5
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.0810	5.1	6.6
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.5941	3.1	4.4
302 ...	11	SURG	KIDNEY TRANSPLANT	3.7570	9.2	10.9
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.6139	7.8	9.5
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3982	6.9	9.6
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1695	3.4	4.3
306 ...	11	SURG	PROSTATECTOMY W CC	1.2168	4.0	5.8
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6455	2.1	2.5
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5120	4.3	6.4
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8760	2.1	2.6
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0248	3.0	4.3
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5866	1.7	2.1
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	.9732	3.1	4.7
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.5783	1.8	2.3
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4916	2.3	2.3
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0601	4.9	8.5
316 ...	11	MED	RENAL FAILURE	1.3089	5.1	7.1
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.5489	2.0	2.9
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1594	4.7	6.7
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5808	2.0	2.8
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8782	4.7	5.9
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5838	3.6	4.3
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5342	3.4	4.3
323 ...	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7555	2.5	3.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
324 ...	11	MED	URINARY STONES W/O CC	.4298	1.7	2.0
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	.6207	3.1	4.2
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4188	2.3	2.9
327 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3516	2.3	3.5
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.6878	2.9	3.9
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.5080	1.9	2.3
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3167	1.6	1.6
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0009	4.4	5.9
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5964	2.7	3.7
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.8389	4.0	5.7
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.6359	4.8	5.4
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.2190	3.7	4.1
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8870	2.9	3.8
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6129	2.1	2.4
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.0950	3.3	5.1
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0038	3.1	4.6
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2815	2.4	2.4
341 ...	12	SURG	PENIS PROCEDURES	1.1089	2.2	3.1
342 ...	12	SURG	CIRCUMCISION AGE >17	.8511	2.9	3.6
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1529	1.7	1.7
344 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.0298	2.1	3.1
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8552	2.7	3.8
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9573	4.5	6.3
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.4603	2.2	3.0
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6958	3.3	4.5
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4154	2.1	2.7
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6797	3.8	4.6
351 ...	12	MED	*STERILIZATION, MALE	.2347	1.3	1.3
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6263	2.9	4.0
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	2.1179	6.4	8.3
354 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.4963	5.0	6.0
355 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9180	3.4	3.6
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7701	2.5	2.8
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.4309	7.6	9.3
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2021	3.8	4.5
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8452	2.9	3.1
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8708	2.7	3.3
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1872	2.6	3.7
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3000	1.4	1.4
363 ...	13	SURG	D&C, CONIZATION & RADIO–IMPLANT, FOR MALIGNANCY	.7485	2.6	3.5
364 ...	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.6985	2.5	3.5
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7085	4.7	7.2
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1857	4.9	7.1
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5309	2.1	2.9
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.9698	4.9	6.2
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5367	2.5	3.4
370 ...	14	SURG	CESAREAN SECTION W CC	1.0587	4.3	5.5
371 ...	14	SURG	CESAREAN SECTION W/O CC	.7054	3.3	3.6
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5590	2.4	3.1
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3987	1.7	2.0
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7625	2.3	2.9
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6809	4.4	4.4
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.4822	2.3	3.2
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.0517	2.5	4.0
378 ...	14	MED	ECTOPIC PREGNANCY	.8126	2.3	2.6
379 ...	14	MED	THREATENED ABORTION	.4028	2.1	2.9
380 ...	14	MED	ABORTION W/O D&C	.3501	1.5	1.8
381 ...	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.4809	1.7	2.3
382 ...	14	MED	FALSE LABOR	.2086	1.2	1.3
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.4636	2.8	3.8

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3539	2.0	2.8
385 ...	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3665	1.8	1.8
386 ...	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5063	17.9	17.9
387 ...	15		*PREMATURITY W MAJOR PROBLEMS	3.0777	13.3	13.3
388 ...	15		*PREMATURITY W/O MAJOR PROBLEMS	1.8570	8.6	8.6
389 ...	15		FULL TERM NEONATE W MAJOR PROBLEMS	1.4862	5.1	6.3
390 ...	15		*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3058	3.4	3.4
391 ...	15		*NORMAL NEWBORN	.1515	3.1	3.1
392 ...	16	SURG	SPLENECTOMY AGE >17	3.1695	8.1	10.6
393 ...	16	SURG	*SPLENECTOMY AGE 0–17	1.3386	9.1	9.1
394 ...	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.6479	4.5	7.5
395 ...	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8181	3.6	5.0
396 ...	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	.6284	2.7	4.0
397 ...	16	MED	COAGULATION DISORDERS	1.2679	4.2	5.8
398 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2242	4.9	6.3
399 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6836	3.2	4.0
400 ...	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6402	6.3	9.7
401 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.5653	8.1	11.7
402 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0145	2.9	4.2
403 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6964	6.0	8.6
404 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.7917	3.3	4.6
405 ...	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	1.8978	4.9	4.9
406 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.6147	7.3	10.1
407 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC.	1.1516	3.5	4.4
408 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.7294	4.7	7.6
409 ...	17	MED	RADIOTHERAPY	.9534	4.3	5.9
410 ...	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.7968	2.6	3.4
411 ...	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4214	1.8	2.3
412 ...	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.5175	2.4	3.4
413 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3777	5.7	8.1
414 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.7041	3.2	4.6
415 ...	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5166	10.8	14.9
416 ...	18	MED	SEPTICEMIA AGE >17	1.4797	5.8	7.7
417 ...	18	MED	SEPTICEMIA AGE 0–17	.7688	3.3	4.3
418 ...	18	MED	POSTOPERATIVE & POST–TRAUMATIC INFECTIONS	.9679	5.0	6.3
419 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8831	4.1	5.2
420 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6064	3.2	4.0
421 ...	18	MED	VIRAL ILLNESS AGE >17	.7069	3.3	4.2
422 ...	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.5347	2.7	3.8
423 ...	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.5690	5.8	8.0
424 ...	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4581	9.9	16.8
425 ...	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION.	.6857	3.2	4.4
426 ...	19	MED	DEPRESSIVE NEUROSES	.5648	3.7	5.2
427 ...	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5818	3.6	5.3
428 ...	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.6975	4.9	7.7
429 ...	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8728	5.4	7.9
430 ...	19	MED	PSYCHOSES	.8073	6.5	9.1
431 ...	19	MED	CHILDHOOD MENTAL DISORDERS	.8371	5.5	8.9
432 ...	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7647	3.7	5.9
433 ...	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3053	2.4	3.3
434 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.6865	4.0	5.3
435 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4015	3.6	4.5
436 ...	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.8110	11.5	14.1
437 ...	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	.7343	8.3	9.9
438 ...	.....		NO LONGER VALID	.0000	.0	.0
439 ...	21	SURG	SKIN GRAFTS FOR INJURIES	1.6391	5.4	8.5
440 ...	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.8456	6.0	9.6
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9298	2.2	3.4
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.1818	5.4	8.3

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9116	2.5	3.4
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7007	3.7	4.8
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4842	2.6	3.7
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2942	2.4	2.4
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.4927	2.0	2.6
448 ...	21	MED	ALLERGIC REACTIONS AGE 0–17	.0968	1.0	1.0
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.7860	2.8	4.1
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4406	1.7	2.2
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2613	2.1	2.1
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	.9476	3.7	5.2
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4960	2.3	3.1
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.9035	3.3	5.2
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4453	2.0	2.7
456 ...	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.7396	3.7	7.3
457 ...	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	1.5860	2.5	4.9
458 ...	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.5746	11.1	16.0
459 ...	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC.	1.5588	6.5	9.3
460 ...	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	.9421	4.4	6.3
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.0123	2.5	4.6
462 ...	23	MED	REHABILITATION	1.4041	10.5	13.1
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.6907	3.6	4.8
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.4872	2.7	3.4
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5858	2.2	3.8
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6336	2.6	4.7
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4669	2.3	4.2
468 ...	.....		EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6202	9.9	14.2
469 ...	.....		**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470 ...	.....		**UNGROUPABLE	.0000	.0	.0
471 ...	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.4771	5.8	6.7
472 ...	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	10.2429	11.8	24.2
473 ...	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4853	7.9	13.6
474 ...	.....		NO LONGER VALID	.0000	.0	.0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.7291	8.2	11.6
476 ...	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2234	9.5	12.7
477 ...	.....	SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.7461	5.5	8.6
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2981	5.2	7.7
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4113	3.2	4.2
480 ...	.....	SURG	LIVER TRANSPLANT	11.4672	19.0	25.3
481 ...	.....	SURG	BONE MARROW TRANSPLANT	11.2821	26.5	30.2
482 ...	.....	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.5999	10.5	13.5
483 ...	.....	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES	16.0451	33.8	43.5
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.7762	10.6	15.4
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	3.1562	8.3	10.6
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8882	8.8	13.5
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0229	5.9	8.3
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.5078	12.1	18.0
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.8009	6.7	9.8
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9952	4.2	6.1
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6579	3.3	3.9
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.6393	11.9	18.0
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7561	4.1	5.7
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	.9400	1.8	2.4
495 ...	.....	SURG	LUNG TRANSPLANT	9.5171	14.8	17.9
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.5214	9.2	11.6
497 ...	08	SURG	SPINAL FUSION W CC	2.7692	5.3	6.8
498 ...	08	SURG	SPINAL FUSION W/O CC	1.6171	3.1	3.8
499 ...	08	SURG	BACK & NECK PROCS EXCEPT SPINAL FUSION W CC	1.4827	4.1	5.3
500 ...	08	SURG	BACK & NECK PROCS EXCEPT SPINAL FUSION W/O CC	.9708	2.6	3.1
501 ...	08	SURG	KNEE PROC W PDX OF INFECTION W CC	2.5660	8.7	11.3

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
502 ...	08	SURG	KNEE PROC W PDX OF INFECTION W/O CC	1.6004	5.9	7.1
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2380	3.4	4.4

*Medicare data have been supplemented by data from 19 states 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
007.4	Other protozoal intestinal diseases, cryptosporidiosis	N	6	182, 183, 184
031.2	Disease due to disseminated mycobacterium avium-intracellulare complex (DMAC).	N	18 25	423 489[1]
038.10	Staphylococcal septicemia, unspecified	Y	15 18 25	387, 389[2] 416, 417 489[1]
038.11	Staphylococcus aureus septicemia	Y	15 18 25	387, 389[2] 416, 417 489[1]
038.19	Other staphylococcal septicemia	Y	15 18 25	387, 389[2] 416, 417 489[1]
275.40	Unspecified disorder of calcium metabolism	N	10	296, 297, 298
275.41	Hypocalcemia	N	10	296, 297, 298
275.42	Hypercalcemia	N	10	296, 297, 298
275.49	Other disorder of calcium metabolism	N	10	296, 297, 298
438.0	Late effect of cerebrovascular disease, cognitive deficits	N	1	12
438.10	Late effect of cerebrovascular disease, speech and language deficits, unspecified.	N	1	12
438.11	Late effect of cerebrovascular disease, speech and language deficits, aphasia.	N	1	12
438.12	Late effect of cerebrovascular disease, speech and language deficits, dysphasia.	N	1	12
438.19	Late effect of cerebrovascular disease, other speech and language deficits.	N	1	12
438.20	Late effect of cerebrovascular disease, hemiplegia affecting unspecified side.	N	1	12
438.21	Late effect of cerebrovascular disease, hemiplegia affecting dominant side.	N	1	12
438.22	Late effect of cerebrovascular disease, hemiplegia affecting nondominant side.	N	1	12
438.30	Late effect of cerebrovascular disease, monoplegia of upper limb affecting unspecified side.	N	1	12
438.31	Late effect of cerebrovascular disease, monoplegia of upper limb affecting dominant side.	N	1	12
438.32	Late effect of cerebrovascular disease, monoplegia of upper limb affecting nondominant side.	N	1	12
438.40	Late effect of cerebrovascular disease, monoplegia of lower limb affecting unspecified side.	N	1	12
438.41	Late effect of cerebrovascular disease, monoplegia of lower limb affecting dominant side.	N	1	12
438.42	Late effect of cerebrovascular disease, monoplegia of lower limb affecting nondominant side.	N	1	12
438.50	Late effect of cerebrovascular disease, other paralytic syndrome affecting unspecified side.	N	1	12
438.51	Late effect of cerebrovascular disease, other paralytic syndrome affecting dominant side.	N	1	12
438.52	Late effect of cerebrovascular disease, other paralytic syndrome affecting nondominant side.	N	1	12
438.81	Other late effect of cerebrovascular disease, apraxia	N	1	12
438.82	Other late effect of cerebrovascular disease, dysphagia	N	1	12
438.89	Other late effects of cerebrovascular disease	N	1	12
438.9	Unspecified late effects of cerebrovascular disease	N	1	12
458.8	Other specified hypotension	N	5	144, 145 121[3]

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
474.00	Chronic tonsillitis	N	pre	482
			3	68, 69, 70
474.01	Chronic adenoiditis	N	pre	482
			3	68, 69, 70
474.02	Chronic tonsillitis and adenoiditis	N	pre	482
			3	68, 69, 70
482.84	Legionnaires' disease	Y	4	79, 80, 81
518.6	Allergic bronchopulmonary aspergillosis	Y	4	92, 93
655.70	Decreased fetal movements unspecified as to episode of care or not applicable.	N	14	469
655.71	Decreased fetal movements delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
655.73	Decreased fetal movements antepartum condition or complication	N	14	383, 384
686.00	Other local infection of skin and subcutaneous tissue, pyoderma, unspecified.	N	9	277, 278, 279
686.01	Other local infection of skin and subcutaneous tissue, pyoderma gangrenosum.	N	9	277, 278, 279
686.09	Other local infection of skin and subcutaneous tissue, other pyoderma	N	9	277, 278, 279
756.70	Congenital anomaly of abdominal wall, unspecified	N	6	188, 189, 190
756.71	Congenital anomaly of abdominal wall, prune belly syndrome	N	6	188, 189, 190
756.79	Other congenital anomalies of abdominal wall	N	6	188, 189, 190
780.31	Febrile convulsions	Y	1	24, 25, 26
			15	387, 389[2]
780.39	Other convulsions	Y	1	24, 25, 26
			15	387, 389[2]
790.94	Other nonspecific findings on examination of blood, euthyroid sick syndrome.	N	23	463, 464
796.5	Abnormal findings on antenatal screening	N	14	383, 384
959.01	Head injury, unspecified	N	pre	482
			21	444, 445, 446
			24	significant trauma list
959.09	Injury of face and neck	N	pre	482
			21	444, 445, 446
			24	significant trauma list
V02.60	Viral hepatitis carrier, unspecified	N	7	205, 206
V02.61	Hepatitis B carrier	N	7	205, 206
V02.62	Hepatitis C carrier	N	7	205, 206
V02.69	Other viral hepatitis carrier	N	7	205, 206
V12.40	Personal history of unspecified disorder of nervous system and sense organs.	N	23	467
V12.41	Personal history of benign neoplasm of the brain	N	23	467
V12.49	Personal history of other disorder of nervous system and sense organs	N	23	467
V16.40	Family history of malignant neoplasm of genital organ, unspecified	N	23	467
V16.41	Family history of malignant neoplasm of ovary	N	23	467
V16.42	Family history of malignant neoplasm of prostate	N	23	467
V16.43	Family history of malignant neoplasm of testis	N	23	467
V16.49	Family history of other malignant neoplasm	N	23	467
V28.6	Antenatal screening for streptococcus B	N	23	467
V42.81	Organ or tissue replaced by transplant, bone marrow	Y	16	398, 399
V42.82	Organ or tissue replaced by transplant, peripheral stem cells	Y	16	398, 399
V42.83	Organ or tissue replaced by transplant, pancreas	Y	7	204
V42.89	Other organ or tissue replaced by transplant	Y	23	467
V45.61	Cataract extraction status	N	23	467
V45.69	Other states following surgery of eye and adnexa	N	23	467
V45.71	Acquired absence of breast	N	23	467
V45.72	Acquired absence of intestine (large) (small)	N	23	467
V45.73	Acquired absence of kidney	N	23	467
V53.01	Fitting and adjustment of cerebral ventricular (communicating) shunt	N	23	467
V53.02	Fitting and adjustment of neuropacemaker (brain) (peripheral nerve) (Spinal cord).	N	23	467
V53.09	Fitting and adjustment of other devices related to nervous system and special senses.	N	23	467
V64.4	Laparoscopic surgical procedure converted to open procedure	N	23	467
V76.10	Screening for malignant neoplasm, breast screening, unspecified	N	23	467
V76.11	Screening mammogram for high-risk patient, malignant neoplasm of breast.	N	23	467
V76.12	Other screening mammogram for malignant neoplasm of breast	N	23	467
V76.19	Other screening breast examination for malignant neoplasm	N	23	467

[1] HIV major related condition in this DRG.
[2] Classified as a ''major problem''in these DRGs.
[3] Classified as a ''major complication'' in this DRG.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
37.35	Partial ventriculectomy	Y	5	108
41.05	Allogeneic hematopoietic stem cell transplant	Y	pre	481
41.06	Cord blood stem cell transplant	Y	pre	481

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
038.1	Staphylococcal septicemia	Y	15	387, 389[1]
			18	416, 417
			25	489[2]
275.4	Disorders of calcium metabolism	N	10	296, 297, 298
438	Late effects of cerebrovascular disease	N	1	12
474.0	Chronic tonsillitis and adenoiditis	N	pre	482
			3	68, 69, 70
686.0	Other local infections of skin and subcutaneous tissue, pyoderma	N	9	277, 278, 279
756.7	Other congenital anomalies of abdominal wall	N	6	188, 189, 190
780.3	Convulsions	Y	1	24, 25, 26
			15	387, 389[1]
959.0	Injury, other and unspecified of head, face, and neck	N	pre	482
			21	444, 445, 446
			24	significant trauma list
V02.6	Carrier or suspected carrier of viral hepatitis	N	7	205, 206
V12.4	Personal history of disorders of nervous system and sense organs	N	23	467
V16.4	Family history of malignant neoplasm of genital organs	N	23	467
V42.8	Unspecified organ or tissue replaced by transplant	Y	7	205, 206
V45.6	Other postsurgical state following surgery of eye and adnexa	N	23	467
V53.0	Fitting and adjustment of devices related to nervous system and special senses.	N	23	467
V76.1	Special screening for malignant neoplasm of the breast	N	23	467

[1] Classified as a ''major problem'' in these DRGs.
[2] HIV major related condition in this DRG.

TABLE 6D.—Revised Diagnosis Code Titles

Diagnosis code	Description	CC	MDC	DRG
041.04	Streptococcus infection in conditions classified elsewhere and of unspecified site, Group D (Enterococcus).	N	18	423

TABLE 6E.—ADDITIONS TO THE CC EXCLUSIONS LIST

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CCs that are added to the list are in Table 6E—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.

*0031	48284	48284	48284	01176	01354	01643	01771
03810	*01140	*01186	*01795	01180	01355	01644	01772
03811	48284	48284	48284	01181	01356	01645	01773
03819	*01141	*01190	*01796	01182	01360	01646	01774
*0074	48284	48284	48284	01183	01361	01650	01775
00841	*01142	*01191	*0202	01184	01362	01651	01776
00842	48284	48284	03810	01185	01363	01652	01780
00843	*01143	*01192	03811	01186	01364	01653	01781
00844	48284	48284	03819	01190	01365	01654	01782
00845	*01144	*01193	*0212	01191	01366	01655	01783
00846	48284	48284	48284	01192	01380	01656	01784
00847	*01145	*01194	*0310	01193	01381	01660	01785
00849	48284	48284	48284	01194	01382	01661	01786
*01100	*01146	*01195	*0312	01195	01383	01662	01790
48284	48284	48284	01100	01196	01384	01663	01791
*01101	*01150	*01196	01101	01200	01385	01664	01792
48284	48284	48284	01102	01201	01386	01665	01793
*01102	*01151	*01200	01103	01202	01390	01666	01794
48284	48284	48284	01104	01203	01391	01670	01795
*01103	*01152	*01201	01105	01204	01392	01671	01796
48284	48284	48284	01106	01205	01393	01672	01800
*01104	*01153	*01202	01110	01206	01394	01673	01801
48284	48284	48284	01111	01210	01395	01674	01802
*01105	*01154	*01203	01112	01211	01396	01675	01803
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*01106	*01155	*01204	01114	01213	01401	01690	01805
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*01110	*01156	*01205	01116	01215	01403	01692	01880
48284	48284	48284	01120	01216	01404	01693	01881
*01111	*01160	*01206	01121	01300	01405	01694	01882
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*01112	*01161	*01210	01123	01302	01480	01696	01884
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*01113	*01162	*01211	01125	01304	01483	01721	01886
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*01115	*01164	*01213	01132	01311	01600	01725	01893
48284	48284	48284	01133	01312	01601	01726	01894
*01116	*01165	*01214	01134	01313	01602	01730	01895
48284	48284	48284	01135	01314	01603	01731	01896
*01120	*01166	*01215	01136	01315	01604	01732	0310
48284	48284	48284	01140	01316	01605	01733	*0362
*01121	*01170	*01216	01141	01320	01606	01734	03810
48284	48284	48284	01142	01321	01610	01735	03811
*01122	*01171	*01280	01143	01322	01611	01736	03819
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*01123	*01172	*01281	01145	01324	01613	01741	03810
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*01124	*01173	*01282	01150	01326	01615	01743	03819
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*01125	*01174	*01283	01152	01331	01620	01745	0362
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*01133	*01182	*01791	01165	01344	01633	01761	03843
48284	48284	48284	01170	01345	01634	01762	03844
*01134	*01183	*01792	01171	01346	01635	01763	03849
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*01135	*01184	*01793	01173	01351	01640	01765	0389
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*01136	*01185	*01794	01175	01353	01642	01770	*03811

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6808	80021	80112	80222	80361	80452	85134	85225
6809	80022	80113	80223	80362	80453	85135	85226
6820	80023	80114	80224	80363	80454	85136	85229
6821	80024	80115	80225	80364	80455	85139	85230
6822	80025	80116	80226	80365	80456	85140	85231
6823	80026	80119	80227	80366	80459	85141	85232
6825	80029	80120	80228	80369	80460	85142	85233
6826	80030	80121	80229	80370	80461	85143	85234
6827	80031	80122	80230	80371	80462	85144	85235
6828	80032	80123	80231	80372	80463	85145	85236
6829	80033	80124	80232	80373	80464	85146	85239
684	80034	80125	80233	80374	80465	85149	85240
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6800	80036	80129	80235	80376	80469	85151	85242
6801	80039	80130	80236	80379	80470	85152	85243
6802	80040	80131	80237	80380	80471	85153	85244
6803	80041	80132	80238	80381	80472	85154	85245
6804	80042	80133	80239	80382	80473	85155	85246
6805	80043	80134	8024	80383	80474	85156	85249
6806	80044	80135	8025	80384	80475	85159	85250
6807	80045	80136	8026	80385	80476	85160	85251
6808	80046	80139	8027	80386	80479	85161	85252
6809	80049	80140	8028	80389	80480	85162	85253
6820	80050	80141	8029	80390	80481	85163	85254
6821	80051	80142	80300	80391	80482	85164	85255
6822	80052	80143	80301	80392	80483	85165	85256
6823	80053	80144	80302	80393	80484	85166	85259
6825	80054	80145	80303	80394	80485	85169	85300
6826	80055	80146	80304	80395	80486	85170	85301
6827	80056	80149	80305	80396	80489	85171	85302
6828	80059	80150	80306	80399	80490	85172	85303
6829	80060	80151	80309	80400	80491	85173	85304
684	80061	80152	80310	80401	80492	85174	85305
*74861	80062	80153	80311	80402	80493	85175	85306
48284	80063	80154	80312	80403	80494	85176	85309
*7790	80064	80155	80313	80404	80495	85179	85310
78031	80065	80156	80314	80405	80496	85180	85311
78039	80066	80159	80315	80406	80499	85181	85312
*7791	80069	80160	80316	80409	8500	85182	85313
78031	80070	80161	80319	80410	8501	85183	85314
78039	80071	80162	80320	80411	8502	85184	85315
*78031	80072	80163	80321	80412	8503	85185	85316
78031	80073	80164	80322	80413	8504	85186	85319
78039	80074	80165	80323	80414	8505	85189	85400
*78039	80075	80166	80324	80415	8509	85190	85401
78031	80076	80169	80325	80416	85100	85191	85402
78039	80079	80170	80326	80419	85101	85192	85403
*7809	80080	80171	80329	80420	85102	85193	85404
78031	80081	80172	80330	80421	85103	85194	85405
78039	80082	80173	80331	80422	85104	85195	85406
*79094	80083	80174	80332	80423	85105	85196	85409
7907	80084	80175	80333	80424	85106	85199	85410
*7998	80085	80176	80334	80425	85109	85200	85411
78031	80086	80179	80335	80426	85110	85201	85412
78039	80089	80180	80336	80429	85111	85202	85413
*95901	80090	80181	80339	80430	85112	85203	85414
80000	80091	80182	80340	80431	85113	85204	85415
80001	80092	80183	80341	80432	85114	85205	85416
80002	80093	80184	80342	80433	85115	85206	85419
80003	80094	80185	80343	80434	85116	85209	9251
80004	80095	80186	80344	80435	85119	85210	9252
80005	80096	80189	80345	80436	85120	85211	*95909
80006	80099	80190	80346	80439	85121	85212	80000
80009	80100	80191	80349	80440	85122	85213	80001
80010	80101	80192	80350	80441	85123	85214	80002
80011	80102	80193	80351	80442	85124	85215	80003
80012	80103	80194	80352	80443	85125	85216	80004
80013	80104	80195	80353	80444	85126	85219	80005
80014	80105	80196	80354	80445	85129	85220	80006
80015	80106	80199	80355	80446	85130	85221	80009
80016	80109	8021	80356	80449	85131	85222	80010

80011	80102	80193	80351	80442	85124	85215	V4282
80012	80103	80194	80352	80443	85125	85216	V4283
80013	80104	80195	80353	80444	85126	85219	V4289
80014	80105	80196	80354	80445	85129	85220	*99685
80015	80106	80199	80355	80446	85130	85221	V4281
80016	80109	8021	80356	80449	85131	85222	*99686
80019	80110	80220	80359	80450	85132	85223	V4283
80020	80111	80221	80360	80451	85133	85224	*99689
80021	80112	80222	80361	80452	85134	85225	V4289
80022	80113	80223	80362	80453	85135	85226	*V090
80023	80114	80224	80363	80454	85136	85229	03810
80024	80115	80225	80364	80455	85139	85230	03811
80025	80116	80226	80365	80456	85140	85231	03819
80026	80119	80227	80366	80459	85141	85232	*V091
80029	80120	80228	80369	80460	85142	85233	03810
80030	80121	80229	80370	80461	85143	85234	03811
80031	80122	80230	80371	80462	85144	85235	03819
80032	80123	80231	80372	80463	85145	85236	*V092
80033	80124	80232	80373	80464	85146	85239	03810
80034	80125	80233	80374	80465	85149	85240	03811
80035	80126	80234	80375	80466	85150	85241	03819
80036	80129	80235	80376	80469	85151	85242	*V093
80039	80130	80236	80379	80470	85152	85243	03810
80040	80131	80237	80380	80471	85153	85244	03811
80041	80132	80238	80381	80472	85154	85245	03819
80042	80133	80239	80382	80473	85155	85246	*V094
80043	80134	8024	80383	80474	85156	85249	03810
80044	80135	8025	80384	80475	85159	85250	03811
80045	80136	8026	80385	80476	85160	85251	03819
80046	80139	8027	80386	80479	85161	85252	*V0950
80049	80140	8028	80389	80480	85162	85253	03810
80050	80141	8029	80390	80481	85163	85254	03811
80051	80142	80300	80391	80482	85164	85255	03819
80052	80143	80301	80392	80483	85165	85256	*V0951
80053	80144	80302	80393	80484	85166	85259	03810
80054	80145	80303	80394	80485	85169	85300	03811
80055	80146	80304	80395	80486	85170	85301	03819
80056	80149	80305	80396	80489	85171	85302	*V096
80059	80150	80306	80399	80490	85172	85303	03810
80060	80151	80309	80400	80491	85173	85304	03811
80061	80152	80310	80401	80492	85174	85305	03819
80062	80153	80311	80402	80493	85175	85306	*V0970
80063	80154	80312	80403	80494	85176	85309	03810
80064	80155	80313	80404	80495	85179	85310	03811
80065	80156	80314	80405	80496	85180	85311	03819
80066	80159	80315	80406	80499	85181	85312	*V0971
80069	80160	80316	80409	8500	85182	85313	03810
80070	80161	80319	80410	8501	85183	85314	03811
80071	80162	80320	80411	8502	85184	85315	03819
80072	80163	80321	80412	8503	85185	85316	*V0980
80073	80164	80322	80413	8504	85186	85319	03810
80074	80165	80323	80414	8505	85189	85400	03811
80075	80166	80324	80415	8509	85190	85401	03819
80076	80169	80325	80416	85100	85191	85402	*V0981
80079	80170	80326	80419	85101	85192	85403	03810
80080	80171	80329	80420	85102	85193	85404	03811
80081	80172	80330	80421	85103	85194	85405	03819
80082	80173	80331	80422	85104	85195	85406	*V0990
80083	80174	80332	80423	85105	85196	85409	03810
80084	80175	80333	80424	85106	85199	85410	03811
80085	80176	80334	80425	85109	85200	85411	03819
80086	80179	80335	80426	85110	85201	85412	*V0991
80089	80180	80336	80429	85111	85202	85413	03810
80090	80181	80339	80430	85112	85203	85414	03811
80091	80182	80340	80431	85113	85204	85415	03819
80092	80183	80341	80432	85114	85205	85416	*V4283
80093	80184	80342	80433	85115	85206	85419	V4283
80094	80185	80343	80434	85116	85209	9251	*V4289
80095	80186	80344	80435	85119	85210	9252	V420
80096	80189	80345	80436	85120	85211	*99664	V421
80099	80190	80346	80439	85121	85212	5990	V422
80100	80191	80349	80440	85122	85213	*99680	V426
80101	80192	80350	80441	85123	85214	V4281	V427

V4289 *V429 V4281 V4282 V4283 V4289							

TABLE 6F.—DELETIONS TO THE CC EXCLUSIONS LIST

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CCs that are deleted from the list are in Table 6F—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.

*0031	0381	7803	80039	80123	80226	80360	80444
0381	*0414	*34989	80040	80124	80227	80361	80445
*0202	0381	7803	80041	80125	80228	80362	80446
0381	*0415	*3499	80042	80126	80229	80363	80449
*0362	0381	7803	80043	80129	80230	80364	80450
0381	*0416	*6860	80044	80130	80231	80365	80451
*0380	0381	6800	80045	80131	80232	80366	80452
0381	*0417	6801	80046	80132	80233	80369	80453
*0381	0381	6802	80049	80133	80234	80370	80454
0362	*04181	6803	80050	80134	80235	80371	80455
0380	0381	6804	80051	80135	80236	80372	80456
0381	*04182	6805	80052	80136	80237	80373	80459
0382	0381	6806	80053	80139	80238	80374	80460
0383	*04183	6807	80054	80140	80239	80375	80461
03840	0381	6808	80055	80141	8024	80376	80462
03841	*04184	6809	80056	80142	8025	80379	80463
03842	0381	6820	80059	80143	8026	80380	80464
03843	*04185	6821	80060	80144	8027	80381	80465
03844	0381	6822	80061	80145	8028	80382	80466
03849	*04186	6823	80062	80146	8029	80383	80469
0388	0381	6825	80063	80149	80300	80384	80470
0389	*04189	6826	80064	80150	80301	80385	80471
0545	0381	6827	80065	80151	80302	80386	80472
*0382	*0419	6828	80066	80152	80303	80389	80473
0381	0381	6829	80069	80153	80304	80390	80474
*0383	*0545	684	80070	80154	80305	80391	80475
0381	0381	*7790	80071	80155	80306	80392	80476
*03840	*1398	7803	80072	80156	80309	80393	80479
0381	0381	*7791	80073	80159	80310	80394	80480
*03841	*34500	7803	80074	80160	80311	80395	80481
0381	7803	*7803	80075	80161	80312	80396	80482
*03842	*34501	7803	80076	80162	80313	80399	80483
0381	7803	*7809	80079	80163	80314	80400	80484
*03843	*34510	7803	80080	80164	80315	80401	80485
0381	7803	*7998	80081	80165	80316	80402	80486
*03844	*34511	7803	80082	80166	80319	80403	80489
0381	7803	*9590	80083	80169	80320	80404	80490
*03849	*3452	80000	80084	80170	80321	80405	80491
0381	7803	80001	80085	80171	80322	80406	80492
*0388	*3453	80002	80086	80172	80323	80409	80493
0381	7803	80003	80089	80173	80324	80410	80494
*0389	*34540	80004	80090	80174	80325	80411	80495
0381	7803	80005	80091	80175	80326	80412	80496
*04089	*34541	80006	80092	80176	80329	80413	80499
0381	7803	80009	80093	80179	80330	80414	8500
*04100	*34550	80010	80094	80180	80331	80415	8501
0381	7803	80011	80095	80181	80332	80416	8502
*04101	*34551	80012	80096	80182	80333	80419	8503
0381	7803	80013	80099	80183	80334	80420	8504
*04102	*34560	80014	80100	80184	80335	80421	8505
0381	7803	80015	80101	80185	80336	80422	8509
*04103	*34561	80016	80102	80186	80339	80423	85100
0381	7803	80019	80103	80189	80340	80424	85101
*04104	*34570	80020	80104	80190	80341	80425	85102
0381	7803	80021	80105	80191	80342	80426	85103
*04105	*34571	80022	80106	80192	80343	80429	85104
0381	7803	80023	80109	80193	80344	80430	85105
*04109	*34580	80024	80110	80194	80345	80431	85106
0381	7803	80025	80111	80195	80346	80432	85109
*04110	*34581	80026	80112	80196	80349	80433	85110
0381	7803	80029	80113	80199	80350	80434	85111
*04111	*34590	80030	80114	8021	80351	80435	85112
0381	7803	80031	80115	80220	80352	80436	85113
*04119	*34591	80032	80116	80221	80353	80439	85114
0381	7803	80033	80119	80222	80354	80440	85115
*0412	*3488	80034	80120	80223	80355	80441	85116
0381	7803	80035	80121	80224	80356	80442	85119
*0413	*3489	80036	80122	80225	80359	80443	85120

85121	85212	V428
85122	85213	*99686
85123	85214	V428
85124	85215	*99689
85125	85216	V428
85126	85219	*V090
85129	85220	0381
85130	85221	*V091
85131	85222	0381
85132	85223	*V092
85133	85224	0381
85134	85225	*V093
85135	85226	0381
85136	85229	*V094
85139	85230	0381
85140	85231	*V0950
85141	85232	0381
85142	85233	*V0951
85143	85234	0381
85144	85235	*V096
85145	85236	0381
85146	85239	*V0970
85149	85240	0381
85150	85241	*V0971
85151	85242	0381
85152	85243	*V0980
85153	85244	0381
85154	85245	*V0981
85155	85246	0381
85156	85249	*V0990
85159	85250	0381
85160	85251	*V0991
85161	85252	0381
85162	85253	*V428
85163	85254	V420
85164	85255	V421
85165	85256	V422
85166	85259	V426
85169	85300	V427
85170	85301	V428
85171	85302	*V429
85172	85303	V428
85173	85304	
85174	85305	
85175	85306	
85176	85309	
85179	85310	
85180	85311	
85181	85312	
85182	85313	
85183	85314	
85184	85315	
85185	85316	
85186	85319	
85189	85400	
85190	85401	
85191	85402	
85192	85403	
85193	85404	
85194	85405	
85195	85406	
85196	85409	
85199	85410	
85200	85411	
85201	85412	
85202	85413	
85203	85414	
85204	85415	
85205	85416	
85206	85419	
85209	9251	
85210	9252	
85211	*99680	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36951	10.0648	2	4	7	13	21
2	6901	10.5740	3	5	8	13	21
3	2	50.5000	1	1	100	100	100
4	6300	8.4741	2	3	6	10	18
5	103092	3.9356	1	2	3	4	8
6	421	3.2470	1	1	2	4	7
7	12078	11.7014	3	5	8	13	22
8	2117	3.8427	1	1	3	5	8
9	1748	7.1070	1	3	5	9	14
10	20265	7.2705	2	3	5	9	15
11	2958	4.2559	1	2	3	6	9
12	26164	6.8367	2	3	5	8	13
13	6421	5.7728	2	3	5	7	10
14	377267	6.7453	2	3	5	8	13
15	145885	4.0663	1	2	3	5	7
16	14071	6.0968	2	3	5	7	11
17	3095	3.6927	1	2	3	5	7
18	24288	5.7924	2	3	4	7	11
19	6604	4.0893	1	2	3	5	8
20	8247	9.3961	2	4	7	12	19
21	1192	7.1032	2	3	5	9	14
22	2904	4.7600	2	2	4	6	9
23	6081	4.5469	1	2	3	6	9
24	58223	5.3289	1	2	4	6	10
25	22286	3.6092	1	2	3	4	7
26	42	5.0952	1	2	4	7	11
27	3845	5.5004	1	1	3	7	13
28	12715	6.3270	1	2	4	8	13
29	4005	3.7231	1	2	3	5	7
30	1	4.0000	4	4	4	4	4
31	3086	4.7664	1	2	3	6	9
32	1434	3.0718	1	1	2	3	6
34	18587	5.8145	1	3	4	7	11
35	3733	3.9207	1	2	3	5	7
36	6765	1.5441	1	1	1	2	2
37	1771	3.9283	1	1	3	5	8
38	197	2.7411	1	1	2	3	5
39	2564	2.0035	1	1	1	2	4
40	2657	3.4159	1	1	2	4	7
42	5414	1.9762	1	1	1	2	4
43	111	3.9910	1	2	3	5	7
44	1477	5.2275	2	3	4	7	9
45	2356	3.6006	1	2	3	5	7
46	3021	4.8431	1	2	4	6	9
47	1182	3.9619	1	1	3	4	7
49	2389	5.2704	1	2	4	6	10
50	3294	2.1072	1	1	2	2	3
51	351	2.8775	1	1	2	3	6
52	91	3.0000	1	1	2	4	7
53	3107	3.6028	1	1	2	4	8
54	2	5.0000	1	1	9	9	9
55	1907	2.9240	1	1	2	3	6
56	749	2.8451	1	1	2	3	6
57	659	3.9484	1	1	2	4	8
58	1	2.0000	2	2	2	2	2
59	106	3.3302	1	1	2	4	6
60	3	1.0000	1	1	1	1	1
61	243	4.5473	1	1	3	5	11
63	3794	4.6009	1	2	3	5	9
64	3378	6.6442	1	2	5	8	14
65	29490	3.1698	1	2	3	4	6
66	6602	3.4727	1	2	3	4	6
67	495	3.8061	1	2	3	5	7
68	10227	4.3213	2	2	4	5	8
69	2963	3.4715	1	2	3	4	6
70	40	3.3000	1	2	3	4	5
71	128	3.9297	1	2	3	5	7
72	725	3.4897	1	2	3	4	7
73	6260	4.6725	1	2	4	6	9
74	4	3.2500	1	1	2	3	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	41372	10.5497	4	5	8	13	20
76	41405	11.7204	3	6	9	14	22
77	2204	5.0912	1	2	4	7	10
78	31193	7.6312	3	5	7	9	13
79	239360	8.6345	3	4	7	11	16
80	8157	6.0829	2	3	5	7	11
81	22	10.2727	1	6	8	11	15
82	71319	7.3214	2	3	6	9	14
83	7516	5.8950	2	3	5	7	11
84	1542	3.4540	1	2	3	4	6
85	20847	6.8707	2	3	5	9	13
86	1389	4.0662	1	2	3	5	8
87	67801	6.4419	1	3	5	8	12
88	361166	5.6526	2	3	5	7	10
89	430920	6.5608	3	4	5	8	12
90	37020	4.6802	2	3	4	6	8
91	77	5.1818	2	3	4	7	9
92	13624	6.6358	2	3	5	8	12
93	1172	4.6860	1	2	4	6	9
94	13846	6.6439	2	3	5	8	13
95	1449	3.9786	1	2	3	5	7
96	59271	5.0562	2	3	4	6	9
97	24153	3.9977	1	2	3	5	7
98	29	2.8621	1	1	2	4	6
99	26718	3.1667	1	1	2	4	6
100	10247	2.2335	1	1	2	3	4
101	20620	4.7299	1	2	4	6	9
102	4570	2.8967	1	1	2	4	5
103	538	47.8662	9	15	32	72	105
104	26488	13.3264	5	8	11	16	24
105	23028	10.2064	5	6	8	12	18
106	107702	11.0480	6	7	9	13	18
107	68747	8.3098	5	6	7	9	13
108	7536	12.0882	4	7	10	15	23
110	63731	10.0931	3	6	8	12	19
111	5575	6.1189	2	4	6	7	9
112	219732	4.2374	1	2	3	6	8
113	48124	13.1573	4	6	9	16	26
114	9126	8.8386	2	4	7	11	17
115	11726	10.2988	4	6	8	13	18
116	88158	5.0220	1	2	4	6	10
117	3828	4.0470	1	1	3	5	9
118	6772	3.0371	1	1	2	4	7
119	1690	5.1065	1	1	3	7	11
120	39847	8.4640	1	2	5	11	19
121	167101	6.9259	2	4	6	9	12
122	91350	4.6310	1	2	4	6	8
123	46249	4.4859	1	1	2	6	11
124	153500	4.5902	1	2	4	6	9
125	61076	2.9372	1	1	2	4	6
126	5166	12.8142	4	6	10	16	26
127	709234	5.7990	2	3	5	7	11
128	18597	6.3449	3	4	6	7	10
129	4489	3.1644	1	1	1	3	7
130	100017	6.2985	2	4	5	8	11
131	25586	4.8476	1	3	5	6	8
132	165201	3.3138	1	2	3	4	6
133	6160	2.7940	1	1	2	3	5
134	29603	3.6026	1	2	3	4	7
135	8086	4.4369	1	2	3	5	8
136	1150	3.0504	1	1	2	4	6
137	5	6.6000	2	2	4	8	16
138	208756	4.1947	1	2	3	5	8
139	65753	2.7449	1	1	2	3	5
140	135211	3.1677	1	2	3	4	6
141	78555	4.0801	1	2	3	5	7
142	35677	2.9447	1	1	2	4	5
143	138162	2.3966	1	1	2	3	4
144	76696	5.3747	1	2	4	7	11
145	6380	2.9914	1	1	2	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
146	9882	10.5266	6	7	9	12	17
147	1674	6.9050	4	5	7	8	10
148	149728	12.6192	6	7	10	15	22
149	14277	7.1339	4	5	7	8	10
150	24560	11.1072	4	6	9	14	20
151	4267	6.1198	2	3	6	8	11
152	4715	8.4846	4	5	7	10	14
153	1651	5.7965	3	4	6	7	9
154	35216	14.0534	4	7	11	17	27
155	4555	5.0119	1	2	4	7	9
156	4	10.7500	3	3	4	5	31
157	9472	5.6010	1	2	4	7	11
158	4361	2.7845	1	1	2	4	6
159	18297	5.0699	1	2	4	6	10
160	9547	2.7709	1	1	2	4	5
161	14988	4.2180	1	2	3	5	9
162	7391	2.0894	1	1	1	3	4
163	11	4.4545	1	1	2	6	10
164	5375	8.7116	4	5	7	10	15
165	1597	5.4264	2	3	5	7	8
166	3365	5.4155	2	3	4	7	10
167	2278	2.9622	1	2	3	4	5
168	1877	4.7475	1	2	3	6	9
169	952	2.5620	1	1	2	3	5
170	13057	11.7430	2	5	9	15	23
171	1059	5.0888	1	2	4	6	10
172	33117	7.3971	2	3	5	9	15
173	2099	3.9700	1	2	3	5	8
174	240184	5.1454	2	3	4	6	9
175	21544	3.2351	1	2	3	4	6
176	17948	5.7574	2	3	4	7	11
177	11802	4.7312	2	3	4	6	8
178	3790	3.3570	1	2	3	4	6
179	12184	6.7228	2	3	5	8	13
180	89240	5.6541	2	3	4	7	11
181	21350	3.7182	1	2	3	5	7
182	239229	4.5646	1	2	4	6	8
183	70013	3.1776	1	2	3	4	6
184	89	3.7191	1	2	3	4	7
185	4134	4.8181	1	2	4	6	10
186	3	3.6667	2	2	4	5	5
187	932	3.9635	1	2	3	5	8
188	70899	5.7808	1	3	4	7	11
189	7941	3.3871	1	1	3	4	7
190	99	4.8990	1	2	3	6	11
191	11157	14.8611	4	7	11	18	30
192	780	7.1346	2	4	6	9	12
193	8380	12.9029	5	7	11	16	23
194	663	7.5053	2	4	6	9	13
195	8780	9.8539	4	6	8	12	17
196	631	6.3376	3	4	6	8	10
197	27389	8.6974	3	5	7	10	15
198	7098	4.7201	2	3	4	6	8
199	2177	10.7184	3	5	8	14	22
200	1549	11.2608	2	4	8	14	23
201	1562	15.0506	4	7	11	19	29
202	28593	7.0940	2	3	5	9	14
203	29628	7.1561	2	3	6	9	14
204	53350	6.3392	2	3	5	8	12
205	23158	6.7829	2	3	5	8	14
206	1672	4.2189	1	2	3	5	8
207	37032	5.2825	1	2	4	7	10
208	9961	3.0344	1	1	2	4	6
209	358501	5.8935	3	4	5	7	9
210	143703	7.6287	4	5	6	9	13
211	26316	5.6097	3	4	5	7	9
212	41	6.1220	3	4	5	7	9
213	7179	8.7551	2	4	7	11	17
214	58431	5.8904	2	3	5	7	11
215	45646	3.2827	1	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
216	6407	10.2995	2	4	8	13	21
217	20940	13.7538	3	5	9	17	29
218	24873	5.6276	2	3	4	7	10
219	18972	3.4441	1	2	3	4	6
220	4	4.7500	1	1	4	4	10
221	5180	7.1959	2	3	5	9	14
222	3506	3.8189	1	2	3	5	7
223	19625	2.6998	1	1	2	3	5
224	8139	2.1058	1	1	2	3	4
225	5926	4.6232	1	2	3	6	10
226	5570	6.2548	1	2	4	7	13
227	4376	2.8551	1	1	2	3	5
228	2997	3.4525	1	1	2	4	7
229	1232	2.3612	1	1	2	3	4
230	2492	4.9767	1	2	3	6	10
231	11066	4.7603	1	2	3	6	10
232	556	4.2248	1	1	2	5	9
233	4761	8.2728	2	3	6	10	17
234	2195	3.8893	1	2	3	5	8
235	5557	5.8101	1	3	4	6	11
236	39976	5.5846	2	3	4	7	10
237	1669	4.2151	1	2	3	5	8
238	7672	9.3749	3	4	7	11	17
239	60788	6.9705	2	3	5	8	13
240	13393	6.9364	2	3	5	8	14
241	3016	4.2338	1	2	3	5	8
242	2855	7.1338	2	3	5	9	14
243	80934	5.1228	2	3	4	6	9
244	12524	5.4313	1	3	4	6	10
245	4417	4.0906	1	2	3	5	7
246	1276	4.2226	1	2	3	5	8
247	11504	3.6954	1	2	3	5	7
248	7427	4.9740	1	2	4	6	9
249	10422	3.9731	1	1	3	5	8
250	3591	4.6441	1	2	3	5	9
251	2139	3.0108	1	1	2	4	5
253	19173	5.2500	1	3	4	6	10
254	9369	3.5203	1	2	3	4	6
255	1	6.0000	6	6	6	6	6
256	4438	5.6717	1	2	4	7	11
257	22791	3.2063	1	2	3	4	6
258	17069	2.2799	1	1	2	3	4
259	4037	3.1962	1	1	2	3	7
260	4576	1.6635	1	1	1	2	3
261	2262	2.2396	1	1	2	3	4
262	669	3.9746	1	1	3	5	8
263	29336	12.5322	3	5	9	15	24
264	3380	7.2843	2	3	6	9	14
265	4205	7.2542	1	2	5	8	15
266	2585	3.5528	1	1	2	5	7
267	226	4.1770	1	1	2	5	8
268	1218	3.7373	1	1	2	4	7
269	10131	8.4881	2	3	6	11	17
270	3100	3.2032	1	1	2	4	7
271	23041	7.7309	3	4	6	9	14
272	6022	6.6724	2	3	5	8	13
273	1397	5.3672	1	2	4	6	11
274	2648	7.1650	1	3	5	9	15
275	243	3.8477	1	1	2	5	8
276	953	4.7408	1	3	4	6	8
277	80661	6.2256	2	3	5	7	11
278	24965	4.8286	2	3	4	6	8
279	7	4.4286	2	2	4	6	6
280	14005	4.6941	1	2	3	6	9
281	5939	3.3597	1	1	3	4	6
282	5	12.0000	1	1	3	14	41
283	5325	5.0186	1	2	4	6	10
284	1764	3.5595	1	2	3	5	7
285	5653	12.0637	3	5	9	15	23
286	2085	7.1947	3	4	5	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
287	6742	12.2094	3	5	8	14	24
288	1244	5.8457	3	4	5	6	9
289	5512	3.4799	1	1	2	3	7
290	8856	2.5833	1	1	2	3	4
291	93	2.1720	1	1	2	3	4
292	5234	11.2042	2	4	8	14	22
293	276	5.8406	1	2	4	7	11
294	84535	5.2478	2	3	4	6	10
295	3739	4.1038	1	2	3	5	8
296	233162	5.7612	2	3	4	7	11
297	32036	3.8589	1	2	3	5	7
298	122	3.1066	1	1	2	4	6
299	1152	5.4852	1	2	4	7	11
300	15755	6.6292	2	3	5	8	13
301	1988	4.3622	1	2	3	5	8
302	8343	10.9475	5	6	8	13	19
303	19359	9.4651	4	5	8	11	17
304	13173	9.5951	2	4	7	12	19
305	2468	4.3302	1	2	4	5	8
306	11672	5.7598	1	2	4	7	12
307	2489	2.5372	1	1	2	3	4
308	9750	6.3917	1	2	4	8	13
309	3377	2.5579	1	1	2	3	5
310	27613	4.3385	1	2	3	5	9
311	8533	2.0550	1	1	2	2	4
312	1880	4.6824	1	2	3	6	10
313	664	2.2846	1	1	2	3	5
315	28798	8.5390	1	2	5	11	19
316	85489	6.9920	2	3	5	9	14
317	858	2.9231	1	1	2	3	6
318	6203	6.6381	1	3	5	8	13
319	433	2.8730	1	1	2	4	6
320	176972	5.8722	2	3	5	7	10
321	23634	4.2737	2	3	4	5	7
322	102	4.4706	2	2	3	5	9
323	17539	3.3728	1	1	2	4	7
324	8050	2.0060	1	1	2	2	4
325	7041	4.1976	1	2	3	5	8
326	2111	2.9019	1	1	2	4	5
327	15	3.1333	1	1	2	3	12
328	678	3.9189	1	2	3	5	8
329	108	2.4352	1	1	2	3	5
331	44368	5.8405	2	3	4	7	11
332	4485	3.5376	1	1	3	5	7
333	348	5.6063	1	2	4	7	12
334	19424	5.4204	3	4	5	6	8
335	9808	4.0533	2	3	4	5	6
336	59377	3.7626	1	2	3	4	7
337	34315	2.4154	1	2	2	3	4
338	3738	5.0698	1	2	3	6	11
339	2131	4.5861	1	2	3	6	10
340	1	1.0000	1	1	1	1	1
341	5981	3.1155	1	1	2	3	6
342	194	4.1649	1	2	3	6	8
344	3544	3.1168	1	1	2	3	6
345	1364	3.8043	1	1	3	5	8
346	5207	6.2906	1	3	5	8	12
347	382	2.9503	1	1	2	4	6
348	3220	4.4851	1	2	3	5	8
349	744	2.6788	1	1	2	3	5
350	6367	4.6220	2	3	4	6	8
351	2	2.5000	2	2	3	3	3
352	551	3.9800	1	1	3	5	8
353	2722	8.3420	3	4	6	9	16
354	10008	5.9796	3	3	5	7	10
355	5600	3.6289	2	3	3	4	5
356	29930	2.8076	1	2	3	3	4
357	6625	9.3250	4	5	7	11	17
358	28909	4.4699	2	3	4	5	7
359	28338	3.0915	2	2	3	4	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
360	18232	3.2826	1	2	3	4	5
361	680	3.6721	1	1	2	4	8
362	1	1.0000	1	1	1	1	1
363	3930	3.4725	1	2	2	3	7
364	1869	3.4912	1	1	2	4	7
365	2454	7.1520	1	2	4	9	16
366	4504	6.9896	1	3	5	9	15
367	546	2.9579	1	1	2	4	6
368	2396	6.2371	2	3	5	8	12
369	2388	3.4317	1	1	2	4	7
370	1223	5.5078	2	3	4	5	9
371	1108	3.5903	2	3	3	4	5
372	909	3.1177	1	2	2	3	5
373	4166	2.0290	1	1	2	2	3
374	170	2.8824	1	2	2	3	4
375	7	8.4286	1	2	5	9	15
376	219	3.2055	1	1	2	4	7
377	51	4.0196	1	1	2	4	9
378	195	2.6256	1	2	2	3	4
379	374	2.9278	1	1	2	3	5
380	101	1.8317	1	1	1	2	4
381	184	2.2935	1	1	1	2	5
382	48	1.3333	1	1	1	1	2
383	1616	3.8342	1	2	3	5	8
384	142	2.8380	1	1	2	3	6
385	5	4.6000	1	1	2	4	15
386	1	49.0000	49	49	49	49	49
387	1	62.0000	62	62	62	62	62
389	24	7.1667	3	3	5	10	13
390	12	5.3333	2	3	4	7	7
392	2562	10.5863	4	5	8	13	21
393	2	11.0000	7	7	15	15	15
394	1814	7.5232	1	2	5	9	16
395	68196	4.9807	1	2	4	6	10
396	20	4.1500	1	1	2	7	7
397	16987	5.7650	1	2	4	7	11
398	18423	6.2558	2	3	5	8	12
399	1310	4.0099	1	2	3	5	7
400	7882	9.7265	2	3	7	12	21
401	6799	11.6851	2	5	9	15	24
402	1510	4.2391	1	1	3	6	9
403	39216	8.5824	2	3	6	11	18
404	3829	4.6453	1	2	4	6	9
406	3486	10.0688	3	4	7	13	21
407	700	4.4243	1	2	4	6	8
408	2860	7.6731	1	2	5	9	18
409	5606	5.9144	2	3	4	6	12
410	74662	3.3563	1	2	3	4	5
411	34	2.2941	1	1	1	3	6
412	30	3.3667	1	1	2	5	7
413	8828	8.0319	2	3	6	10	16
414	735	4.5456	1	2	3	6	10
415	44981	14.8907	4	7	11	18	29
416	220088	7.6836	2	4	6	9	14
417	55	4.5818	1	2	4	6	9
418	20660	6.3190	2	3	5	8	12
419	14953	5.2321	2	3	4	6	10
420	2640	3.9807	1	2	3	5	7
421	10782	4.2452	1	2	3	5	8
422	90	3.7889	1	2	3	4	5
423	10952	7.9356	2	3	6	9	16
424	1953	16.5996	2	6	10	19	31
425	15583	4.3857	1	2	3	5	8
426	4758	5.2222	1	2	4	6	11
427	1712	5.2652	1	2	4	7	11
428	944	7.6684	1	3	5	9	16
429	42557	7.8378	2	3	5	9	15
430	56337	9.0138	2	4	7	11	18
431	222	8.8694	2	3	5	9	17
432	412	5.8422	1	2	3	7	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
433	8265	3.2904	1	1	2	4	7
434	22732	5.2870	2	3	4	6	10
435	16634	4.5310	1	2	4	5	8
436	3556	13.7657	4	8	13	20	26
437	15721	9.9200	4	6	9	13	18
439	1050	8.4581	1	3	6	10	18
440	4863	9.5690	2	3	6	11	20
441	617	3.4376	1	1	2	4	7
442	15740	8.2971	1	3	6	10	17
443	3008	3.3597	1	1	2	4	7
444	3385	4.7634	1	2	4	6	9
445	1251	3.6922	1	1	3	4	6
447	4174	2.6416	1	1	2	3	5
448	29	1.0000	1	1	1	1	1
449	28968	4.0303	1	1	3	5	8
450	6370	2.2462	1	1	1	2	4
451	4	3.0000	1	1	1	2	8
452	21590	5.1530	1	2	4	6	10
453	3635	3.0908	1	1	2	4	6
454	3990	5.1709	1	2	3	6	10
455	908	2.7555	1	1	2	3	6
456	215	7.2930	1	1	3	7	16
457	113	4.8938	1	1	2	6	14
458	1680	15.9685	3	6	12	21	33
459	576	9.3247	2	4	7	12	19
460	2331	6.3218	1	3	5	8	13
461	3249	4.5940	1	1	2	5	11
462	10116	12.9741	4	6	11	17	24
463	13488	4.7710	1	2	4	6	9
464	3208	3.4439	1	2	3	4	7
465	214	3.7477	1	1	2	4	7
466	1783	4.6983	1	1	2	5	10
467	1616	4.2092	1	1	2	4	8
468	63517	13.9982	3	6	11	18	28
471	11672	6.7301	3	4	5	8	11
472	203	24.2217	1	5	18	34	57
473	8739	13.3296	2	4	7	19	34
475	101069	11.4529	2	5	9	15	22
476	6630	12.6427	3	7	11	16	23
477	30337	8.0163	1	2	6	10	16
478	127616	7.6905	1	3	6	10	16
479	17990	4.1819	1	2	3	5	8
480	552	28.5435	9	12	20	36	61
481	157	34.0064	19	23	30	41	54
482	7059	13.4577	5	7	10	15	24
483	40160	43.1397	14	22	34	52	79
484	407	15.4496	3	7	11	20	30
485	3514	10.5552	4	5	8	12	20
486	2589	13.2503	1	6	10	17	26
487	4371	8.1078	2	3	6	10	16
488	1774	16.5141	4	7	12	20	32
489	19038	9.5586	2	4	7	12	20
490	5460	6.0205	1	2	4	7	12
491	10763	3.9181	2	2	3	4	7
492	2229	17.9740	4	5	14	28	37
493	56791	5.6668	1	2	4	7	11
494	25112	2.3755	1	1	2	3	5
495	140	16.9714	8	11	15	20	30
	11173210						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35984	10.2675	2	4	7	13	21
2	6901	10.5740	3	5	8	13	21

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
3	2	50.5000	1	1	100	100	100
4	6301	8.4750	2	3	6	10	18
5	103092	3.9356	1	2	3	4	8
6	421	3.2470	1	1	2	4	7
7	12609	11.3616	2	4	8	13	21
8	2940	3.2000	1	1	2	4	7
9	1754	7.1249	1	3	5	9	14
10	20278	7.2768	2	3	5	9	15
11	2956	4.2534	1	2	3	6	9
12	26180	6.8448	2	3	5	8	13
13	6419	5.7747	2	3	5	7	10
14	377399	6.7458	2	3	5	8	13
15	145920	4.0669	1	2	3	5	7
16	14076	6.0979	2	3	5	7	11
17	3098	3.6927	1	2	3	5	7
18	25872	5.8632	2	3	4	7	11
19	7162	4.1086	1	2	3	5	8
20	6113	10.4880	2	5	8	14	21
21	1193	7.1073	2	3	5	9	14
22	2905	4.7621	2	2	4	6	9
23	6083	4.5463	1	2	3	6	9
24	58312	5.3301	1	2	4	6	10
25	22307	3.6053	1	2	3	4	7
26	47	4.7872	1	2	3	6	10
27	3910	5.4939	1	1	3	7	13
28	12971	6.3277	1	2	4	8	13
29	4104	3.7210	1	2	3	5	7
31	3167	4.8244	1	2	3	6	9
32	1486	3.0606	1	1	2	3	6
34	18601	5.8148	1	3	4	7	11
35	3728	3.9144	1	2	3	5	7
36	6766	1.5443	1	1	1	2	2
37	1771	3.9283	1	1	3	5	8
38	198	2.7374	1	1	2	3	5
39	2565	2.0035	1	1	1	2	4
40	2546	3.3342	1	1	2	4	7
42	5437	1.9847	1	1	1	2	4
43	112	3.9643	1	2	3	5	7
44	1479	5.2427	2	3	4	7	9
45	2358	3.6014	1	2	3	5	7
46	3070	4.8485	1	2	4	6	9
47	1208	3.9305	1	1	3	4	7
49	2389	5.2704	1	2	4	6	10
50	3294	2.1072	1	1	2	2	3
51	351	2.8775	1	1	2	3	6
52	109	3.2202	1	1	2	4	7
53	3177	3.6116	1	1	2	4	8
54	2	5.0000	1	1	9	9	9
55	1907	2.9240	1	1	2	3	6
56	749	2.8451	1	1	2	3	6
57	627	3.9888	1	2	2	5	8
58	1	2.0000	2	2	2	2	2
59	106	3.3302	1	1	2	4	6
60	3	1.0000	1	1	1	1	1
61	243	4.5473	1	1	3	5	11
63	3794	4.6009	1	2	3	5	9
64	3378	6.6442	1	2	5	8	14
65	29508	3.1713	1	2	3	4	6
66	6602	3.4727	1	2	3	4	6
67	495	3.8061	1	2	3	5	7
68	10234	4.3211	2	2	4	5	8
69	2957	3.4711	1	2	3	4	6
70	40	3.3000	1	2	3	4	5
71	128	3.9297	1	2	3	5	7
72	754	3.5000	1	2	3	4	7
73	6264	4.6727	1	2	4	6	9
74	4	3.2500	1	1	2	3	7
75	41373	10.5498	4	5	8	13	20
76	41421	11.7212	3	6	9	14	22
77	2200	5.0882	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
78	31195	7.6312	3	5	7	9	13
79	239461	8.6355	3	4	7	11	16
80	8097	6.0569	2	3	5	7	11
81	8	6.6250	2	3	6	7	10
82	71327	7.3212	2	3	6	9	14
83	7548	5.8922	2	3	5	7	11
84	1550	3.4510	1	2	3	4	6
85	20846	6.8720	2	3	5	9	13
86	1392	4.0560	1	2	3	5	8
87	67808	6.4421	1	3	5	8	12
88	361207	5.6530	2	3	5	7	10
89	431130	6.5624	3	4	5	8	12
90	36919	4.6667	2	3	4	6	8
91	44	4.3409	2	2	4	5	9
92	13630	6.6374	2	3	5	8	12
93	1171	4.6866	1	2	4	6	9
94	13860	6.6431	2	3	5	8	13
95	1450	3.9807	1	2	3	5	7
96	59294	5.0564	2	3	4	6	9
97	24137	3.9948	1	2	3	5	7
98	23	3.8261	1	1	2	4	10
99	26720	3.1667	1	1	2	4	6
100	10247	2.2335	1	1	2	3	4
101	20640	4.7304	1	2	4	6	9
102	4568	2.8956	1	1	2	4	5
103	532	48.1579	9	15	32	72	105
104	26477	13.3305	5	8	11	16	24
105	23042	10.2029	5	6	8	12	18
106	107689	11.0481	6	7	9	13	18
107	68745	8.3095	5	6	7	9	13
108	7570	12.1110	4	7	10	15	23
110	63724	10.0893	3	6	8	12	19
111	5565	6.1146	2	4	6	7	9
112	143226	4.2143	1	2	3	6	8
113	48124	13.1573	4	6	9	16	26
114	9126	8.8386	2	4	7	11	17
115	13920	9.2104	2	4	8	12	17
116	163845	4.7278	1	2	4	6	9
117	3828	4.0470	1	1	3	5	9
118	6772	3.0371	1	1	2	4	7
119	1690	5.1065	1	1	3	7	11
120	39847	8.4640	1	2	5	11	19
121	171781	6.9297	2	4	6	9	12
122	86714	4.5006	1	2	4	6	8
123	46259	4.4861	1	1	2	6	11
124	153509	4.5906	1	2	4	6	9
125	61083	2.9375	1	1	2	4	6
126	5166	12.8142	4	6	10	16	26
127	709301	5.7991	2	3	5	7	11
128	18599	6.3459	3	4	6	7	10
129	4491	3.1639	1	1	1	3	7
130	100064	6.2988	2	4	5	8	11
131	25546	4.8443	1	3	5	6	8
132	165210	3.3140	1	2	3	4	6
133	6158	2.7943	1	1	2	3	5
134	29610	3.6023	1	2	3	4	7
135	8098	4.4395	1	2	3	5	8
136	1153	3.0590	1	1	2	4	6
137	3	9.0000	3	3	8	16	16
138	208875	4.1968	1	2	3	5	8
139	65773	2.7441	1	1	2	3	5
140	135217	3.1677	1	2	3	4	6
141	78828	4.0833	1	2	3	5	7
142	35793	2.9455	1	1	2	4	5
143	138166	2.3966	1	1	2	3	4
144	76722	5.3753	1	2	4	7	11
145	6376	2.9864	1	1	2	4	6
146	9883	10.5263	6	7	9	12	17
147	1673	6.9050	4	5	7	8	10
148	149749	12.6194	6	7	10	15	22

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
149	14256	7.1282	4	5	7	8	10
150	24565	11.1079	4	6	9	14	20
151	4262	6.1100	2	3	6	8	11
152	4725	8.4855	4	5	7	10	14
153	1641	5.7776	3	4	6	7	9
154	35223	14.0521	4	7	11	17	27
155	4548	5.0079	1	2	4	7	9
156	4	10.7500	3	3	4	5	31
157	9475	5.6004	1	2	4	7	11
158	4358	2.7838	1	1	2	4	6
159	18293	5.0712	1	2	4	6	10
160	9550	2.7693	1	1	2	4	5
161	14988	4.2188	1	2	3	5	9
162	7392	2.0878	1	1	1	3	4
163	10	4.7000	1	1	2	8	10
164	5382	8.7124	4	5	7	10	15
165	1590	5.4094	2	3	5	7	8
166	3367	5.4164	2	3	4	7	10
167	2276	2.9587	1	2	3	4	5
168	1840	4.7288	1	2	3	6	9
169	933	2.5638	1	1	2	3	5
170	13057	11.7430	2	5	9	15	23
171	1059	5.0888	1	2	4	6	10
172	33120	7.3970	2	3	5	9	15
173	2099	3.9700	1	2	3	5	8
174	240349	5.1449	2	3	4	6	9
175	21405	3.2299	1	2	3	4	6
176	17949	5.7572	2	3	4	7	11
177	11857	4.7298	2	3	4	6	8
178	3735	3.3414	1	2	3	4	6
179	12182	6.7201	2	3	5	8	13
180	89279	5.6551	2	3	4	7	11
181	21316	3.7131	1	2	3	5	7
182	239438	4.5657	1	2	4	6	8
183	69818	3.1716	1	2	3	4	6
184	88	3.6364	1	2	3	4	7
185	4173	4.8174	1	2	4	6	10
186	3	3.6667	2	2	4	5	5
187	932	3.9635	1	2	3	5	8
188	70915	5.7802	1	3	4	7	11
189	7922	3.3871	1	1	3	4	7
190	99	4.9192	1	2	3	5	11
191	11183	14.8821	4	7	11	18	30
192	780	7.1308	2	4	6	9	12
193	8399	12.9303	5	7	11	16	23
194	660	7.4924	2	4	6	9	13
195	8782	9.8539	4	6	8	12	17
196	629	6.3259	3	4	6	8	10
197	27404	8.6998	3	5	7	10	15
198	7093	4.7194	2	3	4	6	8
199	2178	10.7140	3	5	8	14	22
200	1551	11.2863	2	4	8	14	23
201	1566	15.0811	4	7	11	19	29
202	28611	7.1039	2	3	5	9	14
203	29634	7.1581	2	3	6	9	14
204	53354	6.3393	2	3	5	8	12
205	23176	6.8016	2	3	5	8	14
206	1669	4.2109	1	2	3	5	8
207	37050	5.2852	1	2	4	7	10
208	9948	3.0293	1	1	2	4	6
209	358501	5.8935	3	4	5	7	9
210	143742	7.6286	4	5	6	9	13
211	26310	5.6081	3	4	5	7	9
212	10	5.2000	2	3	3	5	6
213	7179	8.7551	2	4	7	11	17
216	6407	10.2995	2	4	8	13	21
217	20940	13.7538	3	5	9	17	29
218	24871	5.6287	2	3	4	7	10
219	18974	3.4430	1	2	3	4	6
220	5	4.2000	1	1	4	4	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
223	19625	2.6998	1	1	2	3	5
224	8139	2.1058	1	1	2	3	4
225	5926	4.6232	1	2	3	6	10
226	5569	6.2550	1	2	4	7	13
227	4377	2.8556	1	1	2	3	5
228	2997	3.4525	1	1	2	4	7
229	1232	2.3612	1	1	2	3	4
230	2492	4.9767	1	2	3	6	10
231	11065	4.7605	1	2	3	6	10
232	556	4.2248	1	1	2	5	9
233	4762	8.2740	2	3	6	10	17
234	2194	3.8847	1	2	3	5	8
235	5563	5.8068	1	3	4	6	11
236	40042	5.5871	2	3	4	7	10
237	1673	4.2110	1	2	3	5	8
238	7672	9.3749	3	4	7	11	17
239	60793	6.9705	2	3	5	8	13
240	13396	6.9369	2	3	5	8	14
241	3013	4.2273	1	2	3	5	8
242	2855	7.1338	2	3	5	9	14
243	80990	5.1239	2	3	4	6	9
244	12531	5.4307	1	3	4	6	10
245	4414	4.0888	1	2	3	5	7
246	1275	4.2235	1	2	3	5	8
247	11507	3.6954	1	2	3	5	7
248	7430	4.9732	1	2	4	6	9
249	10425	3.9777	1	1	3	5	8
250	3638	4.6564	1	2	3	5	9
251	2168	3.0152	1	1	2	4	5
253	19268	5.2492	1	3	4	6	10
254	9406	3.5232	1	2	3	4	6
256	4463	5.6626	1	2	4	7	11
257	22791	3.2065	1	2	3	4	6
258	17067	2.2797	1	1	2	3	4
259	4037	3.1962	1	1	2	3	7
260	4576	1.6635	1	1	1	2	3
261	2263	2.2391	1	1	2	3	4
262	668	3.9790	1	1	3	5	8
263	29345	12.5324	3	5	9	15	24
264	3371	7.2691	2	3	6	9	14
265	4204	7.2552	1	2	5	8	15
266	2586	3.5526	1	1	2	5	7
267	229	4.1441	1	1	2	5	8
268	967	3.5274	1	1	2	4	7
269	10146	8.4862	2	3	6	11	17
270	3100	3.1906	1	1	2	4	7
271	23041	7.7309	3	4	6	9	14
272	6024	6.6718	2	3	5	8	13
273	1395	5.3677	1	2	4	6	11
274	2647	7.1598	1	3	5	9	15
275	243	3.8477	1	1	2	5	8
276	953	4.7408	1	3	4	6	8
277	80718	6.2272	2	3	5	7	11
278	24912	4.8206	2	3	4	6	8
279	4	4.5000	2	2	2	6	8
280	14160	4.6971	1	2	3	6	9
281	6013	3.3597	1	1	3	4	6
282	1	1.0000	1	1	1	1	1
283	5329	5.0197	1	2	4	6	10
284	1761	3.5548	1	2	3	5	7
285	5653	12.0637	3	5	9	15	23
286	2049	7.2674	3	4	5	8	13
287	6697	12.1784	3	5	8	14	24
288	1289	6.2289	2	4	5	6	9
289	5512	3.4799	1	1	2	3	7
290	8856	2.5833	1	1	2	3	4
291	93	2.1720	1	1	2	3	4
292	5255	11.1772	2	4	8	14	22
293	292	5.6301	1	2	4	7	11
294	84523	5.2489	2	3	4	6	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
295	3775	4.0919	1	2	3	5	8
296	233450	5.7617	2	3	4	7	11
297	31861	3.8491	1	2	3	5	7
298	104	2.5192	1	1	2	3	5
299	1152	5.4852	1	2	4	7	11
300	15757	6.6296	2	3	5	8	13
301	1988	4.3622	1	2	3	5	8
302	8343	10.9475	5	6	8	13	19
303	19359	9.4651	4	5	8	11	17
304	13176	9.5956	2	4	7	12	19
305	2465	4.3209	1	2	4	5	8
306	11670	5.7599	1	2	4	7	12
307	2492	2.5385	1	1	2	3	4
308	9657	6.4205	1	2	4	8	13
309	3324	2.5827	1	1	2	3	5
310	27618	4.3383	1	2	3	5	9
311	8538	2.0546	1	1	2	2	4
312	1883	4.6893	1	2	3	6	10
313	670	2.2881	1	1	2	3	5
315	28828	8.5433	1	2	5	11	19
316	85493	6.9922	2	3	5	9	14
317	858	2.9231	1	1	2	3	6
318	6207	6.6441	1	3	5	8	13
319	432	2.7940	1	1	2	4	6
320	177076	5.8728	2	3	5	7	10
321	23569	4.2659	2	3	4	5	7
322	93	4.2796	2	2	3	5	8
323	17541	3.3743	1	1	2	4	7
324	8048	2.0035	1	1	2	2	4
325	7066	4.1930	1	2	3	5	8
326	2130	2.8793	1	1	2	3	5
327	15	3.4667	1	1	2	3	12
328	681	3.9236	1	2	3	5	8
329	107	2.3458	1	1	2	3	5
331	44033	5.8414	2	3	4	7	11
332	4874	3.6574	1	1	3	5	7
333	362	5.7127	1	2	4	7	12
334	19427	5.4203	3	4	5	6	8
335	9804	4.0529	2	3	4	5	6
336	58837	3.7630	1	2	3	4	7
337	34043	2.4114	1	2	2	3	4
338	3738	5.0698	1	2	3	6	11
339	2130	4.5873	1	2	3	6	10
340	2	1.5000	1	1	2	2	2
341	5981	3.1155	1	1	2	3	6
342	1004	3.5926	1	2	3	4	7
344	3544	3.1168	1	1	2	3	6
345	1364	3.8043	1	1	3	5	8
346	5207	6.2906	1	3	5	8	12
347	382	2.9503	1	1	2	4	6
348	3220	4.4969	1	2	3	5	8
349	744	2.6788	1	1	2	3	5
350	6367	4.6220	2	3	4	6	8
351	2	2.5000	2	2	3	3	3
352	551	3.9800	1	1	3	5	8
353	2722	8.3420	3	4	6	9	16
354	10004	5.9826	3	3	5	7	10
355	5604	3.6253	2	3	3	4	5
356	29892	2.8081	1	2	3	3	4
357	6625	9.3250	4	5	7	11	17
358	28910	4.4709	2	3	4	5	7
359	28337	3.0904	2	2	3	4	4
360	18232	3.2826	1	2	3	4	5
361	680	3.6721	1	1	2	4	8
362	1	1.0000	1	1	1	1	1
363	3930	3.4725	1	2	2	3	7
364	1869	3.4912	1	1	2	4	7
365	2454	7.1520	1	2	4	9	16
366	4507	6.9907	1	3	5	9	15
367	543	2.9263	1	1	2	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
368	2396	6.2371	2	3	5	8	12
369	2424	3.4125	1	1	2	4	7
370	1224	5.5074	2	3	4	5	9
371	1107	3.5890	2	3	3	4	5
372	909	3.1177	1	2	2	3	5
373	4166	2.0290	1	1	2	2	3
374	170	2.8824	1	2	2	3	4
375	7	8.4286	1	2	5	9	15
376	219	3.2055	1	1	2	4	7
377	51	4.0196	1	1	2	4	9
378	195	2.6256	1	2	2	3	4
379	374	2.9278	1	1	2	3	5
380	101	1.8317	1	1	1	2	4
381	184	2.2935	1	1	1	2	5
382	48	1.3333	1	1	1	1	2
383	1616	3.8342	1	2	3	5	8
384	142	2.8380	1	1	2	3	6
385	3	6.6667	1	1	4	15	15
386	1	49.0000	49	49	49	49	49
387	1	62.0000	62	62	62	62	62
389	16	6.2500	3	3	5	7	12
390	7	5.1429	2	2	3	4	7
392	2562	10.5863	4	5	8	13	21
393	2	11.0000	7	7	15	15	15
394	1814	7.5232	1	2	5	9	16
395	68205	4.9806	1	2	4	6	10
396	18	4.0000	1	1	2	7	7
397	16988	5.7650	1	2	4	7	11
398	18434	6.2525	2	3	5	8	12
399	1304	4.0107	1	2	3	5	8
400	7870	9.7126	2	3	7	12	21
401	6799	11.6883	2	5	9	15	24
402	1513	4.2412	1	1	3	6	9
403	39143	8.5499	2	3	6	11	17
404	3818	4.6239	1	2	4	6	9
406	3473	10.1005	3	4	7	13	21
407	695	4.4460	1	2	4	6	8
408	2876	7.6203	1	2	5	9	18
409	5607	5.9162	2	3	4	6	12
410	74657	3.3553	1	2	3	4	5
411	34	2.2941	1	1	1	3	6
412	30	3.3667	1	1	2	5	7
413	8827	8.0314	2	3	6	10	16
414	735	4.5456	1	2	3	6	10
415	44947	14.8941	4	7	11	18	29
416	220123	7.6840	2	4	6	9	14
417	42	4.2857	1	2	3	6	8
418	20661	6.3189	2	3	5	8	12
419	14969	5.2323	2	3	4	6	10
420	2624	3.9737	1	2	3	5	7
421	10783	4.2452	1	2	3	5	8
422	90	3.7444	1	2	3	4	5
423	10953	7.9358	2	3	6	9	16
424	1883	16.7642	2	6	10	19	31
425	15587	4.3867	1	2	3	5	8
426	4759	5.2227	1	2	4	6	11
427	1713	5.2668	1	2	4	7	11
428	944	7.6684	1	3	5	9	16
429	42603	7.8417	2	3	5	9	15
430	56355	9.0159	2	4	7	11	18
431	222	8.8694	2	3	5	9	17
432	412	5.8422	1	2	3	7	12
433	8270	3.2895	1	1	2	4	7
434	22762	5.2873	2	3	4	6	10
435	16653	4.5296	1	2	4	5	8
436	3557	13.7641	4	8	13	20	26
437	15724	9.9197	4	6	9	13	18
439	1050	8.4581	1	3	6	10	18
440	4863	9.5690	2	3	6	11	20
441	617	3.4376	1	1	2	4	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY96 MEDPAR Update 06/97 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
442	15702	8.3069	1	3	6	10	17
443	2996	3.3621	1	1	2	4	7
444	3390	4.7661	1	2	4	6	9
445	1251	3.6843	1	1	3	4	6
447	4174	2.6416	1	1	2	3	5
448	29	1.0000	1	1	1	1	1
449	28988	4.0309	1	1	3	5	8
450	6372	2.2461	1	1	1	2	4
451	4	3.0000	1	1	1	2	8
452	21599	5.1541	1	2	4	6	10
453	3633	3.0790	1	1	2	4	6
454	3997	5.1711	1	2	3	6	10
455	916	2.7424	1	1	2	3	6
456	215	7.2930	1	1	3	7	16
457	113	4.8938	1	1	2	6	14
458	1680	15.9685	3	6	12	21	33
459	576	9.3247	2	4	7	12	19
460	2332	6.3203	1	3	5	8	13
461	3239	4.5952	1	1	2	5	11
462	10116	12.9741	4	6	11	17	24
463	13497	4.7743	1	2	4	6	9
464	3208	3.4286	1	2	3	4	7
465	214	3.7477	1	1	2	4	7
466	1784	4.6962	1	1	2	5	10
467	1617	4.2084	1	1	2	4	8
468	60561	14.1162	3	6	11	18	28
471	11672	6.7301	3	4	5	8	11
472	203	24.2217	1	5	18	34	57
473	8739	13.3313	2	4	7	19	34
475	101087	11.4533	2	5	9	15	22
476	6647	12.6556	3	7	11	16	23
477	30187	8.6072	1	3	6	11	18
478	126280	7.6802	1	3	6	10	16
479	17952	4.1791	1	2	3	5	8
480	417	25.2686	8	12	18	30	50
481	257	30.2490	17	21	26	36	50
482	7059	13.4577	5	7	10	15	24
483	40197	43.1598	14	22	34	53	79
484	407	15.4496	3	7	11	20	30
485	3514	10.5552	4	5	8	12	20
486	2518	13.3761	1	6	10	17	27
487	4435	8.1150	2	3	6	10	16
488	920	17.9750	4	7	13	22	37
489	19832	9.7897	2	4	7	12	20
490	5520	6.0612	1	2	4	7	12
491	10763	3.9181	2	2	3	4	7
492	2229	17.9740	4	5	14	28	37
493	56802	5.6674	1	2	4	7	11
494	25101	2.3728	1	1	2	3	5
495	99	17.8081	7	11	15	23	31
496	695	11.5885	4	6	9	13	22
497	20050	6.8113	2	4	5	8	12
498	10596	3.7558	1	2	3	5	7
499	37778	5.2993	2	3	4	6	10
500	34957	3.1295	1	2	3	4	6
501	1652	11.2125	4	6	9	13	20
502	424	7.0825	3	4	6	8	12
503	6610	4.4082	1	2	4	5	8
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1997

State	Urban	Rural
ALABAMA	0.400	0.449
ALASKA	0.516	0.780
ARIZONA	0.397	0.562
ARKANSAS	0.542	0.491
CALIFORNIA	0.382	0.489
COLORADO	0.477	0.554
CONNECTICUT	0.551	0.555
DELAWARE	0.505	0.489
DISTRICT OF COLUMBIA	0.520	.....
FLORIDA	0.398	0.397
GEORGIA	0.508	0.510
HAWAII	0.458	0.531
IDAHO	0.557	0.618
ILLINOIS	0.474	0.587
INDIANA	0.559	0.596
IOWA	0.526	0.663
KANSAS	0.429	0.659
KENTUCKY	0.503	0.529
LOUISIANA	0.464	0.523
MAINE	0.619	0.578
MARYLAND	0.764	0.815
MASSACHUSETTS	0.557	0.597
MICHIGAN	0.484	0.586
MINNESOTA	0.553	0.618
MISSISSIPPI	0.495	0.514
MISSOURI	0.445	0.535
MONTANA	0.485	0.599
NEBRASKA	0.495	0.660
NEVADA	0.329	0.522
NEW HAMPSHIRE	0.574	0.597
NEW JERSEY	0.455	.....
NEW MEXICO	0.461	0.551
NEW YORK	0.561	0.647
NORTH CAROLINA	0.533	0.478
NORTH DAKOTA	0.619	0.669
OHIO	0.545	0.589
OKLAHOMA	0.475	0.549
OREGON	0.577	0.638

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1997—Continued

State	Urban	Rural
PENNSYLVANIA	0.407	0.540
PUERTO RICO	0.478	0.522
RHODE ISLAND	0.577	.....
SOUTH CAROLINA	0.474	0.496
SOUTH DAKOTA	0.542	0.639
TENNESSEE	0.508	0.551
TEXAS	0.443	0.546
UTAH	0.598	0.641
VERMONT	0.610	0.564
VIRGINIA	0.493	0.509
WASHINGTON	0.663	0.666
WEST VIRGINIA	0.599	0.544
WISCONSIN	0.595	0.653
WYOMING	0.514	0.751

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1997

State	Ratio
ALABAMA	0.054
ALASKA	0.073
ARIZONA	0.047
ARKANSAS	0.055
CALIFORNIA	0.039
COLORADO	0.053
CONNECTICUT	0.039
DELAWARE	0.056
DISTRICT OF COLUMBIA	0.040
FLORIDA	0.047
GEORGIA	0.048
HAWAII	0.046
IDAHO	0.054
ILLINOIS	0.044
INDIANA	0.059

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1997—Continued

State	Ratio
IOWA	0.055
KANSAS	0.054
KENTUCKY	0.054
LOUISIANA	0.067
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.064
MICHIGAN	0.048
MINNESOTA	0.058
MISSISSIPPI	0.056
MISSOURI	0.051
MONTANA	0.057
NEBRASKA	0.057
NEVADA	0.034
NEW HAMPSHIRE	0.067
NEW JERSEY	0.043
NEW MEXICO	0.049
NEW YORK	0.053
NORTH CAROLINA	0.049
NORTH DAKOTA	0.074
OHIO	0.056
OKLAHOMA	0.055
OREGON	0.054
PENNSYLVANIA	0.042
PUERTO RICO	0.090
RHODE ISLAND	0.038
SOUTH CAROLINA	0.055
SOUTH DAKOTA	0.062
TENNESSEE	0.058
TEXAS	0.053
UTAH	0.058
VERMONT	0.053
VIRGINIA	0.058
WASHINGTON	0.067
WEST VIRGINIA	0.055
WISCONSIN	0.048
WYOMING	0.065

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS

Area	1982–1994 difference	1984–1994 difference	1988–1984 difference	1990–1994 difference	1991–1994 difference	1992–1994 difference	1993–1994 difference
Connecticut	21.5862	24.0000	.....	.....	.....	.....	.....
Delaware	.....	8.6774	.....	.....	.....	.....	.....
Hawaii	.....	15.7127	.....	.....	.....	.....	.....
Maryland	.....	8.1722	.....	.....	.....	.....	.....
Massachusetts	23.9560	27.9921	11.2140	.....	.....	.....	.....
New Hampshire	.....	9.5243	.....	.....	.....	.....	.....
Oregon	.....	.....	.....	8.6010	8.1066	.....	.....
South Carolina	.....	10.0774	.....	.....	.....	.....	.....
Vermont	.....	10.6667	.....	.....	.....	.....	.....
Washington	.....	.....	.....	9.9002	.....	.....	.....
Amarillo, TX	.....	.....	.....	8.6330	9.8229	.....	.....
Anderson, SC	.....	.....	15.1961	24.3721	.....	8.9005	.....
Arecibo, PR	.....	.....	.....	13.7540	11.0585	.....	.....
Athens, GA	10.8688	16.5565	9.5058	9.4259	.....	.....	.....
Atlantic City, NJ	.....	13.2602	.....	.....	.....	.....	.....
Augusta, GA–SC	.....	.....	.....	.....	8.0453	.....	.....
Benton Harbor, MI	.....	.....	.....	8.8777	.....	.....	.....
Bergen-Passaic, NJ	14.0017	15.9481	17.9622	.....	.....	.....	.....
Billings, MT	.....	.....	.....	8.6879	12.2161	12.3837	.....
Biloxi-Gulfport, MS	.....	.....	.....	8.0594	.....	.....	.....
Bloomington, IN	.....	.....	.....	.....	.....	8.2928	.....
Boston-Lowell-Brockton-Lawrence-Salem, MA	.....	8.1568	.....	.....	.....	.....	.....

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1994 difference	1984–1994 difference	1988–1984 difference	1990–1994 difference	1991–1994 difference	1992–1994 difference	1993–1994 difference
Bremerton, WA	12.9725	14.8961	15.2452	15.3177	13.7318	.....	.....
Bridgeport-Stamford-Norwalk-Danbury, CT	10.3293	14.6913	.....	.....	.....	.....	.....
Burlington, NC	11.6113	14.9594	9.7961	.....	.....	.....	.....
Burlington, VT	.....	9.3174	9.6092	.....	.....	10.8280	.....
Caguas, PR	.....	12.2326	.....	.....	.....	.....	.....
Charlotte-Gastonia-Rock Hill, NC–SC	9.2601	16.3979	.....	.....	.....	.....	.....
Clarksville-Hopkinsville, TN–KY	.....	8.0204	.....	14.9297	.....	.....	.....
Columbia, SC	.....	8.8584	.....	.....	.....	.....	.....
Columbus, GA–AL	.....	12.8079	10.6690	9.7894	.....	.....	.....
Cumberland, MD–WVA	.....	.....	.....	8.7659	9.2778	.....	.....
Danville, VA	.....	.....	8.4254	.....	.....	.....	.....
Decatur, AL	.....	12.0335	10.5832	.....	.....	.....	.....
El Paso, TX	8.1286	13.8951	16.0628	.....	17.4634	9.2489	.....
Eugene-Springfield, OR	.....	12.1188	12.4054	20.4953	8.0302	.....	.....
Florence, SC	14.2426	13.0711	.....	.....	.....	.....	.....
Gadsden, AL	.....	.....	.....	13.8007	9.0695	.....	.....
Gainesville, FL	.....	9.7617	8.7895	.....	8.5675	.....	.....
Galveston-Texas City, TX	.....	.....	11.9186	.....	.....	.....	.....
Greeley, CO	.....	.....	.....	15.7515	8.6166	10.3980	.....
Greensboro-Winston-Salem-High Point, NC	.....	9.9322	.....	.....	.....	.....	.....
Hagerstown, MD	.....	11.0716	.....	9.5260	8.2039	.....	.....
Hartford-Middletown-NewBritain, CT	10.4740	14.2519	.....	.....	.....	.....	.....
Houma-Thibodaux, LA	.....	.....	9.3263	.....	.....	.....	.....
Jackson, TN	8.5190	12.7249	.....	.....	.....	.....	.....
Jersey City, NJ	.....	.....	8.3144	.....	.....	.....	.....
Killeen-Temple, TX	16.7787	.....	.....	.....	.....	.....	.....
Lafayette, IN	.....	.....	.....	.....	8.7871	10.0572	.....
Laredo, TX	.....	.....	.....	11.5765	.....	8.5185	.....
Las Cruse, NM	.....	.....	9.2218	.....	.....	.....	.....
Lawton, OK	.....	.....	.....	.....	.....	.....	8.1162
Lima, OH	.....	.....	13.8166	8.6982	.....	.....	.....
Macon-Warner Robins, GA	.....	18.2494	.....	.....	.....	.....	.....
Manchester-Nashua, NH	11.5134	12.8915	.....	.....	.....	.....	.....
McAllen-Edinburg-Mission, TX	.....	9.0116	8.4046	.....	.....	.....	.....
Medford, OR	.....	.....	.....	11.0706	.....	.....	.....
Merced, CA	.....	8.8820	.....	9.1317	11.0694	.....	.....
Middlesex-Somerset-Hunterdon, NJ	.....	11.3808	.....	.....	.....	.....	.....
Mobile, AL	.....	.....	.....	8.2725	9.5491	8.3835	.....
Monmouth-Ocean, NJ	11.0502	16.4802	10.3441	.....	.....	.....	.....
Monroe, LA	.....	.....	.....	.....	9.9294	.....	.....
Muncie, IN	.....	.....	13.5975	.....	.....	.....	.....
Muskegon, MI	10.1698	9.3800	13.1266	11.0394	10.3157	.....	.....
Nassau-Suffolk, NY	.....	14.0415	.....	.....	.....	.....	.....
New Bedford-Fall River-Attleboro, MA	15.8880	18.8100	12.4963	.....	.....	.....	.....
New Haven-West Haven-Waterbury, CT	10.3424	14.6360	.....	.....	.....	.....	.....
New London-Norwich, CT	9.0604	12.5972	.....	.....	.....	.....	.....
Newark, NJ	.....	10.9661	.....	.....	.....	.....	.....
Ocala, FL	.....	10.9174	.....	.....	.....	.....	.....
Orange County, NY	22.3089	26.7753	16.7892	10.2286	10.6828	.....	.....
Panama City, FL	.....	.....	.....	.....	10.5996	.....	.....
Parkersburg-Marietta, WV–OH	.....	.....	.....	8.3806	.....	8.4505	.....
Portsmouth-Dover-Rochester, NH	10.1946	9.0222	.....	.....	.....	.....	.....
Poughkeepsie, NY	.....	9.2928	.....	.....	.....	.....	.....
Providence-Pawtucket-Woonsocket, RI	.....	13.4977	.....	.....	.....	.....	.....
Provo-Orem, UT	.....	8.6038	.....	.....	.....	.....	.....
Redding, CA	.....	19.0789	11.6583	.....	.....	.....	.....
Salinas-Seaside-Monterey, CA	16.3647	15.3473	11.1937	.....	.....	.....	.....
San Angelo, TX	.....	.....	.....	.....	9.0858	.....	.....
Santa Cruz, CA	15.0235	15.1075	10.8706	11.2183	.....	.....	.....
Santa Fe, NM	.....	8.8954	12.9551	.....	.....	.....	.....
Tacoma, WA	.....	.....	.....	8.4039	.....	.....	.....
Texarkana, TX-Texarkana, AR	.....	.....	9.6848	8.7486	9.5184	.....	.....
Vallejo-Fairfield-Napa, CA	.....	12.0671	.....	10.2260	.....	.....	.....
Wausau, WI	.....	9.6382	8.0763	.....	.....	.....	.....
West Palm Beach-Boca Raton-Delray Beach, FL	.....	9.5017	.....	.....	.....	.....	.....
Wilmington, DE–NJ–MD	8.3587	10.7306	.....	.....	.....	.....	.....
Wilmington, NC	.....	15.7476	8.5665	.....	.....	.....	.....

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1994 difference	1984–1994 difference	1988–1984 difference	1990–1994 difference	1991–1994 difference	1992–1994 difference	1993–1994 difference
Worcester-Fitchburg-Leomister, MA	.....	13.3694	.....	.....	.....	.....	.....
Yuma, AZ	.....	.....	9.4344	.....	12.1844	.....	.....

Appendix A—Regulatory Impact Analysis

I. Introduction

Section 804(2) of Title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

We estimate that the impact of this final rule with comment period will be to decrease payments to hospitals by approximately $6 billion in FY 1998, compared to the payments that would have been made in FY 1998 if Public Law 105–33 had not been enacted. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule with comment period 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 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made 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 with comment period, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

II. Changes in the Final Rule With Comment Period

After we published the proposed rule, Public Law 105–33 was enacted. (A summary of the provisions related to the prospective payment system for hospitals appears under section I.D. of this preamble.) Several provisions of Public Law 105–33 make significant changes in inpatient hospital payments for the operating and capital prospective payment systems during FY 1998. The provisions that have significant payment impacts for FY 1998 include the following:

- The update factors for the inpatient operating standardized amounts and the hospital-specific rate for FY 1998 are 0 percent. Hospitals that do not receive disproportionate share (DSH) or indirect medial education (IME) payments and are not designated as a Medicare-dependent, small rural hospital (MDH) (referred to hereafter as ''temporary relief'' hospitals) will receive a 0.5 percent update to their applicable standardized amounts if—
  - The hospital is in a State in which the aggregate operating prospective payments to these types of hospitals are less than the aggregate allowable operating costs for inpatient services for FY 1995 cost reporting periods (eligible States are identified in section V.D of the preamble), and
  - The hospital itself has a negative operating prospective payment margin in the payment year.
- The unadjusted standard Federal capital rate and hospital-specific capital rate are reduced by 17.78 percent for FY 1998.
- The additional DSH payments made to eligible hospitals under the operating prospective payment system are reduced by 1 percent.
- The IME formula is revised to reduce the IME adjustment factor from approximately a 7.7 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio to a 7.0 percent increase.
- IME and DSH payments will be made only on the base DRG payment rates, not on the sum of base DRG payments and outlier payments. Also, in determining outlier payments, the estimated cost of a case will no longer be adjusted for IME and DSH.
- The national share of the Puerto Rico payment rate is increased from 25 to 50 percent. Thus, these hospitals will be paid based on 50 percent of the national standardized amount (a discharge-weighted average of the large urban and other urban national standardized amounts) and 50 percent of the Puerto Rico standardized amount.
- The wage index for an urban hospital may not be lower than the Statewide area rural wage index.
- The special treatment of MDHs is reinstated. If the hospital-specific rate for an eligible MDH is higher than the Federal rate, the hospital receives 50 percent of the difference between the Federal rate and the hospital-specific rate.
- Any hospital classified as a rural referral center (RRC) for FY 1991 must continue to be classified as an RRC for FY 1998 and subsequent fiscal years.

- The update factor for prospective payment system excluded hospitals for FY 1998 is 0 percent.
- The target amounts for psychiatric and rehabilitation hospitals and units, and long-term care hospitals are capped at the 75th percentile of target amounts for within the same class.
- The seven State EACH/RPCH program is being replaced by the Critical Access Hospital (CAH) program, a national program that allows States to designate specified rural hospitals as critical access hospitals. Payment to these hospitals is on the basis of reasonable costs.

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 1998, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies 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

A. Included and Excluded Hospitals

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. There were 46 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of August 1997, we have included 5,088 hospitals in our analysis. (This is 41 fewer hospitals than were included in the impact analysis in the FY 1997 final rule (61 FR 46305).) This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals.

B. Critical Access Hospitals (CAHs) (established by Pub. L. 105–33)

As explained earlier in this preamble, section 4201 of Public Law 105–33 replaced the EACH program with a CAH program. The CAH program is not limited to seven States, but is available to any State that both submits the necessary assurances and complies with the other statutory requirements for designation of hospitals as CAHs. Facilities that participated in Medicare as RPCHs before the date of enactment of Public Law 105–33 (August 5, 1997), and that are otherwise eligible to be designated by the States as CAHs, are deemed to be CAHs. There are currently approximately 38 facilities participating as RPCHs. In addition, the 13 facilities currently operating under the Medical Assistance Facility (MAF) demonstration in Montana are deemed to have been certified by HCFA as CAHs, if otherwise eligible for designation by the State as CAHs.

Because of the small number of facilities now participating as RPCHs or MAFs, we do not expect the interim final rule to have a significant impact on a substantial number of small rural hospitals. Moreover, in preparing the regulations applicable to CAHs, we have included only those changes that are required to implement the new legislation. Nonetheless, we are informing the public of our projections of the likely effects of the rules, for those hospitals and beneficiaries who may be affected.

For the currently participating facilities, the primary effect will be greater flexibility, since these facilities will be able to maintain up to 15 inpatient beds, rather than 6, and will be able to keep patients for as long as 96 hours, rather than an average of 72 hours. Patients in these facilities should benefit from this, since there should be fewer cases requiring patient transfer to other facilities due to lack of beds or need for longer periods of care. However, with an expected increase in utilization due to an increase in numbers and lengths of stay, costs to the Medicare program for care in these facilities may be expected to rise. Some or all of this increase may be offset by savings from cases in which the changes make transfer to another hospital unnecessary. Changes in the swing-bed provisions will also increase facility flexibility and patient access to care. These new provisions are less complex than those imposed by prior law, and should simplify program administration.

The changes in payment methodology may also increase Medicare spending for care in these facilities, since payment will now be based on reasonable costs. Fee schedules and blended rates for outpatient care will not apply. However, the elimination of the EACH designation may avoid many unnecessary costs and offset any added spending for CAH care.

While the removal of the seven State limitation will undoubtedly lead to greater participation in the program, we are not able to estimate reliably how many additional States will establish limited-service hospital programs, or how many hospitals in those States will choose to participate in them. To the extent that there is increased participation, beneficiary convenience and access to care in remote rural areas would increase. Medicare spending, however, would also increase, since additional hospitals would be paid on a basis other than the prospective payment system. As noted above, some or all of these increases may be offset by prompt access to treatment in the local community, thus avoiding the need for care in full-service hospitals.

V. Impact on Excluded Hospitals and Units

As of August 1997, there were 1,102 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. This group included 631 psychiatric hospitals, 192 rehabilitation hospitals, 192 long-term care hospitals, 70 children's hospitals and 17 Christian Science sanitoria. In addition, there were 1,472 psychiatric units and 880 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40.

The market basket percentage increase for excluded hospitals and units for FY 1998 is 2.7 percent. However, as a result of section 4411 of Public Law 105–33 the update factor for FY 1998 is 0 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 or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level

below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

In this context, we note that, under § 413.40(d)(3) as revised, an excluded hospital or unit whose costs exceed 110 percent of the ceiling receives its ceiling plus 50 percent of the difference between its costs and 110 percent of the ceiling, not to exceed 110 percent of the ceiling. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

Section 4414 of Public Law 105–33 establishes a cap at the 75th percentile on the target amounts for psychiatric, rehabilitation, and long-term care hospitals. Because the cap is based on an estimate of the 75th percentile, we estimate that 25 percent of the providers will have target amounts in excess of the cap. We have broken down the estimated impact of that reduction as follows:

PERCENT OF PROVIDERS ABOVE CAP

Type of hospital/ unit	Free-standing hospitals	Hospital-based units
Rehabilitation	23.2	76.8
Psychiatric	42.5	57.5
Long-term care ..	25.0	(1)

[1] Not applicable.

PERCENT OF TOTAL PROVIDERS

Type of hospital/ unit	Large urban	Other urban	Rural
Rehabilitation	48.8	38.7	12.5
Psychiatric	49.2	32.2	18.6
Long-term care ..	74.3	17.8	7.9

PERCENT OF PROVIDERS ABOVE THE CAP

Type of hospital/ unit	Large urban	Other urban	Rural
Rehabilitation	54.4	35.5	10.1
Psychiatric	62.6	25.7	11.7

PERCENT OF PROVIDERS ABOVE THE CAP—Continued

Type of hospital/ unit	Large urban	Other urban	Rural
Long-term care ..	95.8	4.2	0.0

These tables show, of those hospitals affected by the cap, the estimated percentage of each type of provider affected, and the proportion of these hospitals that are located in urban or rural areas. Although a higher percentage of hospital-based units may be affected by the cap than freestanding hospitals, there are many more units than hospitals. For instance, there are twice as many hospital-based psychiatric units than freestanding hospitals and five times as many hospital-based rehabilitation units as freestanding hospitals. With regard to the geographic impact of the provision on long-term care hospitals, hospitals in large urban areas are affected in greater proportion than hospitals in other areas. This is not unexpected because the target amount cap is not adjusted for differences in area wage levels. We also observed that long-term care hospitals certified before 1990 were less likely to be affected by the 75th percentile provision than older long-term care hospitals. Psychiatric and rehabilitation facilities appear slightly more likely to be affected by the limit on the target amount if they were certified after 1990 or are located in large urban areas. It is important to note that while these hospitals and units will have their target amounts reduced to the 75th percentile, the impact on a specific provider will depend on the level of its operating costs per discharge in relation to its reduced target amount.

We are extending certain exclusion criteria that currently apply only to long-term care hospitals to all other categories of excluded facilities. These criteria define a minimum level of independence and separate control that a facility must have in order to be excluded as a ''hospital within a hospital.'' We expect that this provision will result in a very small decrease in aggregate payment levels (other things being equal) by, for example, preventing new hospital units from inappropriately qualifying for the exemption from the-rate-of-increase ceiling that is available only to new hospitals. To our knowledge, there are fewer than 50 facilities that would be affected by this proposal.

VI. Quantitative Impact Analysis of the Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule with comment period, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate analyses of the changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1996 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to create some of the variables by which hospitals are categorized. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each 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.

Using cases in the FY 1996 MedPAR file, we simulated 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 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 analyzed here. Estimated payment impacts of the FY 1998 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The changes discussed separately below are the following:

- The effects of the changes enacted by Public Law 105–33. Although we are not able to precisely simulate the effect of every provision of this legislation that may influence hospital payment, we have simulated the payment effects of

each of the significant provisions noted above.

- 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 1998 wage index update (using FY 1994 data).
- The effects of implementing the Puerto Rico-specific wage index to be applied to the Puerto Rico standardized amounts.
- The effects of completing the phase-out of payments for extraordinarily lengthy cases (day outlier cases) with a corresponding increase in payments for extraordinarily costly cases (cost outliers), in accordance with section 1886(d)(5)(A)(v) of the Act.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 1998.
- The total change in payments based on FY 1998 policies relative to payments based on FY 1997 policies.

To illustrate the impacts of the changes resulting from Pub. L. 105–33, our analysis begins with a FY 1998 baseline simulation model using the policies as they existed before enactment of Public Law 105–33 including a 2.7 percent (full market basket) update to the standardized amounts; the FY 1997 GROUPER (version 14.0); the FY 1997 wage index; national wage index values applied to the Puerto Rico standardized amounts; FY 1997 outlier policy (75 percent phase-out of day outlier payments); and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG payments.

From this baseline, we move to a simulation model reflecting the policies enacted by Public Law 105–33. For operating payments, these are: zero update to the standardized amounts and the hospital-specific rate, except for temporary relief hospitals which receive a 0.5 percent update; an increase in payments to Puerto Rico by changing the portion of their payments based on the higher national standardized amount from 25 percent to 50 percent; reductions in IME and DSH payments; the elimination of IME and DSH payments attributable to outliers and the corresponding change of no longer standardizing charges for IME and DSH when identifying outlier cases; reinstating the MDH provision; and the reinstatement of RRCs that lost their status due to the triennial review or MGCRB reclassification. One change enacted by Public Law 105–33 that is not included in this simulation is the floor on the area wage index for urban hospitals. This change is required to be budget neutral so we did not introduce it into the simulation model until we calculated the wage index and DRG budget neutrality factor. Therefore, in our impact analysis, this change is introduced when we bring the new (FY 1994) wage data into the model.

Each additional policy change is then added incrementally to this baseline model, finally arriving at an FY 1998 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1997 to FY 1998. Three factors have significant impacts here. First is the changes enacted by Public Law 105–33, with the exception of the impact of the zero updates for FY 1998 (which results in a zero change from FY 1997).

A second significant factor that has an impact on hospitals' payments per case from FY 1997 to FY 1998 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified for FY 1997 that are no longer reclassified for FY 1998 may have a negative payment impact going from FY 1997 to FY 1998; conversely, hospitals not reclassified for FY 1997 that are reclassified for FY 1998 may have a positive impact. In some cases these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate actual outlier payments during FY 1997 will be 4.8 percent of actual total DRG payments. When the FY 1997 final rule was published, we projected FY 1997 outlier payments would be 5.1 percent of total DRG payments, and the standardized amounts were reduced correspondingly. The effects of the slightly lower than expected outlier payments during FY 1997 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 1997 payments per case to estimated FY 1998 payments per case.

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 estimated impact on the 5,088 hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,858 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,630 hospitals located in large urban areas (populations over 1 million), and 1,228 hospitals in other urban areas (populations of 1 million or fewer). The analysis includes 49 hospitals classified as large urban hospitals that were classified as other urban hospitals in the proposed rule. These hospitals are in four MSAs that have become large urban areas since publication of the proposed rule. There are 2,230 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 hospital groups based on hospitals' FY 1998 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show the numbers of hospitals being paid based on these categorizations (after consideration of geographic reclassifications) are 2,948, 1,776, 1,172, and 2,140, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment), receive DSH payments, or some combination of these two adjustments. There are 3,993 nonteaching hospitals in our analysis, 856 teaching hospitals with fewer than 100 residents, and 239 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next row separately examines hospitals that available data show may qualify for the provision granting a 0.5 percent update to the standardized amounts for FY 1998 (section 4401(b) of

Pub. L. 105–33). To be eligible, a hospital must not receive either IME or DSH, nor may it be an MDH. It must also experience a negative margin on its operating prospective payments during FY 1998. We estimated eligible hospitals based on whether they had a negative operating margin on their FY 1995 cost report. Finally, to qualify, a hospital must be located in a State where the aggregate FY 1995 operating prospective payments were less than the aggregate associated costs for all of the non-IME, non-DSH, non-MDH hospitals in the State. There are 360 hospitals in this row.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, RRCs, MDHs, and EACHs), as well as rural hospitals not receiving a special payment designation. The RRCs (158), SCH/EACHs (642), MDHs (368), and SCH/EACH and RRCs (57) shown here were not reclassified for purposes of the standardized amount. Section 4202(b)(1) of Public Law 105–33 allowed for reinstatement of RRCs that lost their status since FY 1991. As a result, there are 63 more hospitals in this row than were included in the proposed rule. Similarly, there are 16 more hospitals in the SCH/RRC row than appeared in that row in the proposed rule. There are three SCHs that will be reclassified for the standardized amount in FY 1998 that, therefore, are not included in these rows. There are seven EACHs included in our analysis and three EACH/RRCs.

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 primarily from the FY 1995 Medicare cost report files, if available (otherwise FY 1994 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 117 hospitals. For the most part, these are either new hospitals or hospitals filing manual cost reports that are not yet entered into the database.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 1997 and FY 1998, or for either of those 2 years, by urban/rural status. The next rows illustrate the overall number of FY 1998 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1998 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1]	Balanced Budget Act[2]	DRG re-calibration[3]	New wage data[4]	Combined wage & recal.[5]	Puerto Rico specific wage index[6]	Day outlier phase-out[7]	MGCRB reclassification[8]	All FY 98 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(BY GEOGRAPHIC LOCATION):									
ALL HOSPITALS	5,088	−3.9	0.1	0.1	0.0	0.0	0.0	0.0	0.9
URBAN HOSPITALS	2,858	−3.9	0.1	0.1	0.0	0.0	0.0	−0.4	−1.0
LARGE URBAN	1,630	−4.0	0.1	0.0	−0.1	0.0	−0.1	−0.4	−1.2
OTHER URBAN	1,228	−3.8	0.2	0.2	0.2	0.0	0.1	−0.3	−0.7
RURAL HOSPITALS	2,230	−3.4	−0.3	0.4	−0.1	0.0	0.1	2.2	−0.4
BED SIZE (URBAN):									
0–99 BEDS	724	−3.6	−0.3	0.1	−0.4	0.0	0.1	−0.5	−0.9
100–199 BEDS	954	−3.7	−0.1	0.1	−0.2	0.0	0.1	−0.4	−0.7
200–299 BEDS	570	−3.8	0.1	0.1	−0.1	0.0	0.1	−0.3	−0.8
300–499 BEDS	457	−4.0	0.2	0.2	0.2	0.0	0.0	−0.4	−1.0
500 OR MORE BEDS	153	−4.3	0.4	0.0	0.2	0.0	−0.2	−0.3	−1.3
BED SIZE (RURAL):									
0–49 BEDS	1,170	−3.0	−0.6	0.4	−0.4	0.0	0.1	0.1	−0.3
50–99 BEDS	657	−3.1	−0.4	0.4	−0.2	0.0	0.1	1.1	−0.3
100–149 BEDS	235	−3.4	−0.3	0.4	−0.1	0.0	0.1	3.2	−0.5
150–199 BEDS	93	−3.7	−0.2	0.4	0.0	0.0	0.1	2.6	−0.4
200 OR MORE BEDS	75	−3.6	0.0	0.3	0.1	0.0	0.2	4.2	−0.8
URBAN BY CENSUS DIVISION:									
NEW ENGLAND	159	−4.2	0.1	−0.3	−0.4	0.0	0.1	−0.3	−1.9
MIDDLE ATLANTIC	431	−4.4	0.1	0.3	0.1	0.0	−0.7	−0.4	−2.0
SOUTH ATLANTIC	420	−3.8	0.2	−0.2	−0.2	0.0	0.2	−0.3	−0.8
EAST NORTH CENTRAL	475	−4.0	0.1	0.3	0.2	0.0	0.2	−0.3	−0.7
EAST SOUTH CENTRAL	163	−3.8	0.2	1.0	1.0	0.0	0.2	−0.5	0.2
WEST NORTH CENTRAL	191	−4.0	0.2	0.2	0.2	0.0	0.2	−0.4	−0.6
WEST SOUTH CENTRAL	367	−3.8	0.2	0.2	0.1	0.0	0.2	−0.5	−0.5
MOUNTAIN	129	−3.7	0.3	−0.2	−0.1	0.0	0.2	−0.4	−0.6
PACIFIC	475	−3.6	0.1	−0.3	−0.4	0.0	0.2	−0.3	−0.9
PUERTO RICO	48	3.1	−0.2	0.3	−0.1	3.7	−0.1	−0.4	12.2
RURAL BY CENSUS DIVISION:									
NEW ENGLAND	53	−3.9	−0.2	0.6	0.1	0.0	0.2	2.1	−0.6
MIDDLE ATLANTIC	85	−3.3	−0.3	−0.4	−0.9	0.0	−0.1	1.1	−0.9
SOUTH ATLANTIC	297	−3.6	−0.2	0.4	0.0	0.0	0.1	2.4	−1.0
EAST NORTH CENTRAL	302	−3.3	−0.2	0.5	0.0	0.0	0.2	1.4	−0.7
EAST SOUTH CENTRAL	275	−3.4	−0.3	0.6	0.1	0.0	0.2	2.5	0.0
WEST NORTH CENTRAL	512	−3.2	−0.4	0.2	−0.4	0.0	0.1	2.5	0.0

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1998 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1]	Balanced Budget Act[2]	DRG recalibration[3]	New wage data[4]	Combined wage & recal.[5]	Puerto Rico specific wage index[6]	Day outlier phase-out[7]	MGCRB reclassification[8]	All FY 98 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
WEST SOUTH CENTRAL	347	−3.2	−0.4	0.3	−0.3	0.0	0.1	3.3	−0.3
MOUNTAIN	213	−3.1	−0.2	0.3	−0.2	0.0	0.1	1.6	0.3
PACIFIC	141	−3.3	−0.2	1.1	0.6	0.0	0.1	2.1	−0.1
PUERTO RICO	5	4.9	−0.6	2.4	1.5	4.4	0.1	1.5	15.3
BY PAYMENT CATEGORIES:									
URBAN HOSPITALS	2,948	−3.9	0.1	0.1	0.0	0.0	0.0	−0.3	−1.0
LARGE URBAN	1,776	−4.0	0.1	0.0	−0.1	0.0	−0.1	−0.2	−1.1
OTHER URBAN	1,172	−3.8	0.2	0.2	0.2	0.0	0.1	−0.4	−0.6
RURAL HOSPITALS	2,140	−3.3	−0.3	0.4	−0.1	0.0	0.1	1.9	−0.5
TEACHING STATUS:									
NON-TEACHING	3,993	−3.6	−0.1	0.2	−0.1	0.0	0.1	0.3	−0.6
LESS THAN 100 RES	856	−3.9	0.2	0.1	0.1	0.0	0.1	−0.3	−0.8
100+ RESIDENTS	239	−4.4	0.3	0.0	0.2	0.0	−0.3	−0.2	−1.6
DISPROPORTIONATE SHARE HOSPITALS (DSH):									
NON-DSH	3,185	−3.8	0.0	0.2	0.0	0.0	0.1	0.2	−0.8
URBAN DSH:									
100 BEDS OR MORE	1,413	−3.9	0.2	0.1	0.0	0.0	−0.1	−0.3	−1.0
FEWER THAN 100 BEDS	89	−3.7	−0.4	0.3	−0.4	0.0	0.2	−0.4	−0.8
RURAL DSH:									
SOLE COMMUNITY (SCH)	155	−3.1	−0.5	0.3	−0.4	0.0	0.0	0.2	−0.4
REFERRAL CENTERS (RRC)	50	−2.8	−0.1	0.5	0.2	0.0	0.1	3.4	0.6
OTHER RURAL DSH HOSP.:									
100 BEDS OR MORE	66	−3.6	−0.3	0.7	0.1	0.0	0.2	2.3	−1.4
FEWER THAN 100 BEDS	130	−3.4	−0.6	0.7	−0.1	0.0	0.1	0.8	−0.2
URBAN TEACHING AND DSH:									
BOTH TEACHING AND DSH	708	−4.1	0.2	0.0	0.1	0.0	−0.2	−0.4	−1.2
TEACHING AND NO DSH	330	−4.2	0.3	0.3	0.3	0.0	0.1	−0.2	−1.0
NO TEACHING AND DSH	794	−3.6	0.0	0.1	−0.1	0.0	0.1	−0.1	−0.5
NO TEACHING AND NO DSH	1,116	−3.7	0.0	0.0	−0.2	0.0	0.2	−0.3	−0.8
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33)	360	−3.8	−0.1	0.6	0.2	0.1	0.2	0.2	−0.6
RURAL HOSPITAL TYPES:									
NONSPECIAL STATUS HOSPITALS	915	−3.5	−0.4	0.5	−0.1	0.0	0.1	1.5	−0.8
RRC	158	−3.7	−0.1	0.5	0.2	0.0	0.2	4.3	−0.5
SCH/EACH	642	−3.0	−0.4	0.2	−0.5	0.0	0.0	0.6	−0.4
MDH	368	−2.0	−0.5	0.4	−0.3	0.0	0.1	0.5	0.8
SCH/EACH AND RRC	57	−3.2	−0.2	0.2	−0.2	0.0	0.0	0.8	−0.5
TYPE OF OWNERSHIP:									
VOLUNTARY	2,924	−3.9	0.1	0.1	0.0	0.0	0.0	−0.1	−1.0
PROPRIETARY	701	−3.6	0.0	0.0	−0.2	0.1	0.2	0.3	−0.6
GOVERNMENT	1,346	−3.7	0.0	0.4	0.2	0.0	0.1	0.2	−0.4
UNKNOWN	117	−4.0	0.0	−0.5	−0.7	0.2	−1.5	−0.5	−2.4
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:									
0–25	266	−3.6	0.1	−0.3	−0.5	0.0	−0.1	−0.3	−1.2
25–50	1,307	−4.0	0.2	0.0	0.0	0.0	0.0	−0.2	−1.0
50–65	1,988	−3.8	0.1	0.3	0.1	0.0	0.1	0.2	−0.8
OVER 65	1,410	−3.7	−0.1	0.2	−0.2	0.0	0.1	0.1	−0.9

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1998 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1]	Balanced Budget Act[2]	DRG recalibration[3]	New wage data[4]	Combined wage & recal.[5]	Puerto Rico specific wage index[6]	Day outlier phase-out[7]	MGCRB reclassification[8]	All FY 98 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
UNKNOWN	117	−4.0	0.0	−0.5	−0.7	0.2	−1.5	−0.5	−2.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:									
RECLASSIFICATION STATUS DURING FY97 AND FY98:									
RECLASSIFIED DURING BOTH FY97 AND FY98	333	−3.9	0.0	0.5	0.3	0.0	0.2	6.2	−0.9
URBAN	96	−4.2	0.1	0.5	0.4	0.0	0.1	3.6	−1.1
RURAL	237	−3.7	−0.1	0.4	0.1	0.0	0.2	9.0	−0.6
RECLASSIFIED DURING FY98 ONLY	89	−3.6	0.0	0.5	0.3	0.1	0.2	4.0	5.3
URBAN	13	−3.7	0.4	0.7	0.9	0.2	0.2	0.0	2.8
RURAL	76	−3.4	−0.3	0.3	−0.2	0.0	0.2	7.3	7.3
RECLASSIFIED DURING FY97 ONLY	211	−4.0	0.0	0.6	0.3	0.0	0.0	−0.9	−4.2
URBAN	94	−4.2	0.1	0.6	0.5	0.0	−0.1	−1.0	−4.0
RURAL	117	−3.6	−0.2	0.5	0.0	0.0	0.2	−0.2	−4.7
FY 98 RECLASSIFICATIONS:									
ALL RECLASSIFIED HOSP	423	−3.9	0.0	0.5	0.3	0.0	0.2	5.8	−0.1
STAND. AMOUNT ONLY	94	−4.1	0.0	0.4	0.2	0.0	0.1	1.3	−0.9
WAGE INDEX ONLY	282	−3.7	0.0	0.5	0.3	0.0	0.2	7.9	0.2
BOTH	47	−4.2	0.0	0.3	0.1	0.0	0.3	5.5	0.2
NONRECLASSIFIED	4,638	−3.9	0.1	0.1	0.0	0.0	0.0	−0.5	−1.0
ALL URBAN RECLASS	109	−4.1	0.1	0.5	0.4	0.0	0.1	3.2	−0.7
STAND. AMOUNT ONLY	45	−4.0	0.1	0.4	0.3	0.0	0.0	0.6	−0.9
WAGE INDEX ONLY	31	−4.2	0.3	0.8	0.8	0.0	0.2	6.0	−0.8
BOTH	33	−4.2	0.1	0.4	0.2	0.0	0.2	3.3	−0.1
NONRECLASSIFIED	2,749	−3.9	0.1	0.1	0.0	0.0	0.0	−0.5	−1.0
ALL RURAL RECLASS	314	−3.6	−0.1	0.4	0.1	0.0	0.2	8.7	0.6
STAND. AMOUNT ONLY	49	−4.2	−0.3	0.3	−0.2	0.0	0.3	4.3	−1.1
WAGE INDEX ONLY	251	−3.5	−0.1	0.4	0.1	0.0	0.2	8.6	0.6
BOTH	14	−4.4	−0.1	0.2	−0.1	0.0	0.4	18.0	2.2
NONRECLASSIFIED	1,889	−3.2	−0.3	0.4	−0.2	0.0	0.1	−0.4	−0.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	−3.6	−0.3	0.7	0.2	0.0	0.1	0.7	0.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1996, and hospital cost report data are from reporting periods beginning in FY 1994 and FY 1995.

[2] This column displays the impact of the changes enacted by Public Law 105–33. The most significant of those in terms of their impacts here are the zero update, the reduction to the IME adjustment, and no longer paying an IME and DSH adjustment for outliers.

[3] This column displays the payment impact of the recalibration of the DRG weights, based on FY 1996 MedPAR data and the DRG classification changes, 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 1994 cost reports and the Public Law 105–33 provision establishing a floor on the area wage index for urban hospitals.

[5] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2 and 3, and the FY 1998 budget neutrality factor of 0.997731.

[6] This column illustrates the payment impact of the Puerto Rico-specific wage index, applied to the Puerto Rico-specific standardized amounts.

[7] This column illustrates the payment impact of completing the phase-out of day outlier payments, and increasing cost outlier payments, in accordance with section 1886(d)(5) of the Act.

[8] Shown here are the combined effects of geographic reclassification by the Medicare Geographic Classification Review Board (MGCRB). The effects shown here demonstrate the FY 1998 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 1998. Reclassification for prior years has no bearing on the payment impact shown here.

[9] This column shows changes in payments from FY 1997 to FY 1998. It incorporates all of the changes displayed in columns 4 through 7 (the changes displayed in columns 2 and 3 are included in column 4). It also displays the impact of the changes shown in column 1, less the 2.7 percent negative impact of the zero update. Finally, it shows the impact of changes in hospitals' reclassification status in FY 1998 compared to FY 1997, and the difference in outlier payments from FY 1997 to FY 1998. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of Changes Enacted by Public Law 105–33 (Column 1)

Public Law 105–33 contained several provisions that significantly impact hospitals' payments under the operating prospective payment system during FY 1998, relative to payments if Public Law 105–33 had not been enacted. Certainly the largest single impact is the zero update for the standardized amounts and the hospital-specific rate. Prior to this change, the law provided that hospitals were to receive the full market basket of 2.7 percent. As indicated above, temporary relief hospitals do receive an update of 0.5 percent. Freezing the standardized amounts and the hospital-specific rates at their FY 1997 levels (prior to any budget neutrality calculations) is the largest impact evident in column 1.

As discussed previously, to illustrate the impacts of the changes resulting from Public Law 105–33, we begin with a FY 1998 baseline payment model using a 2.7 percent update; the FY 1997 GROUPER; the FY 1997 wage index; no MGCRB reclassifications; outlier payments based on 25 percent day outliers and factoring IME and DSH into DRG payments plus outlier payments; no MDHs; and Puerto Rico hospitals receive 25 percent of the national Puerto Rico amount and 75 percent of the Puerto Rico amount. From this baseline we moved to a payment simulation model incorporating all but one of the changes enacted by Public Law 105–33; we did not include the floor on the wage index for urban hospitals because that change was required to be budget neutral. Therefore, this change is included in the new (FY 1994) wage data column.

The overall impact on hospital operating payments per case due to Public Law 105–33 is a 3.9 percent reduction in payments. As pointed out above, 2.7 percent of this decline relates to the freeze in the update. This negative impact is evident across all hospital categories, although it is offset to a small degree among those hospitals that receive the special 0.5 percent update. However, this update provision has an insignificant impact overall. In fact, the 360 temporary relief hospitals that qualify for this special update have only a slightly smaller decrease in payments (3.8 percent) than the national average. This is largely due to the change that eliminated the IME and DSH adjustments attributable to outlier payments. Although these hospitals by definition do not receive IME or DSH payments, they are negatively impacted by the redistribution of outlier payments that result from the change. Because we no longer standardize the charges of cases by hospitals' IME and DSH factors, the outlier thresholds are higher and there is a substantial redistribution of outlier payments toward hospitals that also receive IME and DSH and away from non-IME, non-DSH hospitals. The negative impact of this change on the latter group of hospitals is approximately 1.8 percent.

The change in outlier policy also affects overall payments. Because IME and DSH are now based only on the base DRG amount, total payments are less than they would be before this change. The net impact of this change is to reduce the overall average payment per case by approximately 0.6 percent. The reduction in the IME adjustment also reduces payments by approximately 0.6 percent overall. The combined impacts of these changes and the other, less significant changes result in an overall decrease in hospitals' average payment per case due to Public Law 105–33 of 3.9 percent.

The only hospital categories demonstrating a net increase in payments in column 1 are urban and rural Puerto Rico hospitals (3.1 percent and 4.9 percent, respectively). This is due to the change in the formula for calculating payments for Puerto Rico hospitals from 25 percent of the national amount and 75 percent of the Puerto Rico amount, to a 50/50 blend of the two amounts. Because the national amount is more than twice the Puerto Rico amount, the change in the blend more than offsets the 2.7 percent decrease in the amounts after Public Law 105–33. The smaller increase among urban Puerto Rico hospitals is explained at least in part by the fact that, because the national Puerto Rico amount is the same for large urban and other area hospitals while the large urban Puerto Rico amount is greater than the other area Puerto Rico amount, large urban Puerto Rico hospitals gain slightly less than other Puerto Rican hospitals from the formula change.

The hospital category with the smallest negative impact in this column is MDHs. Their payments overall drop by only 2.0 percent. Over 30 hospitals in this category have payment increases after being reinstated as an MDH, despite the zero update and the fact that they receive only 50 percent of the difference between their hospital-specific rate and the Federal rate.

The greatest negative impact in this column is a 4.4 percent drop in payments among teaching hospitals with more than 100 residents and urban hospitals in the Middle Atlantic census division (due to the concentration of teaching hospitals in this census division). This effect is due to the reduction in the IME adjustment, although the decrease in the IME adjustment factor is offset for these hospitals to some extent by the outlier changes which result in higher outlier payments to teaching and disproportionate share hospitals. Without the change to remove the IME and DSH adjustments from the outlier calculation, payments to major teaching hospitals would have fallen by approximately 1.0 percent more.

Finally, the decline in payments shown here among rural hospitals is generally not as great as the decline among urban hospitals. Overall, rural hospitals' payments decline by 3.4 percent, compared to 3.9 percent for urban hospitals. This result is attributable to those rural hospitals paid on the basis of their hospital-specific rate, particularly SCHs. Because hospitals receiving their hospital-specific rate do not receive outliers, IME, or DSH, they are unaffected by the policy changes related to these additional payments. Therefore, their net change in payments after Pub. L. 105–33 is generally limited to the 2.7 percent reduction in the update for FY 1998 (from full market basket percentage increase to 0).

C. Impact of the Changes to the DRG Classifications and Relative Weights (Column 2)

In column 2 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this final rule with comment period. 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.

We compared aggregate payments using the FY 1997 DRG relative weights (GROUPER version 14) to aggregate payments using the FY 1998 DRG relative weights (GROUPER version 15). Overall, payments increase by 0.1 percent due to the DRG changes, although this is prior to applying the budget neutrality factor for DRG and wage index changes (see column 4). Consistent with the minor changes we are implementing for the FY 1998 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are small (a 0.1 percent increase for large urban hospitals; a 0.2 percent increase for other urban hospitals; and a 0.3 percent decrease among rural hospitals).

Within hospital categories, the net effects for urban hospitals are small positive changes for larger hospitals (200 or more beds), and slightly negative changes for urban hospitals with fewer than 200 beds. Among rural hospitals, the smallest rural hospitals (fewer than 50 beds) experience a decrease of 0.6 percent. For other rural bed size categories, slight negative impacts prevail. Only the largest rural hospitals (200 or more beds) avoid any negative impact from the changes.

The breakdowns by urban census division show that the increase among urban hospitals is spread across all census categories except Puerto Rico, with the largest increase (0.3 percent) for hospitals in the Mountain census division. For rural hospitals, the largest decrease is 0.4 percent for hospitals in the West North Central and West South Central census divisions and 0.6 percent for the five rural hospitals in Puerto Rico. Rural hospitals in all other census regions experience decreases of 0.2 or 0.3 percent. This pattern of negative impacts upon small and rural hospitals is also apparent when examining the effects of DRG changes on hospitals according to special payment categories, with the largest decreases (0.5 percent) among MDHs, rural DSH SCHs, and rural DSH hospitals with fewer than 100 beds (0.6 percent decrease).

Overall, we attribute the changes associated with DRG recalibration to the increasing gap between the relative weights for medical, diagnostic, and less complicated surgical DRGs and the weights for the more complicated surgical DRGs. Since the cases associated with the former DRGs tend to be treated more often in smaller hospitals with fewer resources available, lower relative weights associated with those cases would disproportionately affect these hospitals. In general, small hospitals that serve a disproportionate share of low-income patients fit this definition. In contrast, larger hospitals in both urban and rural areas, which tend to treat the latter group of DRGs, would experience small payment increases. Teaching hospitals, which also treat the more complicated cases, experience similar effects. We note, however, that both the positive and negative impacts are relatively minor, in almost all categories they are 0.5 percent or less.

D. 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 final wage index for FY 1998 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1993 and before October 1, 1994. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 3 shows the percentage changes in payments when going from a model using the FY 1997 wage index based on FY 1993 wage data before geographic reclassifications to a model using the FY 1998 prereclassification wage index based on FY 1994 wage data. Also included in the model using the FY 1994 wage data are the effects of the provision of Public Law 105–33 that urban hospitals' wage indexes may not be below the wage index of the rural areas in the State in which the urban hospital is located.

The results indicate that the impact of the new wage data is a 0.1 percent increase overall in hospital payments (prior to applying the budget neutrality factor, see column 4). Rural and other urban hospitals generally appear to benefit from the update with payments increasing 0.4 and 0.2 percent, respectively. The increases for rural hospitals are attributable to relatively large increases in the wage index values for the rural areas of particular States (although none increased by more than 5 percent). The increases for other urban hospitals, 0.2 percent compared to 0.1 percent in FY 1997 and in the FY 1998 proposed wage index, appear to be attributable in large part to the requirement that the wage index values for urban hospitals be at least equal to the rural wage index values for the States in which they are located. Hospitals in 32 urban areas experienced increases in their wage index values as a result of that provision. Hospitals in nine of the urban areas experienced increases of more than 5 percent as a result of the provision for a Statewide rural wage index floor for urban hospitals.

Some of the largest changes in payments are found among both urban and rural hospitals grouped by census division, although in almost all cases payments change by less than 1 percent. Our review of the wage data indicates that the changes are attributable to improved reporting, as well as relative changes in labor costs.

Among the urban census divisions, payments change by 0.3 percent or less in all census divisions except one. The East South Central census division experiences an increase of 1.0 percent which stems largely from wage index increases of 5.9 and 5.2 percent in the Mobile, Alabama and the Tuscaloosa, Alabama MSAs.

Among the rural hospitals, all census divisions experience increases except for the Middle Atlantic census division which experiences a slight decrease of 0.4 percent. The largest increase occurs in the Pacific (and Puerto Rico, discussed separately below) census division which experiences an increase of 1.1 percent. Here, Oregon's rural wage index value rises by 3.2 percent, and Washington's rural wage index value increases by 2.9 percent. The next largest increase (0.6 percent) occurs in the rural New England and the East South Central census divisions. In the New England census division, the rural Vermont wage index value increases by 4.4 percent, and the rural Maine wage index value increases by 1.8 percent. In the East South Central census division, the rural Alabama wage index value increases by 1.9 percent, and the rural Mississippi wage index value increases by 1.7 percent.

In Puerto Rico, payments increase by 0.3 percent for the urban hospitals and by 2.4 percent for the five rural hospitals. Although column 5 shows the isolated effects of introducing the Puerto Rico-specific wage index, it is also included in the payment simulations here showing the impacts of the new wage data. Of the six urban areas in Puerto Rico, two experience increases in their national wage index values, including the San Juan-Bayamon area (2.5 percent), which contains the majority of the urban Puerto Rico hospitals (29 of 48), and the Mayaguez area (6.2 percent). The rural Puerto Rico area experiences an increase in its national wage index value of 4.9 percent. The following chart compares the shifts in wage index values for labor market areas for FY 1998 with those from FY 1997.

The majority of labor market areas (334) experience less than a 5 percent change. A total of 33 labor market areas experience a change between 5 and 10 percent; 24 of those experience increases. Still fewer labor markets experience a change of more than 10 percent; two experience increases, and one experiences a decrease. In two urban labor market areas which include both West Virginia and Ohio hospitals, the Ohio hospitals receive their State's rural wage index value. In one of those labor market areas, the Ohio hospitals experience an increase of more than 10 percent. In the other labor market area, the Ohio hospitals experience an increase between 5 and 10 percent.

We reviewed the data for any area that experienced a wage index change of 5

percent or more to determine the reason for the fluctuation.

Percentage change in area wage index values	No. of labor market areas	
	FY 1998	FY 1997
Increase more than 10 percent	2	0
Increase between 5 and 10 percent (inclusive)	24	14
Increase or decrease less than 5 percent	334	341
Decrease between 5 and 10 percent (inclusive)	9	11
Decrease more than 10 percent	1	2

Under the FY 1998 wage index, 95.3 percent of urban hospitals and 99.9 percent of rural hospitals will experience a change in their wage index value of less than 5 percent. Among urban hospitals, 128 will experience a change of between 5 and 10 percent (97 increasing and 31 decreasing), while only 3 rural hospitals fall into this category, all decreasing. Eight urban hospitals and no rural hospitals will experience a change of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	No. of hospitals	
	Urban	Rural
Increase more than 10 percent	4	0
Increase between 5 and 10 percent (inclusive)	97	0
Increase or decrease less than 5 percent	2763	2236
Decrease between 5 and 10 percent (inclusive)	31	3
Decrease more than 10 percent	4	0

E. Combined Impact of DRG and Wage Index Changes— Including Budget Neutrality Adjustment (Column 4)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. Furthermore, as noted above, section 4410 of Pub. L. 105–33 required the implementation of the wage index floor to be budget neutral. We compared aggregate payments using the FY 1997 DRG relative weights and wage index to aggregate payments using the FY 1998 DRG relative weights and wage index, including the wage index floor. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.997731. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 4. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 2 and 3, minus the approximately 0.2 percent decrease attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

F. Puerto Rico-Specific Wage Index (Column 5)

As described in section III. of the preamble to this final rule with comment period, we are adopting a Puerto Rico-specific wage index for FY 1998. These wage index values will be applied to the Puerto Rico standardized amounts. Column 5 shows the effect of implementing this change results in no payment impact for all hospitals. In Puerto Rico, payments increase by 3.7 percent among urban hospitals, and 4.4 percent among rural hospitals. As shown in Table 4F of the Addendum, the Puerto Rico-specific wage index values are considerably higher than Puerto Rico's national wage index values (shown in Table 4A of the Addendum). This results in the increases shown in this column.

However, these increases are less than those shown in the proposed rule as a result of the change to the Puerto Rico payment formula. The amount attributable to the Puerto Rico payment amount (and which is adjusted by the Puerto Rico-specific wage index) is now 50 percent instead of 75 percent.

As indicated above, this change is shown in isolation here for ease in reading Table I. To actually calculate the national DRG and wage index budget neutrality factors, the Puerto Rico-specific wage index was included. As described in the Addendum, we also computed a DRG reclassification and recalibration budget neutrality adjustment for the Puerto Rico standardized amounts equal to 0.999117.

G. Outlier Changes (Column 6)

Currently, Medicare provides extra payment in addition to the basic DRG payment amount for extremely costly or extraordinarily lengthy cases (cost outliers and day outliers, respectively). Beginning with FY 1995, section 1886(d)(5)(A) of the Act requires the Secretary to phase-out payments for day outliers. Under the requirements of section 1886(d)(5)(A)(v), the proportion of day outlier payments to total outlier payments is reduced from FY 1994 levels as follows: 75 percent of FY 1994 levels in FY 1995, 50 percent of FY 1994 levels in FY 1996, and 25 percent of FY 1994 levels in FY 1997. For discharges occurring after September 30, 1997, the Secretary will no longer pay for day outliers under the provisions of section 1886(d)(5)(A)(I) of the Act. This reduction in day outlier payments will be offset by an increase in cost outlier payments.

As discussed in the Addendum, for FY 1998, a case would receive cost outlier payments if its costs exceed the DRG payment amount plus any IME and DSH payments by at least $11,050. We are also maintaining the marginal cost factor for cost outliers at 80 percent.

The payment impacts of these changes are minimal. Hospital categories negatively affected by phasing-out day outliers are consistent with the categories negatively affected in previous years: urban Middle Atlantic census division (0.7 percent decline); urban hospitals with 500 or more beds (0.2 percent decline); teaching hospitals with 100 or more residents (0.3 percent decline); and hospitals for which data were unavailable to calculate Medicare utilization rates (1.5 percent decline). This last category contains a number of New York City public hospitals that file manual cost reports. Because the changes to the outlier policy result in a shift in payments from cases paid as day outliers to cases paid as cost outliers, this indicates that these categories have higher percentages of day outliers.

H. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual 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 hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 7 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1998. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

By March 30 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both.

The FY 1998 wage index values incorporate all of the MGCRB's reclassification decisions for FY 1998 as of the publication of this final rule with comment period. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions for FY 1998. The overall effect of geographic reclassification is required to be budget neutral by section 1886(d)(8)(D) of the Act. Therefore, we applied an adjustment of 0.994720 to ensure that the effects of reclassification are budget neutral. (See section II.A.4 of the Addendum to this final rule with comment period.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.2 percent, while payments to urban hospitals decline 0.4 percent. Large urban hospitals lose 0.4 percent because, as a group, they have the smallest percentage of hospitals that are reclassified (fewer than 2 percent of large urban hospitals are reclassified). There are enough hospitals in other urban areas that are reclassified to limit the decrease in payments to urban hospitals stemming from the budget neutrality offset to 0.3 percent. Among urban hospital groups generally (that is, bed size, census division, and special payment status), payments fall by between 0.3 and 0.5 percent.

A positive impact is evident among all rural hospital groups. The smallest effect among the rural census divisions is 1.1 percent for the Middle Atlantic division. The largest impact is for the West South Central division, with an increase of 3.3 percent.

Among rural hospitals designated as RRCs, 65 hospitals are reclassified for purposes of the wage index only, leading to the 4.3 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 4.2 percent increase in payments.

Rural hospitals reclassified for FY 1997 and FY 1998 experience a 9.0 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 1998 only experience a 7.3 percent increase in payments, while rural hospitals reclassified for FY 1997 only experience a 0.2 decrease in payments. Urban hospitals reclassified for FY 1997 but not FY 1998 experience a 1.0 percent decline in payments overall. This appears to be due to the combined impacts of the budget neutrality adjustment, and a number of Bergen-Passaic, New Jersey hospitals in this category that experience a 4.8 percent drop in their wage index after reclassification. Urban hospitals reclassified for FY 1998 but not for FY 1997 experience no overall change in their payments.

The FY 1998 Reclassification rows of Table I show the changes in payments per case for all FY 1998 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive an 18.0 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive an 8.6 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.8 percent for FY 1998.

Among the 27 rural hospitals deemed to be urban under section 1886(d)(8)(B) of the Act, payments increase 0.7 percent due to MGCRB reclassification. This is because, although these hospitals are treated as being attached to an urban area in our baseline (their redesignation is ongoing, rather than annual like the MGCRB reclassifications), they are eligible for MGCRB reclassification. For FY 1998, one hospital in this category reclassified to a large urban area.

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 are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.5 percent, which corresponds closely with the geographic reclassification budget neutrality factor. Rural nonreclassified hospitals decrease slightly less, experiencing a 0.4 percent decrease. This occurs because the wage index values in some rural areas increase after reclassified hospitals are excluded from the calculation of those indexes.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by March 29, 1997. In addition, changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process are also included.

I. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule with comment period for FY 1998 (including statutory changes), to our estimate of payments per case in FY 1997. It includes the effects of the changes enacted by Public Law 105–33, and reflects the 0.3 percentage point difference between the projected outlier payments in FY 1998 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1997 (4.8 percent), as described in the introduction to this Appendix and the Addendum.

Column 8 also includes the impacts of FY 1998 MGCRB reclassifications compared to the payment impacts of FY 1997 reclassifications. (Column 7 shows the impact of going from no MGCRB reclassifications to the FY 1998 reclassifications.) When comparing FY 1998 payments to FY 1997 payments, the percent changes due to FY 1998 reclassifications shown in column 7 need to be offset by the effects of reclassification on hospitals' FY 1997 payments (column 4 of Table 1, September 1, 1996 final rule; 61 FR 46306). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1997 payments was approximately a 2.3 percent increase, offsetting the 2.2 percent increase in column 7. Therefore, the net change in FY 1998 payments due to

reclassification for rural hospitals is actually closer to a decrease of 0.1 percent relative to FY 1997. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

To factor in the effects of the changes from Public Law 105–33 from column 1 into the overall changes shown in this column, it is first necessary to deduct the impact of the zero update included in column 1. Because column 1 compares a FY 1998 baseline after Public Law 105–33 to a FY 1998 baseline before this law was enacted, it includes the impact of going from a FY 1998 update of 2.7 percent to a zero update. Of course, this 2.7 percent update for FY 1998 does not affect FY 1997 payments, so it does not show up in column 8. The impacts of the other changes, however, such as reducing the IME factor and eliminating the IME and DSH adjustments from outlier payments, are reflected in this column.

Finally, there might 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 8 may not equal the sum of the changes in column 1, minus 2.7, plus the changes in columns 4 through 7 (plus the other impacts that we are able to identify).

The overall payment change from FY 1998 to FY 1997 for all hospitals is a 0.9 percent decrease. This reflects the 0.0 percent net change in total payments due to the proposed changes for FY 1998 shown in columns 4 through 7, the zero update for FY 1998, the 0.3 percent higher outlier payments in FY 1998 compared to FY 1997, as discussed above, and the 1.2 percent decline in payments due to Public Law 105–33 (3.9 percent decrease in column 1 minus 2.7 percent for the FY 1998 update). This 1.2 percent decline is attributable largely to reducing IME and eliminating IME and DSH from outlier payments.

Hospitals in urban areas experience a 1.0 percent drop in payments per case from FY 1997. Similar to all hospitals nationally, this is primarily due to the factors discussed above. Urban hospitals' 0.4 negative impact in FY 1998 due to reclassification is offset by a similar impact from FY 1997 reclassifications. Hospitals in large and other urban areas experience 1.2 percent and 0.7 percent decreases, respectively. The larger decrease for large urban hospitals is primarily due to the reduction in IME payments. Overall payments per case among this group of hospitals would be approximately 0.8 percent higher without this reduction.

Hospitals in rural areas generally fare better during FY 1998 than do urban hospitals. Overall, rural hospitals experience a decrease of 0.4 percent. This smaller decrease for rural hospitals appears to be primarily attributable to the special category rural hospitals. In particular, the 368 rural hospitals categorized as MDHs experience a 0.8 percent average payment increase. As noted previously, hospitals paid on the basis of the hospital-specific rate generally see less negative impact due to the changes in Public Law 105–33 because they do not receive IME, DSH, or outliers.

Puerto Rico stands out as having large payment increases for FY 1998, with urban Puerto Rico hospitals' payments increasing by 12.2 percent, and rural Puerto Rico hospitals' payments increasing by 15.3 percent. As noted above, this is largely due to the implementation of the Puerto Rico-specific wage index during FY 1998 and the change to the payment formula for Puerto Rico hospitals in Public Law 105–33.

Among census divisions, East South Central displays the only increase among urban hospitals, 0.2 percent. This is related to the 1.0 percent overall increase due to the new wage data. On the other hand, the urban Middle Atlantic and New England hospitals lose 2.0 percent and 1.9 percent per case, respectively. This is largely related to the concentration of teaching hospitals in these census areas. In addition, the Middle Atlantic hospitals lose 0.7 percent due to the elimination of day outlier payments, and the New England hospitals lose 0.3 percent as a result of the new wage data.

Among rural census divisions, the Mountain division displays an overall increase of 0.3 percent. This positive impact is largely due to hospitals reclassified during FY 1998 that were not reclassified during FY 1997. Hospitals in the South Atlantic are the biggest losers among the rural census divisions, with FY 1998 average payments per case falling by 1.0 percent from FY 1997. Twenty hospitals reclassified here during FY 1997 are no longer reclassified during FY 1998. Rural Middle Atlantic hospitals are negatively impacted by the DRG recalibration, new wage data, and eliminating the day outlier payments, all leading to their 0.9 percent decrease in FY 1998 payments.

As expected, large teaching hospitals as a group experience the largest payment reductions. Those with more than 100 residents see payments per case decrease by 1.6 percent. Urban hospitals receiving both IME and DSH experience 1.2 percent payment reductions. Hospitals for which we were unable to determine ownership designation or Medicare utilization due to a lack of cost report data, lose 2.4 percent in payments. As indicated previously, this category contains a number of public New York City hospitals, many of which have large teaching programs.

The largest negative payment impacts from FY 1997 to FY 1998 are among hospitals that were reclassified for FY 1997 and are not reclassified for FY 1998. Overall, these hospitals lose 4.2 percent. On the other hand, hospitals reclassified for FY 1998 that were not reclassified for FY 1997 would experience the greatest payment increases (aside from Puerto Rico hospitals): 7.3 percent for 76 rural hospitals in this category and 2.8 percent for 13 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1998 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	No. of hospitals (1)	Average FY 1997 payment per case (2)[1]	Average FY 1998 payment per case (3)[1]	All changes (4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	5,088	6,771	6,711	−0.9
URBAN HOSPITALS	2,858	7,347	7,276	−1.0
LARGE URBAN AREAS	1,630	7,899	7,808	−1.2
OTHER URBAN AREAS	1,228	6,588	6,545	−0.7

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1998 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	No. of hospitals (1)	Average FY 1997 payment per case (2)[1]	Average FY 1998 payment per case (3)[1]	All changes (4)
RURAL AREAS	2,230	4,451	4,432	−0.4
BED SIZE (URBAN):				
0–99 BEDS	724	4,921	4,878	−0.9
100–199 BEDS	954	6,159	6,115	−0.7
200–299 BEDS	570	6,926	6,868	−0.8
300–499 BEDS	457	7,874	7,794	−1.0
500 OR MORE BEDS	153	9,660	9,535	−1.3
BED SIZE (RURAL):				
0–49 BEDS	1,170	3,650	3,639	−0.3
50–99 BEDS	657	4,152	4,141	−0.3
100–149 BEDS	235	4,615	4,594	−0.5
150–199 BEDS	93	4,794	4,775	−0.4
200 OR MORE BEDS	75	5,612	5,570	−0.8
URBAN BY CENSUS DIV.:				
NEW ENGLAND	159	7,913	7,766	−1.9
MIDDLE ATLANTIC	431	8,137	7,971	−2.0
SOUTH ATLANTIC	420	7,008	6,953	−0.8
EAST NORTH CENTRAL	475	7,057	7,004	−0.7
EAST SOUTH CENTRAL	163	6,518	6,530	0.2
WEST NORTH CENTRAL	191	6,948	6,905	−0.6
WEST SOUTH CENTRAL	367	6,830	6,797	−0.5
MOUNTAIN	129	7,084	7,041	−0.6
PACIFIC	475	8,422	8,343	−0.9
PUERTO RICO	48	2,694	3,022	12.2
RURAL BY CENSUS DIV.:				
NEW ENGLAND	53	5,283	5,249	−0.6
MIDDLE ATLANTIC	85	4,752	4,708	−0.9
SOUTH ATLANTIC	297	4,631	4,582	−1.0
EAST NORTH CENTRAL	302	4,502	4,470	−0.7
EAST SOUTH CENTRAL	275	4,115	4,116	0.0
WEST NORTH CENTRAL	512	4,140	4,138	0.0
WEST SOUTH CENTRAL	347	4,005	3,994	−0.3
MOUNTAIN	213	4,772	4,787	0.3
PACIFIC	141	5,582	5,578	−0.1
PUERTO RICO	5	2,072	2,390	15.3
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,948	7,309	7,239	−1.0
LARGE URBAN AREAS	1,776	7,763	7,675	−1.1
OTHER URBAN AREAS	1,172	6,590	6,548	−0.6
RURAL AREAS	2,140	4,429	4,409	−0.5
TEACHING STATUS:				
NON-TEACHING	3,993	5,494	5,462	−0.6
FEWER THAN 100 RESIDENTS	856	7,216	7,158	−0.8
100 OR MORE RESIDENTS	239	11,051	10,869	−1.6
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,185	5,801	5,755	−0.8
URBAN DSH—100 BEDS OR MORE	1,413	7,997	7,917	−1.0
FEWER THAN 100 BEDS	89	5,081	5,041	−0.8
RURAL DSH SOLE COMMUNITY (SCH)	155	4,229	4,211	−0.4
REFERRAL CENTERS (RRC)	50	5,203	5,232	0.6
OTHER RURAL DSH HOSP.—100 BEDS OR MORE	66	4,198	4,138	−1.4
FEWER THAN 100 BEDS	130	3,565	3,557	−0.2
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	708	8,994	8,884	−1.2
TEACHING AND NO DSH	330	7,377	7,301	−1.0
NO TEACHING AND DSH	794	6,413	6,381	−0.5
NO TEACHING AND NO DSH	1,116	5,664	5,621	−0.8
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33	360	5,276	5,247	−0.6
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	915	3,945	3,915	−0.8
RRC	158	5,132	5,107	−0.5
SCH/EACH	642	4,533	4,514	−0.4
MDH	368	3,511	3,540	0.8
SCH/EACH AND RRC	57	5,315	5,291	−0.5
TYPE OF OWNERSHIP:				
VOLUNTARY	2,924	6,945	6,876	−1.0

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1998 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	No. of hospitals (1)	Average FY 1997 payment per case (2)[1]	Average FY 1998 payment per case (3)[1]	All changes (4)
PROPRIETARY	701	6,154	6,120	−0.6
GOVERNMENT	1,346	6,278	6,250	−0.4
UNKNOWN	117	8,176	7,979	−2.4
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	266	8,955	8,850	−1.2
25–50	1,307	8,229	8,148	−1.0
50–65	1,988	6,180	6,133	−0.8
OVER 65	1,410	5,243	5,196	−0.9
UNKNOWN	117	8,176	7,979	−2.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD				
RECLASSIFICATION STATUS DURING FY97 AND FY98:				
RECLASSIFIED DURING BOTH FY97 AND FY98:	333	6,137	6,083	−0.9
URBAN	96	7,297	7,215	−1.1
RURAL	237	5,253	5,221	−0.6
RECLASSIFIED DURING FY98 ONLY	89	5,199	5,475	5.3
URBAN	13	6,729	6,920	2.8
RURAL	76	4,389	4,710	7.3
RECLASSIFIED DURING FY97 ONLY	211	6,047	5,793	−4.2
URBAN	94	6,981	6,704	−4.0
RURAL	117	4,726	4,504	−4.7
FY 98 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSP.:	423	5,994	5,990	−0.1
STAND. AMT. ONLY	94	5,941	5,885	−0.9
WAGE INDEX ONLY	282	5,923	5,936	0.2
BOTH	47	6,333	6,348	0.2
NONRECLASS.	4,638	6,855	6,788	−1.0
ALL URBAN RECLASS.:	109	7,226	7,178	−0.7
STAND. AMT. ONLY	45	6,449	6,390	−0.9
WAGE INDEX ONLY	31	9,160	9,085	−0.8
BOTH	33	6,578	6,568	−0.1
NONRECLASS.	2,749	7,353	7,281	−1.0
ALL RURAL RECLASS.:	314	5,104	5,133	0.6
STAND. AMT. ONLY	49	4,530	4,480	−1.1
WAGE INDEX ONLY	251	5,162	5,195	0.6
BOTH	14	5,356	5,472	2.2
NONRECLASS.	1,889	4,212	4,175	−0.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	4,740	4,744	0.1

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the changes for FY 1998 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 1998 with the average estimated per case payments for FY 1997, as calculated under our models. 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 II equal the percentage changes in average payments from column 8 of Table I.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have data that were unavailable in previous impact analyses for the capital prospective payment system. Specifically, we have cost report data for the fourth year of the capital prospective payment system (cost reports beginning in FY 1995) available through the June 13, 1997 update of the Health Care Provider Cost Report Information System (HCRIS). We also have updated information on the projected 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 and its projected old capital costs for each year. The lack of this 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 individual hospitals.
- Moreover, our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital

is required to notify its intermediary that it has obligated capital by 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 projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual 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 for purposes of the FY 1998 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 1998 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 1998. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 1998 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 randomly generate 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. We continue to be unable to predict accurately FY 1998 capital costs for individual hospitals, but with the more recent data on the experience to date under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

We have revised Table III since the publication of the proposed rule to provide some information on the effects of the Balanced Budget Act of 1997. Section 4402 of Public Law 105–33 requires a 17.78 percent reduction to the unadjusted standard Federal rate for discharges occurring on or after October 1, 1997. Specifically, we are presenting separate blocks in Table III to show (1) what the effects on FY 1998 payments would have been in the absence of the 17.78 percent reduction to the standard Federal rate, and (2) the effects of all changes, including the 17.78 percent reduction to the standard rate, on payments in FY 1998. In Table III, we used the same outlier effects that we used in conjunction with setting the final rate for FY 1998 (that is, the rate with the effects of the 17.78 percent reduction to the standard rate). If we had recalibrated outliers for the unreduced Federal rate, the estimated rate might have been slightly different. However, the estimates in Table III of the effects without the reduction to the standard Federal rate are adequate for the purpose of evaluating the relative impact of the Balanced Budget Act of 1997.

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 1998 payment policies. We have also revised Table V to provide information on the effects of the Balanced Budget Act of 1997. Specifically, we have added two additional columns to Table V. The first additional column presents the average FY 1998 payments per case without the effects of the Balanced Budget Act of 1997. The second column presents changes attributable solely to the Balanced Budget Act of 1997.

B. Projected Impact Based on the FY 1998 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1997 to FY 1998 using a capital cost model. The FY 1998 model, described in Appendix B of this final rule with comment period, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1995 received through the June 13, 1997 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, 1997 in the provider-specific file. We used these data to determine the FY 1998 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 1995, and we age that capital by a formula described in Appendix B. We therefore need to randomly generate only new capital acquisitions for any year after FY 1995. All Federal rate payment parameters are assigned to the applicable hospital.

Recently available cost report data indicate that old capital costs are declining faster than we previously projected. Consequently, for FY 1998 we are projecting faster declines in old capital. To make up for the larger declines in old capital, we are projecting faster growth in new capital. The combination of these two factors will make the 100-percent Federal rate higher than the hold-harmless rate for some hold-harmless hospitals. Therefore, we are now projecting that more hospitals will move to the 100-percent Federal rate than previously projected.

For purposes of this impact analysis, the FY 1998 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge are projected to change at the following rates during these periods:

Average percentage change in capital costs per discharge

Fiscal year	Percentage change
1996	−2.84
1997	4.46
1998	4.50

- The Medicare case-mix index will increase by 0.5 percent in FY 1997 and by 1.0 in FY 1998.

- Beginning in FY 1996 (with the expiration of budget neutrality), the Federal capital rate and hospital-specific rate were updated by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The final FY 1998 update for inflation is 0.90 percent (see section III of the Addendum).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1997 to FY 1998. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high 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 1998 percent of discharges	FY 1998 percent of capital costs	FY 1998 percent of capital payments
Low Cost Hospital	66	62	56	58
High Cost Hospital	34	38	44	42

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 1997 to FY 1998 using the above described actuarial model. With the final FY 1998 Federal rate, we estimate aggregate Medicare capital payments will decrease by 6.74 percent in FY 1998. The main reason for this decrease is the impact of the 17.78 percent reduction to the Federal rate and the hospital-specific rate.

TABLE III.—IMPACT OF FINAL CHANGES FOR FY 1998 ON PAYMENTS PER DISCHARGE

	No. of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1997
FY 1997 Payments per Discharge									
Low Cost Hospitals	3,331	6,898,994	464.25	63.57	135.71	3.07	11.79	614.82	.....
Fully Prospective	3,078	6,246,888	436.83	60.00	149.88	.....	12.52	599.23	.....
100% Federal Rate	235	609,412	752.47	100.00	.....	.....	3.30	755.77	.....
Hold Harmless	18	42,693	362.22	48.77	.....	496.62	25.67	884.51	.....
High Cost Hospitals	1,684	4,226,709	733.06	97.27	.....	26.00	8.63	767.69	.....
100% Federal Rate	1,522	3,963,050	757.10	100.00	.....	.....	6.29	763.39	.....
Hold Harmless	162	263,659	371.65	52.95	.....	416.84	43.77	832.26	.....
Total Hospitals	5,015	11,125,703	566.37	76.62	84.15	11.78	10.59	672.90	.....
FY 1998 Payments per Discharge Before Effects of the Balanced Budget Act of 1997									
Low Cost Hospitals	3,331	7,064,036	568.02	72.69	108.16	2.43	10.80	689.41	12.13
Fully Prospective	3,078	6,396,330	545.02	70.00	119.46	.....	11.49	675.96	12.81
100% Federal Rate	241	632,394	806.40	100.00	.....	.....	2.75	809.15	7.06
Hold Harmless	12	35,312	464.85	54.94	.....	486.07	30.35	981.26	10.94
High Cost Hospitals	1,684	4,327,823	808.62	98.86	.....	11.55	10.34	830.51	8.18
100% Federal Rate	1,591	4,191,128	819.68	100.00	.....	.....	8.26	827.95	8.46
Hold Harmless	93	136,695	469.57	61.33	.....	365.62	73.98	909.17	9.24
Total Hospitals	5,015	11,391,859	659.42	82.91	67.07	5.89	10.63	743.02	10.42
FY 1998 Payments per Discharge After Effects of the Balanced Budget Act of 1997									
Low Cost Hospitals	3,331	7,064,036	458.51	72.64	87.16	2.73	22.08	570.48	–7.21
Fully Prospective	3,078	6,396,330	440.41	70.00	96.25	.....	23.19	559.85	–6.57
100% Federal Rate	238	626,061	650.85	100.00	.....	.....	7.55	658.40	–12.88
Hold Harmless	15	41,645	348.31	53.30	.....	462.72	69.84	880.87	–0.41
High Cost Hospitals	1,684	4,327,823	643.55	97.70	.....	20.40	18.16	682.10	–11.15
100% Federal Rate	1,528	4,070,204	662.07	100.00	.....	.....	15.37	677.44	–11.26
Hold Harmless	156	257,620	351.00	57.92	.....	342.67	62.11	755.78	–9.19
Total Hospitals	5,015	11,391,859	528.81	82.41	54.04	9.44	20.59	612.88	–8.92

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average decrease in payments per case of 6.57 percent, and that high capital cost hospitals will experience an average decrease of 11.15 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 60 percent to 70 percent and the hospital-specific rate payment percentage will decrease from 40 to 30 percent in FY 1998. The Federal rate payment percentage for hospitals 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 high cost hospitals receiving a hold-harmless payment for old capital will increase from 52.95 percent to 57.92 percent. Without the effects of the Balanced Budget Act of 1997, we estimate that this figure would have increased to 61.33 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 90.7 percent to 91.2 percent. Excluding the effects of the Balanced Budget Act of 1997, we estimate that the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate would have increased to 94.6 percent.

We expect that the average hospital-specific rate payment per discharge will decrease from $84.15 in FY 1997 to $54.04 in FY 1998. This is partly due to the decrease in the hospital-specific rate payment percentage from 40 percent in FY 1997 to 30 percent in FY 1998. Excluding the effects of the Balanced Budget Act of 1997, we estimate that the average hospital-specific payment per discharge would have decreased less dramatically to $67.07 in FY 1998.

For FY 1998, the minimum payment levels are:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.57 percent of total capital payments in FY 1997 to 3.36 percent of payments in FY 1998. These figures are lower than prior estimates due to refinements to our actuarial model. For a further explanation of these refinements, refer to Section B of this Appendix.

The projected distribution of the payments is shown in the table below:

Estimated FY 1998 exceptions payments

Type of hospital	No. of hospitals	Percent of exceptions payments
Low Capital Cost	314	67
High Capital Cost	198	33
Total	512	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV 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	5,015	3.4	35.2	61.4
Large urban areas (populations over 1 million)	1,590	3.9	42.7	53.4
Other urban areas (populations of 1 million or fewer)	1,209	4.2	43.4	52.4
Rural areas	2,216	2.6	25.4	72.0
Urban hospitals	2,799	4.0	43.0	52.9
0–99 beds	674	4.7	36.8	58.5
100–199 beds	946	5.6	48.9	45.5
200–299 beds	569	3.3	43.8	52.9
300–499 beds	457	1.8	40.3	58.0
500 or more beds	153	0.7	39.2	60.1
Rural hospitals	2,216	2.6	25.4	72.0
0–49 beds	1,158	2.2	17.6	80.1
50–99 beds	655	3.4	30.1	66.6
100–149 beds	235	2.1	40.4	57.4
150–199 beds	93	4.3	31.2	64.5
200 or more beds	75	1.3	49.3	49.3
By Region:				
Urban by Region	2,799	4.0	43.0	52.9
New England	158	0.0	27.8	72.2
Middle Atlantic	426	1.6	36.9	61.5
South Atlantic	414	4.1	55.1	40.8
East North Central	471	3.8	33.5	62.6
East South Central	159	5.7	52.8	41.5
West North Central	188	4.8	38.3	56.9
West South Central	344	10.2	58.4	31.4
Mountain	124	3.2	51.6	45.2
Pacific	467	2.6	39.4	58.0
Puerto Rico	48	4.2	25.0	70.8
Rural by Region	2,216	2.6	25.4	72.0
New England	53	0.0	22.6	77.4

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)	
Middle Atlantic	84	2.4	29.8	67.9
South Atlantic	293	2.0	33.4	64.5
East North Central	301	1.3	20.9	77.7
East South Central	273	2.2	34.8	63.0
West North Central	511	2.7	17.8	79.5
West South Central	345	2.6	28.7	68.7
Mountain	211	6.2	19.9	73.9
Pacific	140	2.9	25.7	71.4
Large urban areas (populations over 1 million)	1,735	3.6	42.6	53.8
Other urban areas (populations of 1 million or fewer)	1,153	4.3	42.8	52.9
Rural areas	2,127	2.7	25.1	72.2
Teaching Status:				
Non-teaching	3,922	3.5	34.9	61.6
Fewer than 100 Residents	855	3.9	37.5	58.6
100 or more Residents	238	0.4	31.9	67.6
Disproportionate share hospitals (DSH):				
Non-DSH	3,129	3.6	31.3	65.2
Urban DSH:				
100 or more beds	1,408	3.3	45.7	51.0
Less than 100 beds	81	2.5	34.6	63.0
Rural DSH:				
Sole Community (SCH/EACH)	154	4.5	20.8	74.7
Referral Center (RRC/EACH)	50	2.0	52.0	46.0
Other Rural:				
100 or more beds	66	1.5	39.4	59.1
Less than 100 beds	127	0.8	26.0	73.2
Urban teaching and DSH:				
Both teaching and DSH	707	2.3	38.0	59.7
Teaching and no DSH	329	4.6	32.8	62.6
No teaching and DSH	782	4.2	51.4	44.4
No teaching and no DSH	1,070	4.6	42.3	53.1
Rural Hospital Types:				
Non special status hospitals	905	1.3	26.5	72.2
RRC/EACH	158	1.3	41.8	57.0
SCH/EACH	641	5.8	22.5	71.8
Medicare-dependent hospitals (MDH)	366	0.8	17.8	81.4
SCH, RRC and EACH	57	7.0	33.3	59.6
Type of Ownership:				
Voluntary	2,912	3.1	34.9	62.1
Proprietary	684	8.2	60.4	31.4
Government	1,344	1.8	22.8	75.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	254	3.5	33.5	63.0
25–50	1,300	4.4	42.3	53.3
50–65	1,982	3.3	35.3	61.5
Over 65	1,404	2.8	28.5	68.7

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 73 of the 5,088 hospitals in our database. Consequently, the payment methodology distribution is based on 5,015 hospitals. These 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. The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 35.2 percent in FY 1998.

Table IV indicates that 61.4 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.0 percent and 75.4 percent, respectively by payment classification) are being paid under the fully prospective methodology. This is a reflection of their lower than average capital costs

per case. In contrast, only 31.4 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 1998 actuarial model to estimate the potential impact of changes for FY 1998 on total capital payments per case, using a universe of 5,015 hospitals. The individual hospital payment parameters are taken from the best available data, including: The July 1, 1997 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. Table V presents estimates of payments per case under our model for FY 1997 (column 2). For FY 1998, we present estimates of payments per case both before and after the effects of the 17.78 percent reduction to the standard Federal and hospital-specific rates. Column 5 shows the total percentage change in payments from FY 1997 to FY 1998 (after the effects of the Balanced Budget Act of 1997). Column 6 presents the percentage change that can be attributed to the Balanced Budget Act of 1997 (the 17.78 percent reduction). Column 7 presents the percentage change in payments that can be attributed to Federal rate changes.

Federal rate changes represented in Column 7 include the 15.36 percent decrease in the Federal rate which includes the Balanced Budget Act reduction, a 1.0 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in column 7. Column 5 also reflects the effects of all other changes, including: the change from 60 percent to 70 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, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to decrease 8.9 percent in FY 1998. The results show that the effect of the Balanced Budget Act of 1997 is to decrease payments by 17.5 percent. The results show that the effect of the Federal rate changes is to decrease payments by 11.0 percent. (This figure includes the effects of the Balanced Budget Act of 1997, but also includes the other payment adjustments which offset the magnitude of the 17.78 percent reduction.) In addition to the 11.0 percent decrease attributable to the Federal rate changes, a 2.1 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows that capital payments per case to urban and rural hospitals experience similar rates of decrease (8.8 percent and 9.9 percent, respectively). Payments per case for urban hospitals will decrease at about the same rate as payments per case for rural hospitals (11.0 percent and 11.4 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (2.2 percent and 1.5 percent, respectively) from the effects of all other changes.

By region, there are variations in the change in payments per case. All regions are estimated to receive decreases in total capital payments per case, due to the reduction to the rate and due to the increased share of payments that are based on the Federal rate (from 60 to 70 percent). Changes by region vary from the smallest decrease of 5.1 percent (rural New England region) to the largest decrease of 11.4 percent (urban Puerto Rico hospitals). Overall, Puerto Rico hospitals are affected less by the change to the Federal rate and by the rate reduction due to the Balanced Budget Act of 1997 than other hospitals are nationally. Puerto Rico hospitals are projected to experience a slightly larger decrease in overall payments per case than other regions due to the other factors. We project a reduction in exceptions payments to Puerto Rico hospitals relative to the rest of the nation, which means that Puerto Rico hospitals are receiving a greater share of their capital costs as part of their regular payments. We also project a decrease in hold-harmless payments which is greater than the national average.

By type of ownership, proprietary hospitals are projected to have the largest rate of decrease (11.0 percent, 11.8 percent due to Federal rate changes and a positive increase of 0.8 percent from the effects of all other changes). Payments to voluntary hospitals will decrease 8.8 percent (an 11.0 percent decrease due to Federal rate changes and a 2.2 percent increase from the effects of all other changes) and payments to government hospitals will decrease 7.6 percent (a 10.3 percent decrease due to Federal rate changes and a 2.7 percent increase from the effects of all other changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the Federal capital rate is not affected, 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 1998 compared to the effects of reclassification for FY 1997, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1998 reclassifications, we indicate 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 1998 as a whole are projected to experience a 9.2 percent decrease in payments (a 10.9 percent decrease attributable to Federal rate changes and a 1.7 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will decrease slightly less (8.7 percent) than reclassified hospitals (9.2 percent) overall. Payments to nonreclassified hospitals will decrease slightly less than reclassified hospitals from the Federal rate changes (10.8 percent compared to 10.9 percent), but they will gain slightly more from the effects of all other changes (2.1 percent compared to 1.7 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1997 Payments Compared To FY 1998 Payments]

	Number of hospitals	Average FY 1997 payments/case	Average FY 1998 payments/case before Balanced Budget Act of 1997	Average FY 1998 payments/case after Balanced Budget Act of 1997	All changes	Change due to Balanced Budget Act of 1997	Portion attributable to Federal rate change
By Geographic Location:							
All hospitals	5,015	673	743	613	−8.9	−17.5	−11.0
Large urban areas (populations over 1 million)	1,590	770	851	703	−8.7	−17.4	−10.9
Other urban areas (populations of 1 million or fewer)	1,209	664	733	605	−8.9	−17.5	−11.1
Rural areas	2,216	461	507	416	−9.9	−18.0	−11.4
Urban hospitals	2,799	725	801	661	−8.8	−17.4	−11.0
0–99 beds	674	540	588	485	−10.1	−17.5	−11.6
100–199 beds	946	649	710	585	−9.8	−17.5	−11.5
200–299 beds	569	700	771	633	−9.6	−17.9	−11.4
300–499 beds	457	756	840	693	−8.2	−17.4	−10.9
500 or more beds	153	883	985	820	−7.2	−16.8	−9.7
Rural hospitals	2,216	461	507	416	−9.9	−18.0	−11.4
0–49 beds	1,158	367	403	333	−9.3	−17.5	−11.1
50–99 beds	655	433	474	390	−9.9	−17.7	−11.3
100–149 beds	235	480	531	434	−9.7	−18.4	−11.9
150–199 beds	93	499	548	452	−9.5	−17.6	−10.7
200 or more beds	75	581	637	518	−10.7	−18.7	−12.0
By Region:							
Urban by Region	2,799	725	801	661	−8.8	−17.4	−11.0
New England	158	735	815	673	−8.5	−17.4	−11.3
Middle Atlantic	426	769	849	698	−9.3	−17.8	−11.1
South Atlantic	414	719	791	657	−8.6	−17.0	−11.3
East North Central	471	686	760	625	−8.9	−17.8	−10.6
East South Central	159	668	746	620	−7.1	−16.9	−10.0
West North Central	188	709	785	650	−8.3	−17.3	−10.6
West South Central	344	734	806	668	−9.0	−17.1	−10.8
Mountain	124	742	811	668	−9.9	−17.6	−11.3
Pacific	467	790	877	723	−8.5	−17.5	−11.2
Puerto Rico	48	300	319	266	−11.4	−16.7	−10.6
Rural by Region	2,216	461	507	416	−9.9	−18.0	−11.4
New England	53	531	596	504	−5.1	−15.5	−11.1
Middle Atlantic	84	477	518	425	−10.9	−17.9	−12.0
South Atlantic	293	496	541	448	−9.7	−17.2	−11.8
East North Central	301	458	505	414	−9.8	−18.0	−11.4
East South Central	273	425	471	381	−10.4	−19.2	−11.8
West North Central	511	439	480	395	−10.0	−17.7	−10.6
West South Central	345	425	467	379	−10.9	−18.9	−11.8
Mountain	211	486	533	437	−9.9	−17.9	−10.4
Pacific	140	523	584	479	−8.4	−17.9	−11.1
By Payment Classification:							
All hospitals	5,015	673	743	613	−8.9	−17.5	−11.0
Large urban areas (populations over 1 million)	1,735	760	840	693	−8.7	−17.5	−10.9
Other urban areas (populations of 1 million or fewer)	1,153	663	732	605	−8.8	−17.4	−11.1
Rural areas	2,127	456	500	411	−10.0	−17.9	−11.5
Teaching Status:							
Non-teaching	3,922	582	638	523	−10.1	−18.0	−11.7
Fewer than 100 Residents	855	711	787	648	−8.8	−17.6	−10.9
100 or more Residents	238	961	1,075	902	−6.2	−16.2	−9.4
Urban DSH:							
100 or more beds	1,408	764	844	701	−8.2	−16.9	−10.6
Less than 100 beds	81	528	583	477	−9.7	−18.2	−11.3
Rural DSH:							
Sole Community (SCH/EACH)	154	412	448	381	−7.5	−15.0	−10.6
Referral Center (RRC/EACH)	50	534	587	485	−9.2	−17.4	−11.2
Other Rural:							
100 or more beds	66	438	478	389	−11.3	−18.6	−12.3
Less than 100 beds	127	367	405	327	−11.1	−19.3	−11.6
Urban teaching and DSH:							
Both teaching and DSH	707	830	919	767	−7.5	−16.5	−10.1

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1997 Payments Compared To FY 1998 Payments]

	Number of hospitals	Average FY 1997 payments/case	Average FY 1998 payments/case before Balanced Budget Act of 1997	Average FY 1998 payments/case after Balanced Budget Act of 1997	All changes	Change due to Balanced Budget Act of 1997	Portion attributable to Federal rate change
Teaching and no DSH	329	720	805	659	−8.5	−18.2	−10.9
No teaching and DSH	782	657	722	594	−9.6	−17.7	−11.5
No teaching and no DSH	1,070	628	688	562	−10.5	−18.4	−12.1
Rural Hospital Types:							
Non special status hospitals	905	412	452	366	−11.1	−19.0	−12.0
RRC/EACH	158	541	596	481	−11.1	−19.3	−11.7
SCH/EACH	641	444	484	407	−8.4	−15.9	−11.0
Medicare-dependent hospitals (MDH)	366	367	408	337	−8.4	−17.6	−11.3
SCH, RRC and EACH	57	537	581	493	−8.1	−15.0	−10.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:							
Reclassification Status During FY97 and FY98:							
Reclassified During Both FY97 and FY98	333	631	705	569	−9.8	−19.2	−11.6
Reclassified During FY98 Only	89	544	629	515	−5.4	−18.2	−6.8
Reclassified During FY97 Only	178	615	654	529	−13.9	−19.1	−14.4
FY98 Reclassifications:							
All Reclassified Hospitals	422	618	693	561	−9.2	−19.1	−10.9
All Nonreclassified Hospitals	4,511	679	750	620	−8.7	−17.3	−10.8
All Urban Reclassified Hospitals	109	718	804	648	−9.8	−19.4	−11.3
Urban Nonreclassified Hospitals	2,690	725	801	662	−8.7	−17.3	−10.9
All Reclassified Rural Hospitals	313	545	613	498	−8.8	−18.8	−10.6
Rural Nonreclassified Hospitals	1,876	430	467	385	−10.3	−17.5	−11.8
Other Reclassified Hospitals (Section 1886(D)(8)(B))	27	508	564	449	−11.7	−20.5	−11.6
Type of Ownership:							
Voluntary	2,912	688	760	628	−8.8	−17.5	−11.0
Proprietary	684	676	738	602	−11.0	−18.5	−11.8
Government	1,344	590	656	545	−7.6	−17.0	−10.3
Medicare Utilization as a Percent of Inpatient Days:							
0–25	254	756	845	709	−6.2	−16.1	−10.6
25–50	1,300	792	876	727	−8.3	−17.0	−10.4
50–65	1,982	628	694	570	−9.3	−17.8	−11.3
Over 65	1,404	560	616	503	−10.2	−18.2	−12.0

Appendix B: Technical Appendix on the New Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor, and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We have used the capital acquisition model since the start of prospective payments for capital costs. We now have 4 years of cost reports under the capital prospective payment system. Consequently, we have developed a new capital cost model to replace the capital acquisition model. This new model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this final rule: the June 13, 1997 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), and PPS–XII (cost reporting periods beginning in FY 1995). In addition, to model payments, we use the July 1, 1997 update of the provider-specific file, and the March

1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 1997 hospital-specific rates using the provider-specific file and the intermediary audit file. (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 ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Provider-Specific File Only	117
Provider-Specific and Audit File	4971
Total	5088

Ninety-seven of the 5,088 hospitals had unusable or missing data or had no cost reports available. We determined from the cost reports that 24 of the 97 hospitals were paid under the hold-harmless methodology. Since the hospital-specific amount is not used to determine payments for these hospitals, we were able to include these 24 hospitals in the analysis. Seventy-three hospitals could not be used in the analysis because of insufficient information. They account for about 0.2 percent of admissions so any effect should be minimal. Therefore, we used data from cost reports from 5,015 hospitals for the analysis.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large (greater than ±20 percent) changes in bed-size. We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis only for decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should, therefore, decrease as assets become fully depreciated, and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase.

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease)
- Bed-size increases over 20 percent (increase)
- Other (no-change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed-size for large hospitals. We found the probability somewhat dependent on the prior year change in bed-size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed-size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed-size for large hospitals, we first projected changes in bed-size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1996 (the MEDPAR data year) and later, we use the number of discharges from the MEDPAR data. Some hospitals have considerably more discharges in FY 1996 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over many discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We correct this situation by recalculating the cost per discharge with the MEDPAR discharges if the MEDPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received every FY 1996 discharge, and because some discharges are removed from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal Rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that are consistent with our aggregate capital projections.

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 as determined from the provider-specific file and the cost reports. 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 FY 1996 MedPAR file using the FY 1998 DRG relative weights published in section V. of the Addendum of this final rule. The case-mix index is increased each year after FY 1996 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 0.5 percent in FY 1997 and 1.0 percent in FY 1998. (Since we are using FY 1996 cases for our analysis, the FY 1996 increase in case mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from 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 1997, the budget neutrality adjustment factor was 1.00123. To determine the factor for FY 1998, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1998 based on its applicable payment methodology. Using our model, we then compared estimated aggregate Federal rate payments based on the FY 1997 DRG relative weights and the FY 1997 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1998 relative weights and the FY 1998 geographic adjustment factor. In making the comparison, we held the FY 1998 Federal rate portion constant and set the other budget neutrality adjustment factor and the 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 0.99892 for FY 1998 should be applied to the previous cumulative FY 1997 adjustment of 1.00123, yielding a cumulative adjustment of 1.00015 through FY 1998. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTOR

Fiscal year	Incremental adjustment	Cumulative adjustment
1992	.....	1.00000
1993	0.99800	0.99800
1994	1.00531	1.00330
1995	0.99980	1.00310
1996	0.99940	1.00250
1997	0.99873	1.00123
1998	0.99892	1.00015

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 relative 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 payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

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 the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made 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 exceptions reduction factor must be determined through iteration.

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 fiscal years 1992 through 1998, and the estimated factors that would be applicable through FY 2002. We caution that these are estimates for fiscal years 1999 and later, 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 budget neutrality adjustment factor will remain at 1.00015 for FY 1998 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1998.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier) reduction)
1992	N/A	0.9813	0.9602	.....	.9497	.....	415.59
1993	6.07	.9756	.9162	.9980	.9496	.....	417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2].9260	378.34
1995	3.44	.9734	.8432	.9998	.9414	.....	376.83
1996	1.20	.9849	N/A	.9994	.9536	[3].9972	461.96
1997	0.70	.9358	N/A	.9987	.9481	.....	438.92
1998	0.90	.9659	N/A	.9989	.9382	[4].8222	371.51
1999	1.20	.9518	N/A	[5]1.0000	[5].9382	.....	370.48
2000	1.20	.9409	N/A	1.0000	.9382	.....	370.63
2001	1.30	.9324	N/A	1.0000	.9382	.....	372.06
2002	1.30	[6]1.0000	N/A	1.0000	.9382	.....	404.22

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.
[3] Note: Adjustment for change in the transfer policy.
[4] Note: Balanced Budget Act of 1997 adjustment.
[5] Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.
[6] Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

Appendix C: Revised Hospital Market Basket Data Sources

I. Introduction: Market Basket Relative Weights and Choice of Price Proxy Variables for the Operating Hospital Input Price Indexes

In the August 30, 1996 final rule (61 FR 46323), we discussed in detail the current 1992-based hospital market baskets, and noted that we would revise the hospital market baskets when new cost data for 1992 became available. This appendix describes the technical features of the revisions to the 1992-based indexes that we set forth in this final rule with comment period in section IV of the preamble. For both the prospective payment and excluded hospital market baskets, the differences between the revised market basket and the current market basket are noted.

We present this description of the hospital operating market baskets in three steps:

- A synopsis of the differences between the current 1992-based market baskets and the revisions to those market baskets.
- A description of the methodology used to develop the cost category weights in the revised market baskets, making note of the differences from the methodology used to develop the 1992-based current market baskets.
- A description of the data sources used to measure price change for each component of the revised market baskets, making note of the differences from the price proxies used in the 1992-based current hospital market baskets.

II. Synopsis of Differences

Two major differences exist between the 1992-based current hospital market baskets and the hospital market baskets. The first major change is that the revised hospital market baskets are based on additional hospital expenditure data—data not available until after the publication of the August 30, 1996 final rule. The 1992-based current market baskets were derived from hospital cost reports for cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992, augmented by information from the latest available (1987) Input-Output Table for the hospital industry, produced by the Bureau of Economic Analysis, U.S. Department of Commerce. In addition to the data sources cited above, the revised hospital market baskets use data from the 1992 Asset and Expenditure Survey, produced by the U.S. Department of Commerce, Economic and Statistics Administration, Bureau of the Census. These are more recent data made available after the publication of the August 30, 1996 final rule.

The second major difference is that some cost categories have been combined with other cost categories to better reflect the new data sources. Specifically, the Transportation Services category has been combined with All Other Nonlabor-Intensive Services; Business Services and Computer and Data Processing Services with All Other Labor-Intensive Services; and part of Fuel Oil, Coal, etc. was combined with Natural Gas into Fuels, Nonhighway. The remainder of the Fuel Oil, Coal, etc. was combined with Miscellaneous Products. These category mergers reflect the Bureau of the Census categories in the Asset and Expenditure Survey and its information on services.

III. Methodology for Developing the Revised Cost Category Weights

Cost category weights for the revised market baskets were developed in three stages. First, base weights for the six main categories (Wages and Salaries, Employee Benefits, Pharmaceuticals, Nonmedical Professional Fees, Professional Liability Insurance, and All Other Expenses) were obtained from the 1992-based hospital market baskets. As the base year is not changing, these weights, developed last year from HCRIS data and the American Hospital Association (AHA) Annual Survey information, will not change. The weight for All Other Expenses was divided into subcategories using cost shares from the 1992 Asset and Expenditure Survey for Hospitals, U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. These subcategories were further divided using cost shares from the 1987 Input-Output Table for the hospital industry, produced by the U.S. Department of Commerce, Bureau of Economic Analysis (BEA), aged to 1992 using price changes.

A description of the source of the six main category weights is found in the August 30, 1996 final rule (61 FR 46323). The weight for the Utilities category, as well as those for the Electricity, Fuels Nonhighway, and Water and Sewerage Maintenance cost categories, was derived from the 1992 Asset and Expenditure Survey. The All Other Goods and Services category has more subcategories than any other market basket category. Goods found in this category include: direct service food, contract service food, pharmaceuticals, chemicals, medical instruments, photo supplies, rubber and plastics, paper products, apparel,

machinery and equipment and miscellaneous products. Services found in this category include telephone services, postage, other labor-intensive services, and other nonlabor-intensive services. The share for pharmaceuticals was derived from the 1992 Medicare cost reports. Relative shares for the other subcategories were derived from the 1992 Asset and Expenditure Survey, augmented by data from the 1987 Input-Output Table produced by BEA for the hospital industry, aged forward to 1992 using price changes, and then standardized to be consistent with data from the Asset and Expenditure Survey.

IV. Price Proxies Used to Measure Cost Category Growth

Descriptions of the price proxies used to measure cost category price growth in the current hospital market baskets are found in the August 30, 1996 final rule (61 FR 46324). The price proxies used for the revised hospital market baskets are the same as those for the current market baskets. Four cost categories in the current hospital market baskets have been combined with other cost categories to better reflect new data sources.

For further discussion of the rationale for choosing specific price proxies, we refer the reader to the September 3, 1986 final rule (51 FR 31582).

Appendix D: 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 inpatient services furnished in FY 1998 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XIII) of the Act, as amended by section 4401(a)(2) of Pub. L. 105–33, sets the percentage change in the operating cost standardized amounts equal to 0 percent for FY 1998. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1998 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or 0 percent. (As discussed in section V.D. of this preamble, section 4401(b) of Pub. L. 105–33 provides for an increase in the operating cost standardized amounts of 0.5 percentage points for certain hospitals that do not receive disproportionate share or indirect medical education payments and are not designated as Medicare-dependent, small rural hospitals.) Section 1886(b)(3)(B)(ii) of the Act, as amended by section 4411(a) of Pub. L 105–33, sets the FY 1998 percentage increase in the rate-of-increase limits for hospitals excluded from the prospective payment system equal to 0 percent. Therefore, in accordance with section 1886(d)(3)(A) of the Act, we are updating the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system by 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, 1997 an update factor that takes into account changes in the market basket rate of increase index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services. In Recommendation 2 of its March 1, 1997 report, ProPAC recommended update factors to the standardized amounts equal to 0 percentage points for hospitals in both large urban and other areas. ProPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. As required by section 1886(e)(5) of the Act, we published the FY 1998 update factors recommended under section 1886(e)(4) of the Act as Appendix E of the June 2, 1997 proposed rule (62 FR 30034).

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 an update of 0 percentage points for hospitals located in large urban and other areas. We are also recommending an update of 0 percentage points to the hospital-specific rate for sole community and Medicare-dependent, small rural hospitals. We continue to believe these recommended update factors would ensure that Medicare acts as a prudent purchaser and would provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

We are also recommending an update of 0 percentage points for hospitals and hospital units excluded from the prospective payment system. This update is consistent with the updates provided to the prospective payment hospitals.

Comment: Several commenters opposed the Secretary's recommendation that prospective payment hospitals receive a 0 percent update for FY 1998. The commenters observed that HCFA's update framework analysis supports a recommendation of not less than the market basket percentage increase minus 1.6 percentage points and asked why we had not relied on the results of the update framework in determining the recommended update. The commenters further stated that our recommendation ignores the variation in financial condition among hospitals and that the lack of an increase in the standardized amount will have an adverse impact on a significant number of hospitals.

ProPAC supported our recommendation for an update of 0 percentage points, noting that the average Medicare inpatient operating costs per case and lengths of stay in prospective payment hospitals are both continuing to decrease, while total operating margins for hospitals have increased sharply. ProPAC believes that a 0 update will not harm either the hospital industry or Medicare beneficiaries.

Response: In developing our update recommendation, we took into account the results of our update framework analysis in combination with several other factors. As stated in the proposed rule, these factors included the relative decrease in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. We also considered the factors cited by ProPAC, particularly the decrease in costs per case. Thus, although we recognize that there is variation in financial condition among hospitals, we believe that a 0 percentage point update will result in payment rates that adequately compensate hospitals for the costs of efficient and effective treatment of Medicare beneficiaries.

Comment: Several commenters stated that the Secretary's recommendation of

a 0 percentage point update, notwithstanding the results of HCFA's update framework analysis, could lower the confidence of hospitals in HCFA's objectivity. They indicated that the discrepancy between the results of the update framework and the recommended update casts doubts on HCFA's ability to administer the prospective payment system fairly.

Response: We strongly object to the suggestion that the difference between the results of HCFA's update framework analysis and the Secretary's recommended update indicates any lack of objectivity in our analysis process or reflects on our ability to administer the Medicare program impartially. The update framework analysis is a largely empirical process carried out by HCFA that quantifies changes in hospital productivity, scientific and technological advances, practice pattern changes, and hospital case mix. In recommending an update, the Secretary takes these factors into account, as well as other factors such as the recommendations of ProPAC and the long-term solvency of the Medicare trust fund. Thus, the difference between the results of HCFA's update framework and the update recommended by the Secretary is reflective of the integrity of the update framework analysis process, which has not been compromised to produce an artificial congruence with the Secretary's recommendation. We continue to believe that the recommended update of 0 percentage points appropriately adjusts for overall changes occurring in the health care delivery system.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

Our final recommendation is that hospitals and hospital units excluded from the prospective payment system also receive an update of 0 percentage points. This update is consistent with the updates provided to the prospective payment hospitals. We note that we carry out a separate update framework analysis for excluded hospitals and units, but the analysis indicates the same findings regarding changes in productivity, scientific and technological advances, practice patterns, and case mix for FY 1998 for excluded hospitals and for prospective payment system hospitals. We believe these updates will ensure that Medicare acts as a prudent purchaser and will provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

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