Federal Register

Tuesday,
August 1, 2000

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 410, et al.

Medicare Program; Provisions of the Balanced Budget Refinement Act of 1999; Hospital Inpatient Payments and Rates and Costs of Graduate Medical Education; Final Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 412, 413, 482, and 485

[HCFA–1131–IFC]

RIN 0938–AK20

Medicare Program; Provisions of the Balanced Budget Refinement Act of 1999; Hospital Inpatient Payments and Rates and Costs of Graduate Medical Education

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements, or conforms the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that are contained in the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Public Law 106–113). These provisions relate to reclassification of hospitals from urban to rural status, reclassification of certain hospitals for purposes of payment during Federal fiscal year 2000, critical access hospitals, payments to hospitals excluded from the hospital inpatient prospective payment system, and payments for indirect and direct graduate medical education costs.

Many of the provisions of Public Law 106–113 modify changes to the Social Security Act made by the Balanced Budget Act of 1997 (P.L. 105–33). These provisions are already in effect in accordance with Public Law 106–113.

DATES: *Effective Date:* This interim final rule with comment period is effective on August 1, 2000.

Comment Period: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on August 31, 2000.

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1131–IFC, P.O. Box 8010, Baltimore, MD 21244–1850.

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

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the indicated addresses may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1131–IFC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–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 the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1131-IFC; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt HCFA–1131–IFC, HCFA Desk Officer

FOR FURTHER INFORMATION CONTACT:

Steve Phillips, (410) 786–4531, Operating Prospective Payment, Wage Index, and Reclassifications

Tzvi Hefter, (410) 786–4487, Excluded Hospitals, Graduate Medical Education, and Critical Access Hospital Issues

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

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I. Background: Program Summary

Section 1886(d) of the Social Security Act (the Act) sets forth 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. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Payment for cases within each DRG is weighted to account for the average resources used to treat patients within that DRG. In addition, these payments are adjusted by a wage index (and a geographic adjustment factor derived from the wage index in the case of capital payments) to account for the varying costs of labor across areas, and by separate adjustment factors for the additional operating costs associated with graduate medical education (GME) and for treating a disproportionate share of low-income patients.

Certain specialty hospitals are excluded from the prospective payment system. Under section 1886(d)(1)(B) of the Act, the following classes of hospitals and hospital units are excluded from the prospective payment system: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on

reasonable costs subject to a hospital-specific annual limit.

Under sections 1814(l) and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural nonprofit hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(i)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved GME programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's costs per resident in a base year and the hospital's number of residents in that period.

The regulations governing the hospital inpatient prospective payment system are located in 42 CFR Part 412. The regulations governing excluded hospitals and hospital units and the regulations governing direct GME are located in 42 CFR Part 413. The regulations governing CAHs are located in 42 CFR Part 485.

II. Provisions of the Interim Final Rule With Comment Period

On November 29, 1999, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) was enacted. Public Law 106–113 made a number of changes to the Act affecting Medicare payments to hospitals for inpatient services. Many of the provisions of Public Law 106–113 are modifications to provisions of the Act included in the Balanced Budget Act of 1997 (Pub. L. 105–33). Some of the provisions of Public Law 106–113 became effective prior to, or shortly after, its passage on November 29, 1999. Other provisions do not become effective until Federal fiscal year (FY) 2001 or later. The provisions of Public Law 106–113 that are effective beginning October 1, 2000, were included in the proposed rule for FY 2001 Medicare hospital inpatient prospective payment system published in the **Federal Register** on May 5, 2000 (65 FR 26281) which is being finalized in this issue of the **Federal Register**.

The following is a summary of the policy changes we are implementing in this interim final rule with comment period as a result of Public Law 106–113:

A. Changes Relating to Payments for Operating Costs under the Hospital Inpatient Prospective Payment System

- *Reclassification of Certain Counties.* We are implementing the provisions of section 152(a) of Public Law 106–113 that reclassified hospitals in certain designated counties for purposes of making payments to those hospitals under section 1886(d) of the Act for FY 2000. The counties affected by this provision are identified under section III of this preamble.
- *Wage Index.* We are implementing sections 153 and 154 of Public Law 106–113 that contain provisions affecting the wage indexes of specific Metropolitan Statistical Areas (MSA). Under section 153, the Hattiesburg, Mississippi FY 2000 wage index is to be calculated including wage data from Wesley Medical Center. Under section 154, the Allentown-Bethlehem-Easton, Pennsylvania MSA FY 2000 wage index is to be calculated including wage data for Lehigh Valley Hospital.
- *Reclassification of Certain Urban Hospitals as Rural Hospitals.* We are implementing section 401 of Public Law 106–113 which directed the Secretary to treat certain hospitals located in urban areas as being located in the rural area of their State if the hospital meets statutory criteria and files an application with HCFA. This provision is effective on January 1, 2000.
- *Indirect Medical Education (IME) Adjustment.* We are implementing section 111 of Public Law 106–113 which provides for an additional payment to teaching hospitals equal to the additional amount the hospitals would have been paid for FY 2000 if the IME adjustment formula (which reflects the higher indirect operating costs associated with GME) for FY 2000 had remained the same as for FY 1999.
- *Medicare-Dependent, Small Rural Hospitals.* We are implementing section 404 of Public Law 106–113 which extends the Medicare-dependent, small rural hospital (MDH) program and its current payment methodology for an additional 5 years, from FY 2002 through FY 2006.

B. Additional Changes Relating to Direct GME and Indirect Medical Education

- *Initial Residency Period for Child Neurology Residency Programs.* We are implementing section 312 of Public Law 106–113 which provides that in determining the number of residents for purposes of GME and IME payments, the period of board eligibility and the initial residency period for child neurology is the period of board eligibility for pediatrics plus 2 years. This provision applies on and after July 1, 2000, to residency programs that began before, on, or after November 29, 1999.
- *Residents on Approved Leave of Absences.* We are implementing section 407(a) of Public Law 106–113 which provides that, for purposes of determining a hospital's full-time equivalent (FTE) cap for direct GME payments and the IME adjustment, a hospital may count an individual to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. The provision relating to direct GME is effective with cost reporting periods beginning on or after November 29, 1999. The provision relating to the IME adjustment applies to discharges occurring in cost reporting periods beginning on or after November 29, 1999.
- *Expansion of Number of Unweighted Residents in Rural Hospitals.* We are implementing section 407(b) of Public Law 106–113 which provides that a rural hospital's resident FTE count for direct GME and IME may not exceed 130 percent of the number of unweighted residents that the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996. The provision relating to direct GME applies to cost reporting periods beginning on or after April 1, 2000. The provision relating to the IME adjustment applies to discharges occurring on or after April 1, 2000.
- *Urban Hospitals with Rural Training Tracks or Integrated Rural Tracks.* We are implementing section 407(c) of Public Law 106–113 which allows an urban hospital that establishes separately accredited approved medical residency training programs (or rural training tracks) in a rural area or has an accredited training program with an integrated rural track to receive an FTE cap adjustment for purposes of direct GME and IME. The provision is effective with cost reporting periods beginning on or after April 1, 2000, for direct GME, and with discharges occurring on or after April 1, 2000, for IME.
- *Residents Training at Certain Veterans Affairs Hospitals.* We are implementing section 407(d) of Public Law 106–113 which provides that a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who were training at a VA hospital and were transferred on or after January 1, 1997, and before July 31, 1998, to the non-VA

hospital because the program at the VA hospital would lose its accreditation by the Accreditation Council on Graduate Medical Education if the residents continued to train at the facility. This provision applies as if it was included in the enactment of Public Law 105–33, that is, for direct GME, with cost reporting periods beginning on or after October 1, 1997, and for IME, for discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

C. Payments for Nursing and Allied Health Education: Utilization of Medicare+Choice Enrollees

We are implementing section 541 of Public Law 106–113 which provides an additional payment to hospitals that receive payments under section 1861(v) of the Act for approved nursing and allied health education programs to reflect utilization of Medicare+Choice enrollees. This provision is effective for portions of cost reporting periods in a year beginning with calendar year 2000.

D. Changes Relating to Hospitals and Hospital Units Excluded From the Prospective Payment System

We are implementing section 121 of Public Law 106–113 which amended section 1886(b)(3)(H) of the Act to direct the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals for cost reporting periods beginning on or after October 1, 1999.

E. Changes Relating to Critical Access Hospitals (CAHs)

We are implementing—

- Section 401(b)(2) of Public Law 106–113, which contains a conforming change to incorporate the reclassifications made by section 401(a) of Public Law 106–113 to the CAH criteria (section 1820(c)(2)(B)(i) of the Act). This provision is effective beginning on January 1, 2000.
- Section 403(a) of Public Law 106–113, which deletes the 96-hour length of stay restriction on inpatient care in a CAH and authorizes a period of stay that does not exceed, on an annual, average basis, 96 hours per patient. This provision is effective beginning on November 29, 1999.
- Section 403(b) of Public Law 106–113, which allows for-profit hospitals to qualify for CAH status. This provision is effective beginning on November 29, 1999.
- Section 403(c) of Public Law 106–113, which allows hospitals that have closed within 10 years prior to November 29, 1999, or hospitals that downsized to a health clinic or health center, to be designated as CAHs if they satisfy the established criteria for designation, other than the requirement for existing hospital status.
- Section 403(e) of Public Law 106–113, which eliminates the Medicare Part B deductible and coinsurance for clinical diagnostic laboratory tests furnished by a CAH on an outpatient basis. This provision is effective with respect to services furnished on or after November 29, 1999.
- Section 403(f) of Public Law 106–113, entitled ''Participation in Swing Bed Program,'' which amended sections 1883(a)(1) and (c) of the Act.

F. Changes Relating to Hospital Swing Bed Program

We are implementing section 408(a) of Public Law 106–113 which eliminates the requirement for a hospital to obtain a certification of need to use acute care beds as swing beds for skilled nursing facility (SNF) level of care patients; and section 408(b) of Public Law 106–113 which eliminates constraints on the length of stay in swing beds for rural hospitals with 50 to 100 beds. These provisions are effective on the first day after the expiration of the transition period for prospective payments for covered SNF services under the Medicare program (that is, at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998 and extend through the end of the facility's third cost reporting period after this date).

III. Reclassification of Certain Counties

Under section 152(a) of Public Law 106–113 hospitals in certain counties are deemed to be located in specified areas for purposes of payment to the hospitals under the hospital inpatient prospective payment system, for discharges occurring during FY 2000. For payment purposes, hospitals under section 152(a) are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. We have calculated FY 2000 wage indexes for hospitals in the affected counties. These wage indexes are listed below. No other hospitals' FY 2000 wage indexes were affected, including those hospitals in the areas to which these affected hospitals were reclassified, as well as nonreclassified hospitals located in the areas from which these hospitals were reclassified.

Section 152(a) provides that, for purposes of making payments under section 1886(d) of the Act for FY 2000—

- To hospitals in Iredell County, North Carolina, Iredell County is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA;
- To hospitals in Orange County, New York, Orange County is deemed to be located in the New York, New York MSA;
- To hospitals in Lake County, Indiana and Lee County, Illinois, Lake County and Lee County are deemed to be located in the Chicago, Illinois MSA;
- To hospitals in Hamilton-Middletown, Ohio, Hamilton-Middletown is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- To hospitals in Brazoria County, Texas, Brazoria County is deemed to be located in the Houston, Texas MSA;
- To hospitals in Chittenden County, Vermont, Chittenden County is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

In accordance with section 153 of Public Law 106–113, for discharges occurring during FY 2000, the Hattiesburg, Mississippi MSA wage index was recalculated by including the wage data for Wesley Medical Center. In accordance with section 154(a), the Allentown-Bethlehem-Easton, Pennsylvania MSA FY 2000 wage index was recalculated by including the wage data for Lehigh Valley Hospital.

The following table shows the changes to the FY 2000 wage index values and geographic adjustment factors for capital payments for the hospitals in the affected areas. Hospitals affected by section 152(a) of Public Law 106–113 will now also be considered reclassified for purposes of the standardized amount.

County or MSA	New MSA (for wage index and standardized amount)	New wage index	New geographic adjustment factor (GAF)
Iredell County, NC	1520	0.9434	0.9609

County or MSA	New MSA (for wage index and standardized amount)	New wage index	New geographic adjustment factor (GAF)
Orange County, NY	5600	1.4342	1.2801
Lake County, IN	1600	1.0750	1.0508
Lee County, IL	1600	1.0750	1.0508
Hamilton-Middletown, OH	1640	0.9419	0.9598
Brazoria County, TX	3360	0.9388	0.9577
Chittenden County, VT	1123	1.1359	1.0912
Hattiesburg, MS MSA	MSA is not new	0.7634	0.8312
Allentown-Bethlehem-Easton, PA MSA	MSA is not new	1.0228	1.0156

IV. Reclassifications of Hospitals (Sections 401(a) and (b) of Public Law 106–113 and 42 CFR 412.63(b), 412.90(e), 412.102, and New 412.103)

A. Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals

Under Medicare law, the location of a hospital can affect its payment methodology as well as whether the facility qualifies for special treatment both for operating and for capital payments. Whether a facility is situated in an urban or a rural area will, for example, affect payments based on the wage index values and Federal standardized amounts specific to the area. Similarly, the percentage increase in payments made to hospitals that treat a disproportionate share of low-income patients is based, in part, on its urban/rural status, as are determinations regarding a hospital's qualification as a sole community hospital (SCH), rural referral center (RRC), CAH, or other special category of facility. Section 1886(d)(2)(D) of the Act defines an ''urban area'' as an area within a MSA as defined by the Office of Management and Budget. The same provision defines a ''large urban area,'' with respect to any fiscal year, as an urban area that the Secretary determines (in the publications described in section 1886(e)(5) of the Act before the fiscal year) has a population of more than 1 million as determined based on the most recent available published Census Bureau data. Section 1886(d)(2)(D) of the Act further defines a ''rural area'' as an area that is outside of a ''large'' urban area or ''other'' urban area. Since FY 1995, the average standardized amount for hospitals located in rural areas and ''other'' urban areas has been equal, as provided for in section 1886(b)(3)(B)(i)(X) of the Act.

Several provisions of the Act provide procedures under which a hospital can apply for reclassification from one geographic area to another: section 1886(d)(8)(B) of the Act, which provides that if certain conditions are met, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute; and section 1886(d)(10) of the Act, which establishes the Medicare Geographic Classification Review Board (MGCRB) process to permit hospitals to be reclassified for purposes of the standardized amount or the wage index if they meet criteria established by the Secretary.

Section 401(a) of Public Law 106–113, which amended section 1886(d)(8) by adding a new paragraph (E), directs the Secretary to treat any subsection (d) hospital located in an urban area as being located in the rural area of the State in which the hospital is located if the hospital files an application (in the form and manner determined by the Secretary) and meets one of the following criteria:

- The hospital is located in a rural census tract of a MSA (as determined under the most recent modification of the Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992 (57 FR 6725));
- The hospital is located in an area designated by any law or regulation of the State as a rural area (or is designated by the State as a rural hospital);
- The hospital would qualify as a RRC, or as a SCH if the hospital were located in a rural area; or
- The hospital meets any other criteria specified by the Secretary.

The statutory effective date of this provision is January 1, 2000.

The Goldsmith Modification, one of the qualifying statutory criteria, evolved from an outreach grant program sponsored by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA). The program's purpose was to establish an operational definition of rural populations lacking easy geographic access to health services. Using 1980 Census Bureau data, Dr. Harold F. Goldsmith and his associates created a methodology for identification of census tracts that were located within a large metropolitan county of at least 1,225 square miles but were so isolated from the metropolitan core by distance or physical features as to be more rural than urban in character. The most important criterion used to identify these census tracts is the comparatively few residents in these areas, less than 15 percent of the labor force, who commute to work in the metropolitan core and suburbs. Appendix A of this interim final rule with comment period lists the identified urban counties with census tracts that may qualify as rural under the most recent Goldsmith Modification (January 1, 2000). The amendments made by section 401 of Public Law 106–113 enable a hospital located in one of these areas to be treated as if it were situated in the rural area of the State in which it is located. In making determinations under section 1886(d)(8)(E) of the Act, we will utilize the most recent Goldsmith Modification which reflects data based on the 1990 census.

Additionally, section 401(a) of Public Law 106–113 includes hospitals ''* * * located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).'' We are requiring that a hospital's designation as rural be in the form of either State law or regulation if it is the basis for a hospital's request for urban to rural reclassification under section 1886(d)(8)(E) of the Act. We believe this will help ensure that the provision is implemented consistently among States.

Finally, a hospital also may seek to qualify for reclassification premised on the fact that, had it been located in a rural area, it would have qualified as an RRC or as an SCH. The hospital would need to satisfy the criteria set forth in section 1886(d)(5)(C) of the Act (as implemented in regulations at § 412.96) as a RRC, or the criteria set forth in section 1886(d)(5)(D) of the Act (as implemented in regulations at § 412.92) as an SCH.

Although the statute authorizes the Secretary to specify further qualifying criteria for a section 1886(d)(8)(E) reclassification, we do not believe that additional criteria are warranted at this

time. However, we invite comment specifically on whether the criteria in this interim final rule are sufficient at this time, and if not, what additional criteria should be incorporated.

Section IV.C. of this preamble contains information on the application process for requesting reclassification under the section 401 provision.

A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 *et seq.*), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.

B. Conforming Changes Under Section 401(b) of Public Law 106–113

Section 401(b) of Public Law 106–113 sets forth conforming statutory changes relating to urban to rural reclassifications under section 401(a) of Public Law 106–113:

- Section 401(b)(1) provides that if a hospital is being treated as being located in a rural area under section 1886(d)(8)(E) of the Act (for purposes of section 1886(d) of the Act), the hospital will also be treated under section 1833(t) of the Act as being located in a rural area. This provision is being addressed in a separate document.
- Section 401(b)(2) amends section 1820(c)(2)(B)(i) of the Act by extending the reclassification provisions of section 401(a) to the CAH program. A hospital that otherwise would have fulfilled the requirements for designation as a CAH had it been located in a rural area is now eligible for consideration as a CAH if it is treated as being located in a rural area under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113. (A list of certain existing hospitals that have been identified as being located in Goldsmith areas is included in Appendix B of this interim final rule with comment period.) A more detailed discussion of the effect on the CAH program in light of this provision, as well as the additional amendments to section 1820(c)(2)(B)(i) of the Act included in Public Law 106–113, is provided in section X.B. of this preamble.

C. Application Procedures

The statute provides that a hospital seeking reclassification from urban to rural under section 1886(d)(8)(E) of the Act must submit an application ''in a form and manner determined by the Secretary.'' We are providing that a facility seeking reclassification under section 401(a) or (b) of Public Law 106–113 must apply in writing to the HCFA Regional Office and include documentation satisfying the criteria on which its request is based. For information about where to submit an application, hospitals may contact their fiscal intermediaries or utilize the HCFA website at <www.hcfa.gov/medicare/regions/default.htm>. The application must be mailed; facsimile or other electronic means are not acceptable.

1. Qualification Through the Goldsmith Modification Criteria

We are specifying that hospitals seeking reclassification through the Goldsmith Modification criteria must include specific census tract information with their application that can be obtained through the following steps:

(a) The hospital must determine whether it is located within one of the urban counties containing one or more Goldsmith areas included in Appendix A of this interim final rule with comment period.

(b) Since only certain census tracts within these listed counties qualify as Goldsmith areas, a hospital that identifies its county in the listing must find the tract number assigned to its specific street location by the U.S. Census Bureau. One way to determine this is through an interactive website provided by the U.S. Census Bureau: <http:/tier2.census.gov/ctsl/ctsl.htm>.

(c) The hospital must include the 4-digit census tract number in its application to the HCFA Regional Office. The HCFA Regional Office will utilize census tract data to determine whether the census tract in which the hospital is located is situated in a Goldsmith area.

2. Qualification by State Designation

For hospitals selecting reclassification under qualification by State designation, we are providing that the hospital's application must include a copy of the State law or regulation that verifies either the requesting hospital is situated in an area designated rural by the State or that the hospital has been designated as a rural hospital. The application must also note the effective date of the rural designation.

3. Qualification as an RRC or as an SCH

For hospitals seeking reclassification under qualification as an RRC or as an SCH, we are providing that the hospital's application must include documentation that supports the hospital's assertion that, other than its urban location, it satisfies the criteria set forth in section 1886(d)(5)(C) of the Act as an RRC, as implemented in regulations at § 412.90; or as an SCH as set forth in section 1886(d)(5)(D) of the Act and implemented in regulations at § 412.92. The HCFA Regional Office will review the application in a manner consistent with its current procedures in the case of a hospital in a rural area that applies for RRC or SCH status (except for the requirement that the hospital be located in a rural area).

D. Filing and Effective Dates

We are establishing the date of receipt of the application by the HCFA Regional Office as the filing date. The HCFA Regional Office will review the application and forward its approval or disapproval to the hospital within 60 calendar days from the filing date. The HCFA Regional Office also will forward a copy of its decision to the HCFA Central Office and the fiscal intermediary. A hospital that satisfies any of the criteria for rural reclassification under section 401(a) of Public Law 106–113 will be treated as being located in the rural area of the State in which it is located as of its application filing date.

The statutory effective date of the amendments made by section 401 of Public Law 106–113 is January 1, 2000. To allow hospitals a grace period for filing applications to accommodate this effective date, we are providing that a qualifying hospital whose application is received by HCFA on or before September 1, 2000, will be considered as being located in the rural area of its State for purposes of section 1886(d) of the Act as of January 1, 2000. Following that grace period, a hospital's filing date is the date on which a complete application is received by HCFA. A qualifying hospital that bases its application for rural reclassification under section 1886(d)(8)(E) of the Act on its satisfaction of either SCH or RRC criteria, and that files on or before September 1, 2000, will benefit from the grace period and will be considered as being located in the rural area of its State as of January 1, 2000, unless the hospital withdraws its request as described in section IV.D.3 of this preamble. Once the hospital is rural, it may seek either an SCH or an RRC status by following a two-step process described respectively, in sections IV.D.1 and IV.D.2 of this preamble. The process for approval of the hospital as either an SCH or an RRC must be consistent with the processes currently in place for approving these applications. We note that whereas SCH designation is effective 30 days after written notification of HCFA's approval,

under § 412.92(b)(2)(i), the effective date of RRC designation, under 1886(d)(5)(C)(i) of the Act, is linked to the beginning of a hospital's reporting period.

1. A Hospital Reclassified as Rural Seeking Designation as an SCH

A hospital that bases its application for rural reclassification on its satisfaction of all SCH criteria set forth in § 412.92, except rural location, may seek subsequent designation as an SCH if HCFA determines that it qualifies to be treated as rural under section 1886(d)(8)(E) of the Act. The hospital must indicate this intent on its application for rural reclassification. Designation as an SCH for such hospital, therefore, would be a two-step process: (1) The hospital's reclassification as rural for all payment purposes as of its filing date under section 1886(d)(8)(E) of the Act; and (2) the now-rural hospital's request for SCH status, which would be effective 30 days following the date of HCFA's written notification of approval, as set forth in the regulations at § 412.92(b)(2)(i).

In order to implement section 401(a) of Public Law 106–113 in the most expeditious and efficient manner, allowing for necessary payment system modifications, for the grace period which extends from January 1, 2000 to September 1, 2000, we are bundling the above two operations: the rural reclassification of a hospital, under section 401(a) of Public Law 106–113, and the designation of the hospital as an SCH. A hospital that has applied for rural status based on its eligibility as an SCH and also is applying to become an SCH, will be granted SCH status as of January 1, 2000, if it satisfies the conditions for SCH designation in § 412.92, except for rural location as of January 1, 2000, and its application is filed by September 1, 2000.

2. Hospitals Reclassified as Rural Seeking Designation as a RRC

A hospital qualifying for rural reclassification under section 401(a) of Public Law 106–113 because it satisfies RRC criteria under § 412.96, except for rural location, will be considered rural for all payment purposes as of January 1, 2000, if its application is received by September 1, 2000. After September 1, 2000, when the grace period expires, the filing date is the date HCFA receives the hospital's complete application. If the hospital seeks designation as a RRC, the hospital must state its intent to apply for RRC status on its application for rural reclassification under section 1886(d)(8)(E) of the Act. Designation as an RRC for such a hospital, therefore, is a two-step process: (1) The hospital's classification as rural for all payment purposes as of its filing date under section 1886(d)(8)(E) of the Act; and (2) the now rural hospital's request for RRC status by way of a letter to the Regional Office during the quarter preceding the start of a cost reporting period, referencing the data it previously submitted for rural status. If approved, the hospital is designated an RRC at the start of the hospital's next cost reporting period under section 1886(d)(5)(C)(i) of the Act (55 FR 36059). Therefore, whereas the grace period would grant rural status under section 1886(d)(8)(E) of the Act to such a hospital filing on or before September 1, 2000, statutory requirements preclude us from granting RRC status simultaneously as we are able to do in the case of SCHs described above.

3. Withdrawal of an Application for Rural Reclassification

A hospital may withdraw an application for rural reclassification at any time prior to the date of HCFA's decision on whether or not the hospital qualifies for rural reclassification under section 1886(d)(8)(E) of the Act.

4. Cancellation of Rural Reclassification

We are specifying that a hospital seeking cancellation of rural status established under section 1886(d)(8)(E) of the Act must submit its written request to HCFA not less than 120 days prior to the end of its current cost reporting period. With the beginning of the hospital's next cost reporting period, the hospital will be treated as being located in an urban area.

E. Changes in the Regulations

We are adding a new § 412.103 to incorporate the provisions on the urban to rural reclassification options set forth in section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, and the application procedures for requesting reclassification. A formula for transition payments to hospitals located in an area that has undergone geographic reclassification from urban to rural is set forth in section 1886(d)(8)(A) of the Act and implemented in regulations at §§ 412.90 and 412.102. We are revising existing §§ 412.63(b)(1) and 412.90(e) and the title of § 412.102 to clarify the distinction between hospital reclassification from urban to rural and the geographic reclassification (or redesignation) of an urban area to rural.

We are revising § 485.610 by redesignating paragraph (b)(4) as paragraph (b)(5) and adding a new paragraph (b)(4) to reflect the conforming provision of section 401(b)(2) of Public Law 106–113.

V. Medicare-Dependent, Small Rural Hospitals (Section 404 of Public Law 106–113 and 42 CFR 412.90(j) and 412.108)

Section 404 of Public Law 106–113 added a 5-year extension of the Medicare-dependent, small rural hospital (MDH) program (FY 2002 through FY 2006). This category of hospitals was originally created by section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), which added section 1886(d)(5)(G) to the Act.

As set forth in section 1886(d)(5)(G) of the Act, in order to be classified as an MDH, a hospital must meet 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).
- 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.

As provided by the law, MDHs were eligible for a special payment adjustment under the prospective payment system, effective 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 SCHs, 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 (Public Law 103–66) extended the MDH provision through FY 1994 and provided that, 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 the hospital-specific rate exceeded the Federal rate.

Section 4204(a)(3) of Public Law 105–33 reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise either the

qualifying criteria for these hospitals or the payment methodology.

Section 404(a) of Public Law 106–113 extended the MDH provision to discharges occurring on or after October 1, 2002 and before October 1, 2006.

We are revising §§ 412.90(j) and 412.108 to reflect the extension of the MDH program.

VI. Changes to the IME Adjustment (Section 111 of Public Law 106–113 and 42 CFR 412.105(d)(3))

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved GME program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the IME adjustment, are located at § 412.105.

Section 111(a) of Public Law 106–113 amended section 1886(d)(5)(B) of the Act by modifying the transition for the IME adjustment. The IME adjustment factor is calculated using a formula multiplier that is represented as c in the following equation: $c \times [(1 + r)^{.405} - 1]$. The variable r represents the hospital's resident-to-bed ratio.

Public Law 105–33 established the formula multiplier for discharges occurring during FY 2000 at 1.47. However, section 111(b) of Public Law 106–113 provides for special payments to each hospital to reflect the amount of IME payments if c equaled 1.6 for discharges occurring during FY 2000, rather than 1.47. In accordance with section 111(b)(2) of Public Law 106–113, these special payments will not affect any other payments, determinations, or budget neutrality adjustments under section 1886(d) of the Act.

Under amendments enacted by section 111(a) of Public Law 106–113, for discharges occurring during FY 2001, the formula multiplier is 1.54. Changes to the factor for discharges occurring in FY 2001 were addressed in the proposed rule on FY 2001 hospital inpatient prospective payment system rates and changes that was published in the **Federal Register** on May 5, 2000 (65 FR 26281) and that will be finalized by August 1, 2000. Changes to the factor for discharges occurring in FY 2002 and thereafter are discussed in the final rule to be published by August 1, 2000.

We are amending § 412.105(d)(3) to reflect the additional payment provided for discharges occurring during FY 2000 under section 111(b)(1) of Public Law 106–113.

VII. Payment for Costs of GME

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of GME. The payments are based on the number of residents trained by the hospital. Section 1886(h) of the Act, as revised by Public Law 105–33, caps the number of residents a hospital may count for direct GME and IME. In general, the total number of residents in the fields of allopathic or osteopathic medicine in a hospital may not exceed the number of such FTE residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. In the regulations we published on August 29, 1997 (62 FR 46003), May 12, 1998 (63 FR 26327), July 31, 1998 (63 FR 40986), and July 30, 1999 (64 FR 41517), we established special rules for adjusting the FTE resident caps for indirect and direct GME for new medical residency programs. Public Law 106–113 further revised sections 1886(d) and 1886(h) of the Act to allow a hospital's caps to be adjusted if certain additional criteria are met.

A. Counting Primary Care Residents on Certain Approved Leaves of Absence in Base-Year FTE Count (Section 407(a)(1) of Public Law 106–113 and new 42 CFR 412.105(f)(1)(xi) and 413.86(g)(9))

The limit that was placed on the number of residents that a hospital may count for purposes of direct GME and IME is based on the number of residents in the hospital's most recent cost reporting period ending on or before December 31, 1996. In the situation where a primary care resident was previously training in a hospital's residency program, but was on an approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996, the hospital's FTE cap may be lower than it would have been had the resident not been on an approved leave of absence. Section 407(a) of Public Law 106–113 amended section 1886(h)(4)(F) of the Act to direct the Secretary to count an individual for purposes of determining a hospital's FTE cap, to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence.

The statute allows a hospital to receive an adjustment for those residents to its individual FTE cap of up to three additional FTE residents. We are providing in this interim final rule with comment period that, in order for a hospital to receive this adjustment, the leave of absence must have been approved by the residency program director to allow the residents to be absent from the program and return to the program after the absence. We are requiring that no later than 6 months after the date of publication of this interim final rule, the hospital must submit a request to the fiscal intermediary for an adjustment to its FTE cap and must provide contemporaneous documentation of the approval of the leave of absence by the residency program director, specific to each additional resident that is to be counted for purposes of the adjustment. For example, a letter to the resident by the residency program director before the resident takes the leave would be sufficient documentation of prior approval of the leave of absence.

Under section 407(a)(3) of Public Law 106–113, this provision is effective for direct GME FTE counts with cost reporting periods beginning on or after November 29, 1999, and for IME FTE counts, with discharges occurring in cost reporting periods beginning on or after November 29, 1999.

We are adding new §§ 412.105(f)(1)(xi) and 413.86(g)(9) to incorporate the provisions of section 407(a) of Public Law 106–113.

B. Adjustments to the FTE Cap for Rural Hospitals (Section 407(b)(1) of Public Law 106–113 and 42 CFR 412.105(f)(l)(iv) and 413.86(g)(4))

Public Law 105–33 included several provisions with the intent of encouraging physician training and practice in rural areas. Section 1886(h)(4)(H)(i) of the Act, as added by section 4623 of Public Law 105–33, directed the Secretary, in promulgating rules for the purpose of the FTE cap, to give special consideration to facilities that meet the needs of underserved rural areas. Consistent with the intent of this provision, section 407(b) of Public Law 106–113 provides a 30-percent expansion of a rural hospital's direct and indirect FTE count for purposes of establishing the hospital's individual FTE cap. Specifically, section 407(b) provides that, effective for direct GME with cost reporting periods beginning on or after April 1, 2000, and for IME, with discharges occurring on or after April 1, 2000, the FTE count may not exceed 130 percent of the number of unweighted residents the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996.

For example, if a hospital located in a rural area had 10 unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period

ending on or before December 31, 1996, under this new provision the hospital would have a FTE cap of 13 unweighted FTEs, instead of 10 unweighted FTEs, because the hospital is located in a rural area. The revised FTE cap is equal to 130 percent of the number of unweighted residents in its most recent cost reporting period ending on or before December 31, 1996. The rural hospital's new FTE cap, effective April 1, 2000, is now 13 FTEs. However, if a hospital located in a rural area had zero unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period ending on or before December 31, 1996, under this new provision, this hospital would receive no adjustment to its FTE cap (130 percent of zero is zero FTEs).

We are incorporating the provisions of section 407(b) of Public Law 106–113 in §§ 412.105(f)(1)(iv) and 413.86(g)(4).

C. Rural Track FTE Limitation for Purposes of GME and IME for Urban Hospitals That Establish Separately Accredited Approved Medical Programs in a Rural Area (Section 407(c) of Public Law 106–113 and new 42 CFR 412.105(f)(1)(x) and 413.86(g)(11))

Section 407(c) of Public Law 106–113 amended section 1886(h)(4)(H) of the Act to add a provision that, in the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment may be made to the hospital's cap on the number of residents in order to encourage the training of physicians in rural areas. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April l, 2000.

Section 407(c) of Public Law 106–113 does not define ''rural tracks'' or an ''integrated rural track,'' nor are these terms defined elsewhere in the Social Security Act or in any applicable Federal regulations. Currently, there are a number of accredited residency programs, particularly 3-year primary care residency programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility. These separately accredited ''rural track'' programs are identified by the Accreditation Council of Graduate Medical Education (ACGME) as ''1–2'' rural track programs. We are implementing section 407(c) to address these ''1–2'' programs. In addition, we are implementing section 407(c) to account for other programs that are not ''1–2'' programs but which include rural training portions.

As stated above, there is no existing definition of ''rural track'' or ''integrated rural track.'' We are defining at § 413.86(b) a ''rural track'' and an ''integrated rural track'' as an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or to a rural nonhospital site(s). We note that ''rural track'' and ''integrated rural track,'' for purposes of this definition, are synonymous.

We are amending § 413.86 to add paragraph (g)(11) (and amending § 412.105 to add paragraph (f)(1)(x)) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, (or, for IME, for discharges occurring on or after April 1, 2000), an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). An urban hospital may count the residents in the rural track up to a ''rural track FTE limitation'' for that hospital. We are defining this rural track FTE limitation at § 413.86(b) as the maximum number of residents (as specified at § 413.86(g)(11)(i) through (vi)) training in a rural track residency program that an urban hospital may include in its FTE count, that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: Rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. These two categories are then subdivided according to where the residents are training in the rural area; the residents may be trained in a rural hospital or the residents may be trained in a rural nonhospital site. To account for rural track residency programs with rural rotations that have program lengths greater than or less than 3 years, or that are not ''1–2'' programs, we are specifying ''two-thirds of the length of the program,'' instead of ''2 out of 3 program years,'' as a qualification to count FTEs in the rural track.

We are specifying that urban hospitals that wish to count FTE residents in rural tracks, up to a rural track FTE limitation, must comply with the conditions discussed below:

1. Rotating Residents for at Least Two-Thirds of the Program to a Rural Hospital(s)

We are specifying at § 413.86(g)(11)(i) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program; and (b) the number of years those residents are training at the urban hospital.

We are utilizing the term ''designated'' at § 413.86(g)(11)(i) (as well as at §§ 413.86(g)(11)(ii) and (iv)) to refer to the calculation of the rural track FTE limitation. ''Designated'' means that the residents must actually have enrolled in that rural track program to rotate for a portion of the rural track program to a rural area (either rural hospital(s) or rural nonhospital site(s)). To be counted as an FTE in this first scenario, these enrolled residents must actually rotate for at least two-thirds of the duration of the program to a rural hospital(s). If a resident, at the beginning of his or her training, intends to train in the rural area for at least two-thirds of the duration of the program, but ultimately never does so, this resident would be proportionately excluded from the urban hospital's FTE count and rural track FTE count.

We note that if the residents in the rural track are rotating to a rural hospital(s), the rural hospital(s) may be eligible to count the residents as part of

its FTE count. If the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track for the time those residents are training at the rural hospital(s), in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may be eligible to count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended in this interim final rule to implement section 407(b)(1) of Public Law 106–113.

2. Rotating Residents for at Least Two-Thirds of the Program to a Rural Nonhospital Site

We are specifying at § 413.86(g)(11)(ii) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital and the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program and the rural nonhospital site(s); and, (b) the number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

We note that we specify at § 413.86(g)(11)(ii) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under § 413.86(f)(4). The regulations at § 413.86(f)(4) provide, in part, that a hospital that incurs ''all or substantially all'' of the costs of training residents in a nonhospital site may include those residents in determining the number of FTE residents (not to exceed the FTE cap) for that hospital. Under this new rural track policy, where the urban hospital rotates residents for at least two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4).

An example of this second scenario is where urban hospital A has a new internal medicine residency program that was established July 1, 1998, and rotates six PGY (program year) 2s and five PGY 3s in the third year of the program to rural nonhospital site B. In the third year of the program, five PGY 1s who will subsequently rotate to the rural nonhospital site are training at hospital A. If hospital A is complying with the requirements at § 413.86(f)(4) by incurring all or substantially all of the cost of the training at rural nonhospital site B, beginning with the fourth year of the program, hospital A will receive a rural track FTE limitation of 18 FTEs, because the highest number of residents training at either hospital A or rural nonhospital site B is six PGY 2s at rural nonhospital site B and the minimum accredited length for internal medicine is 3 years (thus, six PGY 2s × 3 years = 18 FTEs). (Note that for the first 3 years of the new rural track program, the actual count of residents training in the rural track at both hospital A and rural nonhospital site B will be hospital A's rural track FTE count (and rural track FTE limitation for the first 3 years of the new rural track program).)

3. Rotating Residents for Less Than Two-Thirds of the Program to a Rural Hospital(s)

We are specifying at § 413.86(g)(11)(iii) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may not include those residents in its FTE count (if the urban hospital FTE count exceeds the urban hospital FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE count. However, we note that, in this scenario, if the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track, in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended, to incorporate the provisions of section 407(b)(1) of Public Law 106–113.

We are not permitting an urban hospital to count the FTE of residents in a rural track rotating to a rural hospital(s) for less than two-thirds the duration of the program (either as part of the urban hospital's FTE count or as part of its rural track FTE limitation), because to do so would inappropriately allow the urban hospital to circumvent the FTE caps (assuming the urban hospital's FTE count exceeds its FTE cap) by creating a new program with minimal training in a rural track. However, in this situation, like the other three provisions that concern the training of residents in rural areas, we will allow Medicare payment for the rural portion of the training to the rural hospital.

4. Rotating Residents for Less Than Two-Thirds of the Program to a Rural Nonhospital Site

We are specifying at § 413.86(g)(11)(iv) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents training in the rural track at the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) the highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s); and (b) the length of time in which the residents are being trained at the rural nonhospital site(s).

We note that, in this situation, an urban hospital would not be able to count the FTE for the rural track

resident while the resident is training at the urban hospital (unless the urban hospital's FTE count does not exceed its FTE cap). The rural track FTE count and the rural track FTE limitation for the urban hospital would be limited to account for the residents training at the rural nonhospital site.

As in the second scenario at new § 413.86(g)(11)(ii), we are specifying at § 413.86(g)(11)(iv) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under § 413.86(f)(4). Under this new rural track policy, where the urban hospital rotates residents for less than two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4).

We note that, in this last scenario, we are allowing the urban hospital to receive a rural track FTE limitation even in situations where it is rotating residents to a rural area for a minimal period of time (less than two-thirds the duration of the program). We believe that this last scenario can be distinguished from the third scenario in which the urban hospital is rotating residents to a rural area for a minimal portion of the program but to a rural hospital instead of a rural nonhospital site. In the third scenario, we are allowing Medicare payment to go to the rural hospital for the portion of the urban hospital program that involves rural training (but not to the urban hospital, since the rural hospital is receiving an FTE cap adjustment for that training). However, in the last scenario, we are allowing the urban hospital to include the rural track residents in its FTE count (and as part of its rural track FTE limitation), based on how long it rotates the residents to the rural nonhospital site (and also incurs all or substantially all of the training costs). We do not believe that the urban hospital can circumvent its FTE cap in this last scenario because it will only count the rural track residents based on the portion of training in the rural nonhospital site (assuming the urban hospital's FTE count exceed its FTE cap).

An example of this last scenario would be in the situation where urban hospital C establishes a new residency program in FY 2001 by training six PGY 1s in the first year of the program's existence at the urban hospital. In the second year of the program, urban hospital C trains six PGY 1s and rotates the (now) six PGY 2s to rural nonhospital site D. In the third year of the program, urban hospital C trains seven PGY 1s, zero PGY 2s (rotating the six PGY 2s to rural nonhospital site D) and six PGY 3s. Urban hospital C would receive a rural track FTE limitation of zero FTEs in the first year of the program's existence, since urban hospital C did not rotate any residents to a rural nonhospital site in that first year; in the second year of the program, urban hospital C may count six FTE residents above its FTE cap as its second year rural track FTE limitation, since it rotated six PGY 2s to rural nonhospital site D in that second year; in the third year of the program, urban hospital C may count six FTE residents above its FTE cap as its third year rural track FTE limitation, as well, since it rotated six PGY 2s to the rural nonhospital site D in the third year. Finally, beginning with the fourth year of the rural track program's existence, urban hospital C will receive a rural track FTE limitation of seven FTEs (seven PGY 1 residents training at urban hospital C that are designated to rotate for one year of their training to rural nonhospital site D × 1 year of training at rural nonhospital site D), assuming urban hospital C complies with the requirements at § 413.86(f)(4) that urban hospital C incurs all or substantially all of the costs of training the six residents in rural nonhospital site D.

5. Conditions That Apply to All Urban Hospitals

We are specifying that all urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitations, must comply with each of the following conditions, as stated at §§ 413.86(g)(11)(v) and (vi):

(a) A hospital may not include in its rural track limitation or its FTE count (assuming the hospital's FTE count exceeds its cap), FTE residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap (if the rural track program was in existence during the hospital's most recent cost reporting period ending on or before December 31, 1996).

(b) A hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the urban hospital intends to rotate for a portion of the residency program to a rural area. For example, written contemporaneous documentation might be a letter of intent signed and dated by the rural track residency program director and the resident at the time of the resident's entrance into the rural track program as a PGY 1.

(c) All residents who are included by the hospital as part of its FTE count (not to exceed its rural track FTE limitation) must ultimately train in the rural area.

(d) If HCFA finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, HCFA will reopen the urban hospital's cost report within the 3-year reopening period (as specified in § 405.1885) and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

D. Not Counting Against Numerical Limitation Certain Residents Transferred From a Department of Veterans Affairs Hospital's Residency Program That Loses Accreditation (Section 407(d) of Public Law 106–113 and new 42 CFR 412.105(f)(1)(xii) and 413.86(g)(10))

Section 407(d) of Public Law 106–113 addresses the situation where residents were training in a residency training program at a Veterans Affairs (VA) hospital and then were transferred on or after January 1, 1997, and before July 31, 1998, to a non-VA hospital because the program in which the residents were training would lose its accreditation by the ACGME if the residents continued to train at the VA hospital. In this situation, the non-VA hospital may receive a temporary adjustment to its FTE cap to reflect those residents who were transferred to the non-VA hospital for the duration that those transferred residents were training at the non-VA hospital. We are specifying that, in order to receive this adjustment, the non-VA hospital must submit a request to its fiscal intermediary for a temporary adjustment to its FTE cap, document that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specify the length of time the adjustment is needed.

We note that section 407(d) of Public Law 106–113 only refers to programs that would lose their accreditation by the ACGME. This provision does not apply to accreditation by the American Osteopathy Association (AOA), the American Podiatry Association (APA), or the American Dental Association (ADA).

Under section 407(d)(3) of Public Law 106–113, this policy is effective as if included in the enactment of Public Law 105–33, that is, for direct GME, with cost reporting periods beginning

on or after October 1, 1997, and for IME, discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

We are adding new §§ 412.105(f)(1)(xii) and 413.86(g)(10) to incorporate the provisions of section 407(d) of Public Law 106–113.

E. Initial Residency Period for Child Neurology Residency Programs (Section 312 of Public Law 106–113 and 42 CFR 413.86(g)(1))

Generally, section 1886(h)(5)(F) of the Act defines the term ''initial residency period'' to mean the ''period of board eligibility.'' The period of board eligibility is defined in section 1886(h)(5)(G) of the Act as the period recognized by ACGME as specified in the *Graduate Medical Education Directory* which is published by the American Medical Association. The initial residency period limitation was designed to limit full Medicare payment for direct GME to the time required to train in a single specialty. Therefore, the initial residency period is determined based on the minimum time required for a resident to become board eligible in a specialty and the published periods included in the *Graduate Medical Education Directory.* During the initial residency period, the residents are weighted at 1.0 FTE for purposes of Medicare payment. Residents seeking additional specialty or subspecialty training are weighted at 0.5 FTE.

In order to become board eligible in child neurology, residents must complete training in more than one specialty. Thus, for example, before the effective date of section 312 of Public Law 106–113, if a resident enrolled in a child neurology residency program by first completing 2 years of training in pediatrics (which is associated with a 3-year initial residency period), followed by 3 years of training in child neurology, the resident would be limited by the initial residency period of pediatrics. Section 312 of Public Law 106–113 amended section 1886(h)(5) of the Act by adding at the end a clause (v) which states that ''in the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.'' (The initial residency period for pediatrics is currently 3 years). The amendments made by section 312(a) of Public Law 106–113 applies to future child neurology residents and to child neurology residents who have already begun their training (for whom an initial residency period was already established). However, it does not apply to residents who have completed their child neurology training before July 1, 2000.

We are revising § 413.86(g)(1) to reflect that, effective on or after July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for child neurology is now the period of board eligibility for pediatrics plus 2 years. We note that the initial residency period is the same for all child neurology residents, regardless of whether or not the resident completes the first year of training in pediatrics or neurology.

Following are four examples of how a child neurology resident's FTE status would be determined:

Example 1: Assume the resident completes 2 years of training in pediatrics followed by 3 years of training in child neurology.

Before Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 0.5 FTE
Year 5: July 1, 2001–June 30, 2002. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 1.0 FTE
Year 5: July 1, 2001–June 30, 2002. 1.0 FTE

Example 2: Assume the resident completes 2 years of training in pediatrics followed by 3 years of training in child neurology.

Before Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 0.5 FTE
Year 5: July 1, 2001–June 30, 2001. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 0.5 FTE
Year 5: July 1, 2000–June 30, 2001. 1.0 FTE

Example 3: Assume the resident completes 1 year of neurology training, followed by 1 year of pediatrics training, followed by 3 years of child neurology training.

Note: The initial residency period for neurology is currently 4 years.

Before Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 1.0 FTE
Year 5: July 1, 2001–June 30, 2002. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 1.0 FTE
Year 5: July 1, 2001–June 30, 2002. 1.0 FTE

Example 4: Assume the resident completes 1 year of neurology training, followed by 1 year of pediatrics training, followed by 3 years of child neurology training.

Note: The initial residency period for neurology is currently 4 years.

Before Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 1.0 FTE
Year 5: July 1, 2000–June 30, 2001. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 1.0 FTE
Year 5: July 1, 2000–June 30, 2001. 1.0 FTE

F. Technical Amendment

It has come to our attention that the first sentence of existing § 413.86(g)(1) contains a technical error. The first sentence of this paragraph reads ''For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year.'' This section of the regulation was revised as a result of section 13563(b) of Public Law 103–66, and was effective only until June 30, 1995. Generally, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Therefore, we are revising the first sentence of paragraph (g)(1) of § 413.86 accordingly. The remainder of paragraph (g)(1) of § 413.86 is unchanged.

VIII. Additional Payment to Hospitals That Operate Approved Nursing and Allied Health Education Programs (Section 541 of Public Law 106–113 and 42 CFR 413.86(d) and new 413.87)

Under sections 1861(v) and 1886(a) of the Act, hospitals that operate approved nursing or allied health education programs may be eligible for the pass-through payment under the prospective payment system. Section 1886(h) of the Act establishes the methodology for determining payments to hospitals for the direct costs of GME programs. Section 1886(h) of the Act, as implemented in regulations at § 413.86, specifies that Medicare payments for direct costs of GME are based on a prospectively determined per resident amount (PRA). The PRA is multiplied by the number of FTE residents working in all areas of the hospital complex (and nonhospital sites, where applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payment.

Section 1886(h)(3)(D) of the Act, as added by section 4624 of Public Law 105–33, provides a 5-year phase-in of payments to teaching hospitals for direct costs of GME associated with

services to Medicare+Choice (managed care) enrollees for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment for direct GME is equal to the product of the PRA, the number of FTE residents working in all areas of the hospital (and nonhospital sites, if applicable), the ratio of the number of inpatient bed days that are attributable to Medicare+Choice enrollees to total inpatient bed days, and an applicable percentage. The applicable percentages are 20 percent for portions of cost reporting periods occurring in calendar year 1998, 40 percent in calendar year 1999, 60 percent in calendar year 2000, 80 percent in calendar year 2001, and 100 percent in calendar year 2002 and subsequent years. (Section 1886(d)(11) of the Act, as added by section 4622 of Public Law 105–33, provides a 5-year phase-in of payments to teaching hospitals for IME associated with services to Medicare+Choice enrollees for portions of cost reporting periods occurring on or after January 1, 1998, as well. However, the Medicare+Choice IME payments are irrelevant for the purposes of this section of the interim final rule, because although section 541 of Public Law 106-113 affects the payments for Medicare+Choice direct GME, it in no way affects the payments for Medicare+Choice IME.)

Section 541 of Public Law 106–113 further amended section 1886 of the Act by adding subsection (l) and amending section 1886(h)(3)(D) to provide for additional payments to hospitals for nursing and allied health education programs associated with services to Medicare+Choice enrollees. Hospitals that, under § 413.85, operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs would receive additional payments. This provision is effective for portions of cost reporting periods occurring in a calendar year, beginning with calendar year 2000.

Section 1886(l) of the Act, as added by section 541 of Public Law 106–113, specifies the methodology to be used to calculate these additional payments and places a limitation on the total amount that is projected to be expended in any calendar year; that is, $60 million. In this document, we refer to the total amount of $60 million or less as the payment ''pool.'' We emphasize that we use the term ''pool'' solely for ease of reference; the term reflects an estimated dollar figure, a number that is plugged into a formula to calculate the amount of additional payments. The term ''pool'' does not refer to a discrete fund of money that is set aside in order to make the additional payments (thus, for example, if the estimated ''pool'' is $50 million, we use the number 50 million to calculate the amount of additional payments, but this does not mean that we set aside $50 million in a separate fund from which we make the additional payments). The total amount of additional payments associated with utilization of Medicare+Choice enrollees is based on the ratio of total direct GME payments for Medicare+Choice enrollees to total Medicare direct GME payments, multiplied by the total Medicare nursing and allied health education payments. A hospital would receive its share of these additional payments in proportion to the amount of Medicare nursing and allied health education payments received in the cost reporting period that ended in the fiscal year that is 2 years prior to the current calendar year, to the total amount of nursing and allied health payments made to all hospitals in that cost reporting period. Section 541(b) of Public Law 106–113 amended section 1886(h)(3) of the Act to provide that direct GME payments for Medicare+Choice utilization will be reduced to account for the additional payments that are made for nursing and allied health education programs under the provisions of section 1886(l) of the Act.

We are implementing section 541 by establishing regulations at new § 413.87 to incorporate the provisions of section 1886(l) of the Act. We are specifying the rules for a hospital's eligibility to receive the additional payment under section 1886(l), the requirements for determining the additional payment to each eligible hospital, and the methodologies for calculating each additional payment and for calculating the payment ''pool.'' These provisions are discussed below:

A. Qualifying Conditions for Payment

We are providing that, for portions of cost reporting periods occurring on or after January 1, 2000, a hospital that operates a nursing or allied health education program in accordance with § 413.85 may receive an additional payment amount associated with Medicare+Choice utilization if it meets two conditions.

First, section 541 of Public Law 106–113 directs the Secretary to determine the amount of payment for each hospital based on an ''* * * estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the *second preceding fiscal year* to the *total of such amounts for all hospitals for such cost reporting periods.*'' (Emphasis added). Accordingly, we are providing that the hospital must have received reasonable cost Medicare payment for a nursing or allied health education program(s) in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. For example, if the current calendar year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998. In this example, if a hospital did not receive reasonable cost payment for approved nursing or allied health education programs in FY 1998, but first establishes these programs and receives such payment as specified in § 413.85 after FY 1998, the hospital will only be eligible to receive an additional payment amount in the calendar year that is 2 years after the respective fiscal year. For example, if the hospital establishes a nursing or allied health program in FY 1999, it will first be eligible to receive an additional payment amount in calendar year 2001.

Second, section 541 of Public Law 106–113 states, ''For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that *receives* payments for the costs of approved educational activities for nurse and allied health professional training * * *.'' (Emphasis added). Accordingly, we are specifying that the hospital also must be receiving reasonable costs payment for its nursing or allied health education program(s) in the current calendar year to receive these additional payments for nursing and allied health training.

B. Calculating the Additional Payment Amount

The Medicare fiscal intermediary will determine if the hospital is eligible to receive the additional payment by applying the two criteria specified in section VIII.A.1. of this preamble. For portions of cost reporting periods occurring on or after January 1, 2000, an eligible hospital will receive the additional payment amount calculated according to the following steps:

Step 1: Determine the hospital's total Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

For example, if the current calendar year is 2000, determine the hospital's total nursing or allied health education payments made in its cost reporting period ending in FY 1998. If a hospital

has more than one cost reporting period ending in that fiscal year, the fiscal intermediary will sum the nursing and allied health payments made to the hospital over those cost reporting periods.

Step 2: Determine the ratio of the individual hospital's total nursing or allied health payments from Step 1, to the total of all nursing and allied health education program payments made across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

To determine these total payments, we will use the best available cost reporting data for the applicable hospitals from the Hospital Cost Report Information System (HCRIS) that is for cost reporting periods in the fiscal year that is 2 years prior to the current calendar year. If the necessary data are not included in HCRIS because a hospital files a manual cost report, we will obtain the necessary data from the fiscal intermediaries that serve those hospitals. If a hospital has more than one cost reporting period ending in the fiscal year that is 2 years prior to the current calendar year, we will include all of the hospital's cost reports for those periods in our calculations. If a hospital does not have a cost reporting period ending in the fiscal year that is 2 years prior to the current calendar year (such as a hospital with a long cost reporting period), the hospital will be included in the calculations for the calendar year that is 2 years after the fiscal year in which the long cost reporting period ends.

Each calendar year, HCFA will determine and publish in a proposed rule and a final rule the total amount of nursing and allied health education payments made across all hospitals during the fiscal year that is 2 years prior to the current calendar year.

Step 3: Multiply the ratio calculated in step 2 by the Medicare+Choice nursing and allied health payment ''pool'' (described under section VIII.C. of this preamble) that is determined by HCFA for the current calendar year.

The resulting product is each respective hospital's additional payment amount. We note that, as evidenced by the methodology outlined above, in accordance with section 541 of Public Law 106–113, Congress is not requiring each hospital's additional payment amount for a given period to be based on the hospital's Medicare+Choice utilization in that period.

C. HCFA Calculation of Medicare+Choice Nursing and Allied Health Payment ''Pool''

In accordance with section 1886(l) of the Act, each calendar year, HCFA estimates a total amount, not to exceed $60 million, which is the basis for determining the additional payments for nursing and allied health education associated with Medicare+Choice enrollees to hospitals that operate approved nursing or allied health education programs. The total amount is calculated in the following manner:

Step 1: We determine the ratio of projected total Medicare+Choice direct GME payments across all hospitals in the current calendar year to projected total direct GME payments across all hospitals in the current calendar year.

Step 2: We multiply the ratio calculated in step 1 by projected total nursing and allied health education reasonable cost payments across all hospitals in the current calendar year.

The resulting product of Step 1 and Step 2, not to exceed $60 million, is the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year.

The projections of Medicare+Choice direct GME, direct GME, and nursing and allied health payments for a calendar year are based on such payments from the best available cost report data from the HCRIS. (For example, for calendar year 2000, the projections are based on the best available cost report data from HCRIS 1998). These payment amounts are then increased to the appropriate calendar year using the increases allowed by section 1886(h) of the Act for these services (using the percentage applicable for the current calendar year for Medicare+Choice direct GME and the Consumer Price Index (CPI) increases for direct GME, and assuming nursing and allied health remains a constant percentage of inpatient hospital spending).

D. Proportional Reduction to Medicare+Choice Direct GME Payments

In order for the Secretary to make the additional payments to eligible hospitals operating approved nursing or allied health education programs, section 1886(h)(3)(D) of the Act, as amended by section 541(b) of Public Law 106–113, specifies that the Secretary will carve out an estimated percentage of payments that are made to teaching hospitals for direct GME associated with services to Medicare+Choice enrollees. Specifically, the law provides that the estimated reductions in Medicare+Choice direct GME payments must equal the estimated total additional Medicare+Choice nursing and allied health education payments. Because the data for the components of the formula used to calculate this percentage will change each year (due to percentage changes in the Medicare+Choice direct GME phase-in, changes in direct GME payment amounts, and changes in nursing and allied health education payment amounts), we will calculate and publish the applicable percentage reduction each year in the proposed rule and the final rule for the annual update to the hospital inpatient prospective payment system rates. The percentage is estimated by calculating the ratio of the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year to the projected total Medicare+Choice direct GME payments made across all hospitals for the current calendar year.

E. Calculation of Amounts for Calendar Year 2000

The total amount of nursing and allied health education payments made across all hospitals for cost reporting periods ending in FY 1998, that is, 2 fiscal years prior to calendar year 2000, is estimated at $220,622,805. We have calculated this amount for FY 2000 based upon data from hospitals' cost reporting periods ending during FY 1998 (October 1, 1997 through September 30, 1998), as provided by section 541 of Public Law 106–113. (Section VIII.B. of this preamble provides a more detailed explanation of how this amount was derived.) We note that, if a hospital did not have a cost reporting period ending in FY 1998, such as a hospital with a long cost reporting period beginning in FY 1997 and ending in FY 1999, the hospital was excluded from our calendar year 2000 calculations (but will be included in our calendar year 2001 calculations). We are including data for 1,257 hospitals in the calendar year 2000 calculations. Ten of these hospitals had more than one cost reporting period.

According to the methodology outlined in section VIII.C. of this preamble, we have estimated the Medicare+Choice nursing and allied health education payment ''pool'' for calendar year 2000 to be $26,272,140. The ratio of each hospital's nursing and allied health education payments from its cost reporting period ending in FY 1998 to total nursing and allied health education payments made from all cost reporting periods ending in FY 1998 is then multiplied by $26,272,140 to determine each hospital's additional

payment amount (as described in section VIII.B. of this preamble).

For calendar year 2000, the projected total Medicare+Choice direct GME payments made to all hospitals is $250 million. Therefore, consistent with the methodology described in section VIII.D. of this preamble, the ratio for calendar year 2000 is $26,272,140 to $250 million, which equals a 10.5 percent reduction to each hospital's Medicare+Choice direct GME payment during calendar year 2000.

Accordingly, for portions of cost reporting periods occurring in calendar year 2000, hospitals that receive Medicare+Choice direct GME payments will have these payments reduced by 10.5 percent. Specifically, each hospital with a calendar year cost reporting period that is receiving Medicare+Choice direct GME payments will have those payments reduced by 10.5 percent for the period of January through December 2000. If a hospital does not have a calendar year cost reporting period, then the reductions to its Medicare+Choice direct GME payments will depend upon the portion of its cost reporting period that falls within the current calendar year. For example, if a hospital has an October through September fiscal year, its Medicare+Choice direct GME payments from October through December 1999 will not be affected. However, the hospital's Medicare+Choice direct GME payments from January through September 2000 (from its FY 2000 cost reporting period), and its Medicare+Choice direct GME payments from October through December 2000 (from its FY 2001 cost reporting period), will be reduced by 10.5 percent. Its Medicare+Choice direct GME payments for the remainder of its FY 2001 cost reporting period, which extends from January through September 2001, will be reduced by the applicable percentage for calendar year 2001. Similarly, if a hospital has a July through June cost reporting period, its Medicare+Choice direct GME payments from July through December 1999 will not be affected. However, its Medicare+Choice direct GME payments from January through June 2000, and its Medicare+Choice direct GME payments from July through December 2000, will be reduced by 10.5 percent. Its Medicare+Choice direct GME payments for the remainder of its cost reporting period, which extends from January through June 2001, will be reduced by the applicable percentage for calendar year 2001.

In general, we note that hospitals that operate both GME and nursing or allied health education programs should experience either a net gain or loss as a result of this provision, because although their Medicare+Choice direct GME payments will be reduced by a certain percentage, their Medicare+Choice nursing and allied health payments will be increased. However, hospitals that operate only GME programs will see their Medicare reimbursement reduced, and hospitals that operate only nursing or allied health education programs will see their Medicare reimbursement increased.

F. Regulation Changes

We are adding a new § 413.87 to incorporate the provisions of section 541 of Public Law 106–113. In addition, we are making a conforming change to §§ 413.86(d)(4) through (d)(6) to account for the revised methodology in determining a hospital's Medicare+Choice direct GME payments.

IX. Hospitals and Units Excluded From the Prospective Payment System (Section 121 of Public Law 106–113 and 42 CFR 413.40(c)(4)(iii)(B) and 413.40(c)(4)(v))

A. Limitation on the Target Amounts

In the August 29, 1997 final rule (62 FR 46018), in accordance with section 4414 of Public Law 105–33, we implemented section 1886(b)(3)(H) of the Act, which provides for caps on the target amounts for excluded hospitals and 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 classes of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. In establishing the caps on the target amounts within each class of hospital for new hospitals, section 1886(b)(7)(C) of the Act, as amended by section 4416 of Public Law 105–33, instructed the Secretary to provide an appropriate adjustment to take into account area differences in average wage-related costs. However, since the statutory language under section 4414 of Public Law 105–33 did not provide for the Secretary to account for area differences in wage-related costs in establishing the caps on the target amounts within each class of hospital for existing hospitals, HCFA did not account for wage-related differences in establishing the caps on the target amounts for existing facilities in FY 1998.

Section 121 of Public Law 106–113, which amended section 1886(b)(3)(H) of the Act, directed the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Section 1886(b)(3)(H)(iii) of the Act, as added by Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

For cost reporting periods beginning in FY 2000, we update the FY 1996 wage-neutralized national 75th percentile target amount for each class of hospital by the market basket percentage increase up through FY 2000. For cost reporting periods beginning during FY 2001 through 2002, we update the previous fiscal year's wage-neutralized national 75th percentile target amount for each class of hospital by the applicable market basket percentage increase. In determining the national 75th percentile target amount for each class of hospital and consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act (as added by Public Law 106–113) to determine the appropriate wage adjustment, we have accounted for differences in wage-related costs by adjusting the caps on the target amounts for each class of hospital (psychiatric, rehabilitation, and long-term care) using the methodology described in the following section.

B. Wage-Neutralized National 75th Percentile Target Amounts

In determining the wage-neutralized national 75th percentile target amount for each class of hospital, we used FY 1996 hospital cost report data and determined the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the most recent actuarial estimate of the labor-related portion of excluded hospital costs (or 0.71553). This actuarial estimate of the labor-related share of excluded hospital costs reflects revisions made in connection with other revisions to the excluded hospital market basket published in the August 29, 1997 final rule (62 FR 45996). Based on the most recent estimate of the relative weights of the labor cost

categories (wages and salaries, employee benefits, professional fees, postal services, and all other labor intensive services), the labor-related portion is 71.553 percent. The remaining 28.447 percent is the most recent estimate of the nonlabor-related portion. Similarly, we determined the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, we wage-neutralized each hospital's FY 1996 target amount by dividing the labor-related portion of each hospital's FY 1996 target amount by the hospital's FY 2000 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), as shown in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585). The FY 2000 wage index is the most current wage index available. Moreover, the FY 2000 hospital inpatient prospective payment system wage index was calculated using FY 1996 data. Within the specified class of hospital, each hospital's FY 1996 target amount was wage-neutralized using the published FY 2000 wage index. Each hospital's wage-neutralized FY 1996 target amount was calculated by adding the nonlabor-related portion of its target amount and the wage-neutralized labor-related portion of its target amount.

This methodology for wage-neutralizing each hospital's target amount to determine the national 75th percentile of the target amounts for each class of hospital is identical to the methodology we utilized for the wage index adjustment described in the August 29, 1997 final rule (62 FR 46020) to calculate the wage-adjusted 110 percent of the national median target amounts for new excluded hospitals and units. Again, we recognize that wages may differ for prospective payment hospitals and excluded hospitals and units, but we believe that the wage data reflect area differences in wage-related costs.

In light of the short timeframe we have for implementing section 121 of Public Law 106–113 for cost reporting provisions beginning in FY 2000, the FY 2000 wage data for acute care hospitals was the most feasible data source to determine the wage-neutralized national 75th percentile target amounts since reliable wage data for hospitals and hospital units excluded from the prospective payment system is not available.

Within each class of hospital, the wage-neutralized national 75th percentile target amounts were determined by arraying the hospitals' wage-neutralized FY 1996 target amounts. The wage-neutralized national 75th percentile target amount for each class of hospital is then separated into a labor-related share and a nonlabor-related share based on actuarial estimates of 71.553 percent labor-related share and 28.447 percent nonlabor-related share.

In the July 30, 1999 final rule (64 FR 41557), based on the national 75th percentile of the target amounts for cost reporting periods ending during FY 1996 (which did not account for area wage-related differences), updated by the market basket percentage increase to FY 2000, we had established the caps on the target amounts for existing excluded hospitals and units as follows:

- Psychiatric hospitals and units: $11,100
- Rehabilitation hospitals and units: $20,129
- Long-term care hospitals: $39,712

Using the wage-neutralized national 75th percentile of the target amounts for cost reporting periods ending during FY 1996, updated by the applicable market basket percentage increase to FY 2000, and the wage adjustment provided for under the amendments made by Public Law 106–113, we are establishing the labor-related share and nonlabor-related share of the FY 2000 wage-neutralized national 75th percentile target amounts for each class of hospital to determine a hospital's FY 2000 cap on the target amount as follows:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$7,863	$3,126
Rehabilitation	14,666	5,831
Long-Term Care	28,321	11,259

We note that the March 2000 Program Memorandum (Transmittal Number A–00–16) issued to all Medicare fiscal intermediaries listed incorrect amounts for the labor-related portion and nonlabor-related portion of the wage-neutralized caps on the target amounts for FY 2000. The FY 2001 proposed rule (65 FR 26314) also listed incorrect amounts for the labor-related portion and nonlabor-related portion of the proposed FY 2001 wage-neutralized national 75th percentile caps on the target amounts. The correct labor-related and nonlabor-related portions of the wage-neutralized national 75th percentile cap on the target amount for FY 2000 for each class of hospital are listed above. The correct labor-related and nonlabor-related portions of the FY 2001 wage-neutralized national 75th percentile caps on the target amounts for each class of hospital will be included in the FY 2001 hospital inpatient prospective payment system final rule to be published by August 1, 2000.

The estimates of the national 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 increase for FY 2000. We used the data that have been reported to HCFA for over 3,000 hospitals and units within the three classes of hospitals specified by the statute. We note that, with respect to long-term care hospitals, we used the same data (provider universe and target amount figures for hospitals within that class) as were used to establish the caps on the target amounts for long-term care hospitals published in the May 12, 1998 final rule (63 FR 26347). The data for psychiatric hospitals and units and rehabilitation hospitals and units used to establish the caps on the target amounts for these classes of hospitals included updates to the hospital's FY 1996 target amounts resulting from settling cost reports that previously had not been settled prior to August 1997 when the final rule establishing the caps on the target amounts for existing excluded hospitals was published.

C. Wage-Adjusted Target Amounts

We are specifying that, within each class of hospital, a hospital's wage-adjusted cap on the target amount per discharge for FY 2000 is determined by adding the hospital's nonlabor-related portion of the wage-neutralized national 75th percentile cap to its wage-adjusted labor-related portion of the national 75th percentile cap. A hospital's wage-adjusted labor-related portion of the target amount is calculated by multiplying the labor-related portion of the wage-neutralized national 75th

percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2000, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system (see § 412.63) for cost reporting periods beginning on or after October 1, 1999, and ending on or before September 30, 2000 as shown in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585). The FY 1996 wage-neutralized national 75th percentile target amount for each class of hospital updated through FY 2000 by the applicable market basket percentage increase for excluded hospitals and hospital units used to determine a hospital's limitation on its FY 2000 target amount. For FY 2000, a hospital's FY 2000 limitation on its target amount is used to determine payments for excluded hospitals and units under § 413.40(d). The FY 2000 acute care hospital wage index is used to wage-adjust the labor-related portion of the FY 2000 wage-neutralized national 75th percentile target amount within the specified class of hospital since it is used to provide for an appropriate wage adjustment by accounting for differences in area wage-related costs in FY 2000 hospital inpatient prospective payment system payments. As we stated previously in this section, we recognize that wages may differ for prospective payment hospitals and excluded hospitals and units, but we believe that these wage data reflect area differences in wage-related costs. A hospital's applicable wage index is the wage index value for the area in which the hospital or unit is physically located (MSA or rural area) without taking into account prospective payment system hospital reclassification under section 1886(d)(10) of the Act, and section 1886(d)(8) of the Act as amended by section 401 of Public Law 106–113.

D. Changes in the Regulations

We are revising §§ 413.40(c)(4)(iii)(B) and (c)(4)(v) to incorporate the changes in the methodology used to determine the limitation on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, as provided for under the amendments made by section 121 of Public Law 106–113.

X. Critical Access Hospitals (CAHs)

A. Background: The Medicare Rural Hospital Flexibility Program and CAHs

Section 4201 of Public Law 105–33 amended section 1820 of the Act to create a nationwide Medicare Rural Hospital Flexibility (MRHF) Program to replace the 7-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program. Under section 1820(c)(2) of the Act, as amended, a State could designate certain rural hospitals as CAHs if they were located a specified distance from other hospitals, made 24-hour emergency care available, and kept inpatients for a limited period of time. Additionally, CAH staffing requirements differed from those of other hospitals under Medicare and CAHs received payment for inpatient and outpatient services on the basis of reasonable cost. A comprehensive discussion of CAHs within the context of the MRHF Program may be found in the August 29, 1997 **Federal Register** (62 FR 45970 and 46008–46010).

Sections 401(b) and 403 of Public Law 106–113 modified the CAH program set forth in section 1820 of the Act.

B. Permitting Certain Facilities To Be Designated as CAHs (Section 401(b) of Public Law 106–113 and 42 CFR 485.610)

One of the threshold criteria for designation as a CAH under section 1820(c)(2)(B)(i) of the Act is that the hospital must be rural as defined in section 1886(d)(2)(D) of the Act. Section IV. of this preamble discusses the option of urban to rural classification for a ''subsection (d)'' hospital authorized by section 401(a) of Public Law 106–113 under an amendment to section 1886(d)(8) of the Act. Section 401(b)(2) of Public Law 106–113 amended section 1820(c)(2)(B)(i) of the Act to authorize a State to designate a hospital in an urban area as a CAH if, under one of the criteria set forth in section 1886(d)(8)(E) of the Act, it would be treated as being located in the rural area of the State in which the hospital is located. Section 401(b)(2) only provides authority for a hospital to meet the rural requirement. We note that the hospital would have to otherwise meet the statutory and regulatory requirements governing CAH designation.

The first criteria in section 401(a) specified that a hospital will be treated as located in a rural area if the hospital is located in a rural census tract of an MSA, as determined under the most recent Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992. A listing of existing hospitals that may qualify as CAHs because they are located in Goldsmith areas is included in Appendix B of this interim final rule with comment period.

The application procedures and effective dates for an urban hospital seeking to reclassify as rural and thus eligible for CAH designation are set forth in the new regulation at § 412.103 that implements section 401(a), and discussed in section IV.C. of this interim final rule with comment period. We also are revising the regulation concerning CAH location at § 485.610(b) to reflect this amendment.

C. Other Legislative Changes Affecting CAHs

1. 96-hour Average Length of Stay Standard (Section 403(a) of Public Law 106–113 and 42 CFR 485.620(b))

Prior to the enactment of Public Law 106–113, section 1820(c)(2)(B)(iii) of the Act limited CAH designation only to facilities that provided inpatient care to each patient for a period of time not to exceed 96 hours, unless a longer period was required because of inclement weather or other emergency conditions, or a peer review organization (PRO) or equivalent entity, on request, waived the 96-hour restriction. Section 403(a) of Public Law 106–113 amended section 1820(c)(2)(B)(iii) of the Act to require that the 96-hour limit on stays be applied on an annual average basis, and to delete the provisions regarding waiver of longer stays. Therefore, CAHs will be permitted to keep some individual patients more than 96 hours without a waiver request, so long as the facility's average length of acute stays in any 12-month cost reporting period is not more than 96 hours.

The effective date of this provision is November 29, 1999.

We are revising the conditions of participation for length of stay for CAHs at § 485.620(b) to reflect this change.

2. For-Profit Facilities (Section 403(b) of Public Law 106-113 and 42 CFR 485.610(a))

Prior to enactment of Public Law 106–113, section 1820(c)(2)(B) of the Act allowed only nonprofit or public hospitals to be designated as CAHs. Section 403(b) of Public Law 106–113 revises section 1820(c)(2)(B) of the Act to remove the words ''nonprofit or public'' before ''hospitals,'' thus enabling for-profit hospitals to qualify for CAH status.

We are revising the conditions of participation related to the status and location for CAHs at § 485.610(a) to reflect this change.

3. Closed and Downsized Hospitals (Section 403(c) of Public Law 106–113 and 42 CFR 485.610(a)(1))

Under section 1820(c)(2) of the Act, CAH designation was available only to facilities currently operating as hospitals. Section 403(c) of Public Law 106–113 amended the statute to permit

a State to designate as a CAH a facility that previously was a hospital but ceased operations on or after November 29, 1989 (10 years prior to the enactment of Public Law 106–113), if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act for CAH designation as of the effective date of its designation. The amendment also allows State CAH designation for facilities that previously had been hospitals, but are currently State-licensed health clinics or health centers if they meet the revised criteria for CAH designation under section 1820(c)(2)(B) of the Act as of the effective date of designation.

We are revising the CAH criteria for State certification at § 485.610(a)(1) to reflect this change.

4. Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH (Section 403(e) of Public Law 106–113 and 42 CFR 410.152 and 413.70))

Under the law in effect before the enactment of Public Law 106–113, clinical diagnostic laboratory services furnished by a CAH to its outpatients were, like other outpatient CAH services, paid for on a reasonable cost basis, subject to the Part B deductible and coinsurance provisions. With respect to coinsurance, this means that the beneficiary was responsible for payment of 20 percent of the CAH's customary charges for the services and the CAH received payment from the Medicare program equal to 80 percent of its reasonable costs of furnishing the services.

Section 403(e) of Public Law 106–113 eliminated the Part B coinsurance and deductible for laboratory tests furnished by a CAH on an outpatient basis by providing for Medicare payment to the full amount of the lesser of the fee schedule or billed charges. Thus, CAHs are not permitted to impose a deductible or coinsurance charge on the beneficiary for these services, and Medicare Part B is to pay 100 percent of the lesser of the amount determined under the local laboratory fee schedule, the national limitation amount for that test, or the amount of the charges billed for the tests. In the case of services paid for on the basis of a negotiated rate under section 1833(h)(6) of the Act, the amount to be paid is equal to 100 percent of the negotiated rate. The effect of this change is that clinical diagnostic laboratory tests furnished by a CAH to its outpatients will be paid for on the same basis as is paid for these services furnished by all hospitals to outpatients.

Section 403(e)(2) of Public Law 106–113 provides that this provision is effective with respect to services furnished on or after November 29, 1999.

We are clarifying our policy and incorporating the provisions of section 403(e) of Public Law 106–113 in §§ 410.152 and 413.70 of the regulations.

Since enactment of Public Law 106–113, we have received many inquiries from the provider community about implementation of section 403(e). In response, we wish to note that revised payment instructions were issued in June 2000 as Medicare Intermediary Manual Transmittal No. 1799 and as Medicare Hospital Manual Transmittal No. 757, and that needed Part B electronic bill processing system changes will be made as soon as possible. The payment instructions explain that CAHs are to no longer collect deductible or coinsurance for these services and that any amounts collected from beneficiaries for these services provided on or after November 29, 1999, are to be returned to the beneficiaries in an appropriate and timely manner. The instructions also explain that payments to CAHs for the services will be adjusted, at cost report settlement, to reflect the payment method required by section 403(e).

5. Participation in Swing-Bed Program (Section 403(f) of Public Law 106–113)

Section 403(f) of Public Law 106–113, entitled ''Improvements in the Critical Access Hospital Program,'' includes a provision on swing-bed agreements. Since our existing regulations at § 485.645 already provide for swing beds in CAHs, we are not making any changes to our regulations based on this provision.

XI. Hospital Swing-Bed Program

Section 408(a) of Public Law 106–113 amended section 1883(b) of the Act to remove the provision that in order for a hospital to enter into an agreement to provide Medicare post-hospital extended care services, the hospital had to be granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located. Section 408(b) of Public Law 106–113 amended section 1883(d) of the Act to remove the provisions under paragraphs (d)(2) and (d)(3) that placed restrictions on lengths of stays in hospitals with more than 49 beds for post-hospital extended care services. These provisions are effective on the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Act for payment for covered skilled nursing facility (SNF) services under the Medicare program; that is, at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998 and extend through the end of the facility's third cost reporting period after this date.

The Medicare regulations that implemented the provision of section 1883(b) of the Act are located at § 482.66(a)(3). The regulations that implemented the provisions of sections 1883(d)(2) and (d)(3) of the Act are located at §§ 482.66(a)(6) and (a)(7). As a result of the changes made by section 408(a) and (b) of Public Law 106–113, we are removing §§ 482.66(a)(3), (a)(6), and (a)(7). (Existing paragraphs (a)(4) and (a)(5) are being redesignated as (a)(3) and (a)(4) respectively as a result of the removal of existing paragraph (a)(3).)

XII. Waiver of Notice of Proposed Rulemaking and 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 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 July 30, 1999, we published a final rule addressing FY 2000 payment rates and policies for prospective payment system hospitals and excluded hospitals (64 FR 41490). Subsequently, on November 29, 1999, Public Law 106–113 was enacted. Public Law 106–113 contained a number of provisions relating to issues addressed in the final rule that have effective dates of October 1, 1999, November 29, 1999, or dates prior to the beginning of FY 2001 (that is, October 1, 2000).

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 106–113 that take effect on October 1, 1999, November 29, 1999, January 1, 2000, or

April 1, 2000. In addition, we find good cause to waive prior notice and comment procedures with respect to the provisions of this interim final rule with comment period that implement the specified provisions of Public Law 106–113 with these effective dates (except for sections 404 and 408), because the statutory provisions implemented by this document are clear and specific. Moreover, it would be impracticable to undertake such procedures before those provisions take effect, given the extremely short timeframe for implementing these statutory provisions.

Sections 404 and 408 are both provisions of Public Law 106–113 that contain changes to programs that have prospective effective dates after October 1, 2000. However, these provisions are specific and leave no room for further interpretation. That is, section 404 extends the MCH program as it is currently operated from FY 2002 through 2006. Sections 408(a) and (b) remove two provisions relating to implementation of the hospital swing-bed provision under sections 1883(b) and (d) that are effective on the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Act for payment for covered SNF services; that is at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998, and extend through the end of the facility's third cost reporting period after that date. These provisions of Public Law 106–113 require no exercise of discretion and we are merely conforming the Medicare regulations to the statute.

We are providing a 30-day period for public comments on all of these provisions.

This rule has been determined to be a major rule as defined in Title 5, United States Code, section 804(2). Ordinarily, under 5 U.S.C. 801, as added by section 251 of Public Law 104–121, major rule shall take effect 60 days after the later of (1) the date a report on the rule is submitted to Congress or (2) the date the rule is published in the **Federal Register**. However, section 808(2) of Title 5, United States Code, provides that, notwithstanding 5 U.S.C. 801, a major rule shall take effect at such time as the Federal agency promulgating the rule determines, if, for good cause, the agency finds that notice and public procedure are impracticable, unnecessary, or contrary to the public interest. As indicated above, for good cause we find that it was impracticable to complete notice and comment procedures before publication of this rule and to delay the effective date of this rule . Accordingly, pursuant to 5 U.S.C. 808, these regulations are effective August 1, 2000.

XIII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. Comments on the provisions of this interim final rule with comment period will be considered if we receive them by the date specified in the **DATES** section of this preamble.

XIV. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this interim 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, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, all hospitals are considered to be small entities. Individuals and States are not included in the definition of a small entity.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This interim final rule with comment period does not mandate any requirements for State, local, or tribal governments.

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. We are providing below, in combination with the rest of this interim final rule with comment period, a discussion of the regulatory impact on providers of the various provisions of Public Law 106–113 implemented in this interim final rule with comment period for which we are able to compute estimates of fiscal impact. Two sections of Public Law 106–113, sections 401 and 403, authorize certain hospitals to reclassify into different payment categories or apply for designation as a different class of provider. Since we have no way of anticipating how many hospitals will avail themselves of these options, we cannot predict the financial impact on the Medicare program of these provisions. The total anticipated impact of the provisions for which we can gather data is $400 million for FY 2000. These provisions, along with those for which data cannot be predicted, are discussed below.

B. Anticipated Effects

1. Impact of Changes Relating to the IME Adjustment Factor Schedule

As discussed in section VI. of this interim final rule with comment period, we are implementing the revised transition schedule for the IME adjustment for FY 2000. Section 111 of Public Law 106–113 provides for special payments to be made to each hospital to reflect the amount of IME payments if the payment factor for FY 2000 equaled 1.6 rather than 1.47.

For the purposes of this interim final rule, we have simulated the difference in IME payments due to the change described above based on the figures we used for computing the proposed FY 2001 prospective payment system rates. We have estimated that, for FY 2000, the total increase in IME payments to teaching hospitals is approximately $342.2 million, or 0.81 percent.

2. Impact on Excluded Hospitals and Units

We are implementing section 121(a) of Public Law 106–113, which amended section 1886(b)(3)(H) of the Act to direct the Secretary to make an appropriate wage adjustment to the 75th percentile cap on target amounts for psychiatric

hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, established in FY 1998 by section 4414 of Public Law 105–33. The data sources for determining the wage-neutralized national 75th percentile target amounts were FY 1996 cost report data and the FY 2000 inpatient hospital prospective payment system wage index data.

Prior to the enactment of Public Law 106–113, target amounts for these hospitals were set, in accordance with the regulations at § 413.40(c)(4)(iii), at the lesser of the hospital-specific target amount or the national 75th percentile target amount, which was not adjusted to account for area differences in wage-related costs. Public Law 106–113 amended the regulations at § 413.40(c)(4)(iii) to specify that target amounts for FY 2000 for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals are set at the lesser of the hospital-specific target amount or the wage-adjusted cap on the target amount, which is derived from the national 75th percentile wage-neutralized target amount for each class of hospital.

In order to estimate the impact of the wage-adjusted target amounts on hospitals within each class, we first calculated the target amount for each hospital as it was set under section 4414 of Public Law 105–33. Each hospital's target amount was set at the lesser of the hospital's hospital-specific target amount or the national 75th percentile target amount. In accordance the regulations at 42 CFR 413.40(d), we then compared the resulting target amount to the hospital's costs per discharge.

Taking into account the provisions of section 123(a) of Public Law 106–113, we then repeated the comparative calculations described above, replacing the national unadjusted 75th percentile target amount with each hospital's wage-adjusted target amount. The results were compared to show the estimated impact on these classes of hospitals and units as follows:

PERCENT OF TOTAL PROVIDERS BY TYPE

Class of hospital/unit	Percent of free-standing hospitals	Percent of hospital-based units
Psychiatric	30.7	69.3
Rehabilitation	16.4	83.6
Long-Term Care	100.0	([1])

[1] Not applicable.

PERCENT OF TOTAL PROVIDERS BY GEOGRAPHIC LOCATION

Class of hospital/unit	Percent of large urban	Percent of other urban	Percent of rural
Psychiatric	48.3	33.5	18.2
Rehabilitation	49.8	38.1	12.1
Long Term Care	68.6	23.1	8.3

NET CHANGE IN FY 2000 CAP PER DISCHARGE

Class of hospital/unit	Unadjusted FY 2000 target amount [1]	Wage-neutral FY 2000 target amount	Net percentage change
Psychiatric	$11,100	$10,990	−1.0
Rehabilitation	20,129	20,496	+1.8
Long-Term Care	39,712	39,580	−0.3

[1] As published in the July 30, 1999 Final Rule (64 FR 41557).

NET CHANGE BY CLASS OF HOSPITAL

Class of hospital/unit	Percent of Providers estimated to experience negative impact	Percent of providers estimated to experience no impact	Percent of providers estimated to experience positive impacts
Psychiatric	6.7	87.7	5.6
Rehabilitation	2.5	95.0	2.5
Long-Term Care	6.5	90.2	3.3

The impact of the wage-adjusted caps on target amounts on excluded hospitals and units (psychiatric, rehabilitation, and long-term care) was estimated based on FY 1996 data as this was the most complete data source available. The target amounts (hospital-specific targets, 75th percentile targets, and wage-adjusted targets) and costs compared in this estimated impact analysis were trended forward to account for inflation through FY 2000.

When comparing the costs to target amounts to determine the impact on hospitals, we did not attempt to determine the impact on incentive payments, continuous improvement bonus payments, or other payment adjustments for excluded hospitals outlined in the regulations at § 413.40(d). The actual impact on payments to each class of hospital depends on the cost experienced by each excluded hospital or unit since its

applicable base period. It is important to note that while the providers whose hospital-specific target amounts exceed the wage-adjusted cap on the target amounts will have their target amounts reduced to their wage-adjusted target amount, the real impact on each hospital and unit will depend on the level of its operating cost per discharge in relation to its target amount as outlined in at § 413.40(d).

As discussed in the preceding paragraphs, excluded hospital payments are calculated based on the lesser of costs per discharge or the target amount as set forth under § 413.40(c)(4)(iii). Consequently, the fact that the wage-neutralized national 75th percentile target amounts decreased slightly for both psychiatric hospitals and units and long-term care hospitals does not necessarily imply lower payments.

Approximately 75 percent of the hospitals and units in each of these classes have hospital-specific target amounts lower than both the unadjusted and wage-neutralized target amounts, and of those hospitals and units whose hospital-specific target amounts are higher than both the unadjusted and wage-neutralized target amounts, many have costs lower than their target amounts. Consequently, as shown in the table ''Net Change by Class of Hospital,'' most hospitals and hospital units do not appear to experience an impact from the wage-adjustment to the target amounts.

Among those hospitals that do appear to experience an impact from the wage-adjustment to the target amount, the wage-index associated with their location is an indicator in determining whether that impact is positive or negative. Since the wage-neutralized target amounts are wage-adjusted using the hospital inpatient prospective payment system wage index, hospital's located in areas with wage-index values greater than one will have higher wage-adjusted target amounts relative to hospitals located in areas with wage-index values less than one.

3. Impact of Provisions on Reclassification of Hospitals

We are implementing section 401(a) of Public Law 106–113, which added a new section 1886(d)(8)(E) to the Act that directs the Secretary to treat any hospital located in an urban area as being located in the rural area of a State if the hospital files an application and meets certain criteria specified in the statute.

The number of hospitals that will seek to reclassify from urban to rural is unknown at this time. However, generally, reclassification may affect payment rates under the prospective payment system, wage index calculations, and DSH, SCH, and IME adjustments.

4. Impact of Provisions on CAHs

We are implementing sections 401(b) and 403 of Public Law 106–113, which made a number of modifications to the CAH program under section 1820 of the Act. Specifically, it—

- Authorizes a State to designate a hospital as a CAH if, as set forth in the section 401(a) criteria for a hospital to be eligible to request reclassification from urban to rural, it would be considered as being located in the rural area of the State in which the hospital is located.
- Requires the 96-hour limit on stays in CAHs to be applied on an annual average basis and deletes the provisions regarding waiver for longer stays.
- Provides that for-profit hospitals may qualify for CAH status.
- Permits a State to designate as a CAH a facility that previously was a hospital but ceased operations on or after November 29, 1989 if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act as of the effective date of its designation.
- Permits a State to designate as a CAH a facility that was once a hospital that downsized and now functions as a State licensed health clinic or health center, if the facility meets criteria under section 1820(c)(2)(B) of the Act as of the effective date of its designation.
- Eliminates the coinsurance and deductible for outpatient clinical diagnostic laboratory tests furnished by a CAH and requires that such tests be paid for on the same basis as would apply if the tests had been performed on an outpatient basis.
- Reaffirms the eligibility of CAHs that meet the applicable requirements to enter into ''swing-bed'' agreements, thus permitting inpatient CAH facilities to be used for furnishing of extended care services type (SNF) services.

The number of facilities that qualify as CAHs will increase as a consequence of the Public Law 106–113 amendments to the CAH program. CAHs are paid on a reasonable cost basis rather than under the prospective payment system. The budgetary impact of these amendments will correlate with the number of facilities that are designated as CAHs under the statutory amendment made by sections 401(b) and 403 of Public Law 106–113. However, we are unable at this time to predict the number of facilities that will be designated as CAHs under these provisions.

5. Impact of Provisions on MDHs

We are incorporating the provisions of section 404 of Public Law 106–113, which extended special payments under the prospective payment system to MDHs for 5 years, from FY 2002 through FY 2006. We estimate that the extension will amount to an increase in payment of 4.4 percent for each of the 5 years of the MDH extension. There is no increase in payment amounts for MDHs for FY 2000 as a result of PublicLaw 106–113.

6. Impact of Direct GME and IME Provisions

We are amending our regulations to incorporate changes mandated by sections 407(a) through (d) of Public Law 106-113, which amended sections 1886(d) and (h) of the Act to address specific GME FTE cap issues. These changes include increasing the cap for rural hospitals and urban hospitals that establish programs with training in rural areas, revising the FTE caps for hospitals with certain residents on leave during the base period, and temporarily increasing the cap for hospitals that train residents that transferred from certain VA hospitals. The regulations also reflect the provisions of section 312 of Public Law 106–113, which amended section 1886(h)(5) of the Act to change (for purposes of payment) the initial residency period for child neurology residents.

a. Approved Leave of Absences of Residents. Section VII.A. of this interim final rule implements section 407(a) of Public Law 106–113, which directs the Secretary to count an individual for purposes of determining a hospital's FTE cap, to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. The provision allows a hospital to receive an adjustment to its individual FTE cap of up to three additional FTE residents. We are unable to predict at this time the number of residents affected by this provision. However, we believe the financial impact will be negligible, because few hospitals and FTEs are likely to be affected.

b. Adjustment to FTE Caps for Rural Hospitals. As explained in section VII.C. of this interim final rule, we are implementing section 407(b) of Public Law 106-113 which provides for a 30-percent expansion to a rural hospital's FTE resident cap. We have calculated an estimated impact on the Medicare program as a result of this provision. We used the best available cost report data

from 1995 HCRIS, which included the resident counts from which the rural hospitals' (and urban hospitals') caps were set. Seventy rural teaching hospitals were included in this impact analysis.

To determine the impact of this provision, we first estimated the average GME (direct GME and IME combined) payment amount made to rural hospitals in FY 1995. Then, we increased the average GME payment amount by 30-percent and multiplied this amount by 70 to reflect a potential 30-percent increase in the number of FTEs across all rural hospitals. Next, we updated this amount for inflation from FY 1995 to FY 2000, and from FY 2000 through FY 2004. Specifically, the estimated costs for each fiscal year are as follows:

FY 2000: $28.8 million
FY 2001: $29.5 million
FY 2002: $30.2 million
FY 2003: $31.1 million
FY 2004: $31.9 million

The total maximum estimated cost for FY 2000 through FY 2004 is $151.5 million. However, we do not anticipate that all rural hospitals will expand their counts by 30-percent in FY 2000. Therefore, we believe that the actual cost in FY 2000 will be somewhat less than $28.8 million.

c. Urban Hospitals with Rural Track Residency Programs. As discussed in section VII.C. of this interim final rule with comment period, we are implementing the provision that allows an urban hospital that establishes a new residency program or has an existing residency program with a rural track (or an integrated rural track) to include in its FTE count residents in those rural tracks, in addition to the residents already included in the hospital's FTE cap.

We estimated the costs to the Medicare program from FY 2000 through FY 2004 based on the number of currently existing (as of May 2000), separately accredited, ''1–2'' rural training track programs. Considering that there are currently 26 such programs, each averaging 4 residents, and making assumptions about the growth of new programs, we estimate that the cost from FY 2000 through FY 2004 will be $75 million. Specifically, the estimated cost per year is $5 million for FY 2000, $10 million for FY 2001, and $20 million for FYs 2002, 2003, and 2004.

d. Residents Training at VA Hospitals That Would Lose Accreditation. Section VII.D. of this interim final rule with comment period implements section 407(d) of Public Law 106–113 which addresses the situation where a non-VA hospital temporarily takes on residents training at a VA hospital because the program at the VA hospital would lose its ACGME accreditation if the residents continued to train at the VA hospital. We estimate that the number of residents affected by this provision will be small; we know of only one hospital that is affected by this provision. Therefore, the financial impact will be negligible.

e. Child Neurology Training. We are implementing the provisions of section 312 of Public Law 106–113 which amended section 1886(h)(5) of the Act to revise the initial residency period for child neurology residency programs. We believe this provision will have a minimal financial impact, because there are so few hospitals that will be affected by this provision.

7. Medicare+Choice Nursing and Allied Health Education Payments

As discussed in section VIII. of this interim final rule, we are implementing the methodology for determining the additional payments to be made to hospitals that receive reasonable cost payment for approved nursing or allied health education programs for their services associated with Medicare+Choice enrollees. The estimated total amount calculated for these payments, not to exceed $60,000,000 in a calendar year, is based on the proportion of projected total direct GME payments for Medicare+Choice enrollees to projected total direct GME payments, multiplied by projected total nursing and allied health education payments. Hospitals would receive these payments in proportion to the amount of Medicare nursing and allied health education payments received in the cost reporting period that ended in the fiscal year that is 2 years prior to the current calendar year, to the total amount of nursing and allied health education payments paid to all hospitals in that cost reporting period. Direct GME payments for Medicare+Choice utilization would be reduced to reflect the estimated amount of additional payments that would be made for nursing and allied health education programs under this provision. For a more detailed explanation of this policy, refer to section VIII. of this preamble.

By requiring that the Medicare+Choice direct GME payments be reduced in order to provide for the additional nursing and allied health education payments, this provision is designed to be budget neutral in the aggregate. However, on a hospital specific basis, hospitals that operate both GME and nursing or allied health education programs may experience either a net gain or loss as a result of this provision. This is because, although their Medicare+Choice direct GME payments will be reduced by a certain percentage, their nursing and allied health education payments will be increased. However, those hospitals that operate only GME programs will see their Medicare reimbursement reduced, and those hospitals that operate only nursing or allied health education programs will see their Medicare reimbursement increased.

As explained in section VIII.E. of this preamble, the percentage decrease to hospitals' Medicare+Choice direct GME payments is 10.5 percent. For purposes of this interim final rule with comment period, we have estimated a percentage increase to hospitals' nursing and allied health education payments for calendar year 2000. When the nursing and allied health education payment ''pool'' is added to the total projected nursing and allied health education payments for calendar year 2000, the estimated percentage increase in total nursing and allied health payments is 10.2 percent.

8. Hospital Swing Bed Program

The elimination of the requirements for State certification of need to use acute care beds as swing beds for long-term care patients and the elimination of the constraints on the length of stay in swing beds for rural hospitals with 50 to 100 beds will have a positive effect on providers, especially rural hospitals. However, we do not have the necessary data to determine at this time a budgetary impact of these provisions on Medicare payments.

C. Federalism

We have examined this interim final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that this interim final rule with comment period will not have any negative impact on the rights, rules, and responsibilities of State, local, or tribal governments.

D. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

XV. Information Collection Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is

submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for § 412.103(b), which contains information collection and recordkeeping requirements.

Section 412.103(b) specifies that a facility seeking reclassification under section 401(a) or (b) of Public Law 106–113 must apply in writing to the HCFA Regional Office and include documentation of the criteria on which its request is based. The application must be mailed; facsimile or other electronic means are not acceptable.

The hospital's application must include a copy of the State law or regulation or other authoritative document verifying that the requesting hospital is situated in an area determined to be rural by the State or the hospital is considered to be a rural hospital.

We estimate that it will take each hospital approximately 30 minutes to complete the application process. We estimate that additional time would be needed to collect the required documentation. This recordkeeping should take no more than approximately 2 hours. Therefore, the paperwork burden associated with the reclassification process would add up to an additional 2½ hours per hospital that request reclassification under section 401 of Public Law 106–113.

These information collection and recordkeeping requirements are not effective until they are approved by OMB.

Comments on these information collection and recordkeeping requirements should be mailed to the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850, Attn: John Burke HCFA–1131-IFC; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt HCFA–1131–IFC, HCFA Desk Officer.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 482

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

42 CFR Part 485

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

42 CFR Chapter IV is amended as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

A. 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).

2. 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.* (1) Payment for CAH 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, with § 413.70(b) and (c) of this chapter, and with the applicable principles of cost reimbursement in part 413 and in part 415 of this chapter.

(2) Payment for CAH outpatient services is subject to the applicable Medicare Part B deductible and coinsurance amounts, except as described in § 413.70(c) of this chapter, with Part B coinsurance being calculated as 20 percent of the customary (insofar as reasonable) charges of the CAH for the services.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

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).

2. Section 412.63 is amended by revising paragraph (b)(1) to read as follows:

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

* * * * *

1. *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, except that, effective January 1, 2000, a hospital reclassified as rural may mean a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.

* * * * *

3. Section 412.90 is amended by revising paragraphs (e) and (j) to read as follows:

§ 412.90 General rules.

* * * * *

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban to rural as defined in § 412.62(f). This adjustment is set forth in § 412.102.

(2) HCFA establishes a procedure by which certain individual hospitals located in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in § 412.103.

* * * * *

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006, 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.

* * * * *

4. The section heading of § 412.102 is revised to read as follows:

§ 412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.

5. A new § 412.103 is added to read as follows:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at *http://www.nal.usda.gov/orph* or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.

(b) *Application requirements.* (1) *Written application.* A hospital seeking reclassification under this section must submit a complete application in writing to HCFA in accordance with paragraphs (b)(2) and (b)(3) of this section.

(2) *Contents of application.* An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request.

(3) *Mailing of application.* An application must be mailed to the HCFA Regional Office by the requesting hospital and may not be submitted by facsimile or other electronic means.

(4) *Notification by HCFA.* Within 5 business days after receiving the hospital's application, the HCFA Regional Office will send the hospital a letter acknowledging receipt, with a copy to the HCFA Central Office.

(5) *Filing date.* The filing date of the application is the date HCFA receives the application.

(c) *HCFA review.* The HCFA Regional Office will review the application and notify the hospital of its approval or disapproval of the request within 60 days of the filing date.

(d) *Effective dates of reclassification.* (1) Except as specified in paragraph (d)(2) of this section, HCFA will consider a hospital that satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.

(2) If a hospital's complete application is received in HCFA by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, HCFA will consider the filing date to be January 1, 2000.

(e) *Withdrawal of application.* A hospital may withdraw an application at any time prior to the date of HCFA's decision as set forth in paragraph (c) of this section.

(f) *Duration of classification.* An approved reclassification under this section remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Cancellation of classification.* (1) A hospital may cancel its rural reclassification by submitting a written request to the HCFA Regional Office not less than 120 days prior to the end of its current cost reporting period.

(2) The hospital's cancellation of the classification is effective beginning with the hospital's next full cost reporting period following the date of its request for cancellation.

6. Section 412.105 is amended by:

A. Revising paragraph (d)(3)(iv).

B. Revising paragraph (f)(1)(iv).

C. Adding and reserving paragraphs (f)(1)(viii) and (ix).

D. Adding new paragraphs (f)(1)(x), (f)(1)(xi), and (f)(1)(xii).

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(d) *Determination of education adjustment factor.* * * *

(3) *Step three.* * * *

(iv) For discharges occurring during fiscal year 2000, 1.47.

(A) Each hospital receives an amount that is equal in the aggregate to the difference between the amount of payments made to the hospital if 'c' equaled 1.6, rather than 1.47.

(B) The payment of this amount will not affect any other payments, determinations, or budget neutrality adjustments.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) * * *

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of FTE residents in the fields of allopathic and osteopathic medicine in either a hospital or a nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such FTE residents in the hospital (or, in the case of a hospital located in a rural area, effective for discharges occurring on or after April 1, 2000, 130 percent of that number) with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

* * * * *

(x) Effective for discharges occurring on or after April 1, 2000, an urban hospital that establishes a new residency program (as defined in § 413.86(g)(12) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the provisions of §§ 413.86(g)(11) of this subchapter.

(xi) Effective for discharges occurring in cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional FTEs to the extent that the additional residents would have been counted as primary care residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence, in accordance with the provisions of § 413.86(g)(9) of this subchapter.

(xii) For discharges occurring on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had been previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if the hospital meets the criteria and other provisions of § 413.86(g)(10) of this subchapter.

* * * * *

§ 412.108 [Amended]

6. Section 412.108 is amended as follows:

a. In paragraph (a)(1), the date ''October 1, 2001'', is removed and ''October 1, 2006'' is added in its place.

b. In paragraph (c)(2)(ii) the date ''October 1, 2001'', is removed and ''October 1, 2006'' is added in its place.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

C. Part 413 is amended as follows:

1. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.40 is amended by republishing the introductory text of paragraph (c)(4) and of paragraph (c)(4)(iii) and revising paragraphs (c)(4)(iii)(B) and (c)(4)(v), to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) *Costs subject to the ceiling.* * * *

(4) *Target amounts.* The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

* * * * *

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of—

* * * * *

(B) One of the following for the applicable cost reporting period—

(*1*) 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.

(*2*) For cost reporting periods beginning during fiscal year 1999, the amount determined under paragraph (c)(4)(iii)(B)(*1*) of this section, increased by the market basket percentage up through the subject period, subject to the provisions of paragraph (c)(4)(iv) of this section.

(*3*) For cost reporting periods beginning during fiscal year 2000—

(*i*) The labor-related portion and the nonlabor-related portion of the wage-neutralized 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, are increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1999.

(*ii*) The labor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(*4*)(*i*) of this section is wage adjusted by multiplying it by the hospital's FY 2000 hospital inpatient prospective payment system wage index.

(*iii*) The wage-adjusted 75th percentile target amounts for hospitals in the same class is determined by adding the nonlabor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section and the hospital's wage-adjusted labor-related portion of the wage-neutralized 75th percentile target amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*ii*) of this section, subject to the provisions of paragraph (c)(4)(iv) of this section.

(*4*) For cost reporting periods beginning during fiscal years 2001 and 2002—

(*i*) The amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section are increased by the market basket percentage up through the subject period.

(*ii*) The labor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(**4**)(*i*) of this section is wage-adjusted by multiplying by the hospital's FY 2001 hospital inpatient prospective payment system wage index, for cost reporting periods beginning during fiscal year 2001 and the hospital's FY 2002 hospital inpatient prospective payment system wage index for cost reporting periods beginning during fiscal year 2002.

(*iii*) The wage-adjusted 75th percentile target amounts for hospitals in the same class are determined by adding the nonlabor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(*4*)(*i*) of this section and the hospital's wage-adjusted labor-related portion of the wage-neutralized 75th percentile target amounts determined under paragraph (c)(4)(iii)(B)(*4*)(*ii*) of this section, subject to the provisions of paragraph (c)(4)(iv) of this section.

* * * * *

(v) In the case of a hospital that received payments under paragraph (f)(2)(ii) of this section as a newly created hospital or unit, to determine the hospital's target amount for the hospital's third 12-month cost reporting period, the payment amount determined under paragraph (f)(2)(ii)(A) of this section for the preceding cost reporting period is updated to the third cost reporting period.

* * * * *

3. Section 413.70 is amended by:

A. Revising paragraphs (b)(2)(iii) and (b)(2)(iv).

B. Removing paragraph (b)(2)(v).

C. Adding a new paragraph (c).

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(2) * * *

(iii) Any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7); and

(iv) Blended payment amounts for ASC, radiology, and other diagnostic services.

(c) The following payment principles are used when determining payment for outpatient clinical diagnostic laboratory tests:

(1) The amount paid is equal to 100 percent of the least of—

(i) Charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act;

(ii) The limitation amount for that test determined under section 1833(h)(4)(B) of the Act or the amount of the charges billed for the test; or

(iii) A negotiated rate established under section 1833(h)(6) of the Act.

(2) Payment for outpatient clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts, as specified in § 410.152(k) of this chapter.

4. Section 413.86 is amended by:

A. Adding definitions of ''rural track FTE limitation'' and ''rural track or integrated rural track'' in alphabetical order under paragraph (b).

B. Revising paragraphs (d)(4) and (d)(5).

C. Adding a new paragraph (d)(6).

D. Revising paragraph (g)(1).

E. Revising the first sentence of paragraph (g)(4).

F. Redesignating paragraph (g)(9) as paragraph (g)(12).

G. Add new paragraphs (g)(9), (g)(10), and (g)(11).

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

Rural track FTE limitation means the maximum number of residents (as

specified in paragraph (g)(11) of this section) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or *integrated rural track* means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

* * * * *

(d) *Calculating payment for graduate medical education costs.* * * *

(4) *Step four.* Effective for cost reporting periods beginning on or after January 1, 2000, the product derived from step three is reduced in accordance with the provisions of § 413.87(f).

(5) *Step five.* (i) For portions of cost reporting periods beginning on or after January 1, 1998 and before January 1, 2000, add steps two and three.

(ii) Effective for portions of cost reporting periods beginning on or after January 1, 2000, add the results of steps two and four.

(6) *Step six.* 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.

* * * * *

(g) *Determining the weighted number of FTE residents.* (1) Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Prior to July 1, 1995, the initial residency period equals the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to 2 additional years. Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years. Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations. For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. 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 1 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 (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996. * * *

(9) Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(i) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

(ii) The leave of absence was approved by the residency program director to allow the residents to be absent from the program and return to the program after the leave of absence; and

(iii) No later than 6 months after August 1, 2000, the hospital submits to the fiscal intermediary a request for an adjustment to its FTE cap, and provides contemporaneous documentation of the approval of the leave of absence by the residency director, specific to each additional resident that is to be counted for purposes of the adjustment.

(10) For cost reporting periods beginning on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if that hospital meets the following criteria:

(i) The transferred residents had been training previously at a VA hospital in a program that would have lost its accreditation by the ACGME if the residents continued to train at the VA hospital;

(ii) The residents were transferred to the hospital from the VA hospital on or after January 1, 1997, and before July 31, 1998; and

(iii) The hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(11) For cost reporting periods beginning on or after April 1, 2000, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (g)(4) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (g)(11)(i) through (g)(11)(vi) of this section.

(i) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital.

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-

thirds of the duration of the program, and the number of years those residents are training at the urban hospital.

(ii) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training at the urban hospital and the rural nonhospital site(s).

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(*1*) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at—

(*i*) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program; and

(*ii*) The rural nonhospital site(s); and

(*2*) The number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

(iii) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for periods of time that are less than two-thirds of the duration of the program, the rural hospital may not include those residents in its FTE count (if the urban hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(iv) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents training in the rural track at the rural nonhospital site(s).

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(*1*) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital site(s) for a period that is less than two-thirds of the duration of the program; and

(*2*) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(v) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(A) An urban hospital may not include in its rural track FTE limitation or (assuming the urban hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(B) The hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(C) All residents that are included by the hospital as part of its FTE count (not to exceed its rural track FTE limitation) must ultimately train in the rural area.

(vi) If HCFA finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, HCFA will reopen the urban hospital's cost report within the 3-year reopening period as specified in § 405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

* * * * *

5. A new § 413.87 is added to read as follows:

§ 413.87 Payments for Medicare+Choice nursing and allied health education programs.

(a) *Statutory basis.* This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

(b) *Scope.* This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.

(c) *Qualifying conditions for payment.* For portions of cost reporting periods occurring on or after January 1, 2000, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraph (c)(1) and (c)(2) of this section are met.

(1) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(2) of this section.

(2) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.

(d) *Calculating the additional payment amount.* Subject to the provisions of paragraph (f) of this section relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

(1) *Step one.* Each calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

(2) *Step two.* Determine the ratio of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

(3) *Step three.* Multiply the ratio calculated in step two by the amount determined in accordance with paragraph (e) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

(e) *Calculation of the payment ''pool.''* (1) Subject to paragraph (e)(3) of this section, each calendar year, HCFA will calculate a Medicare+Choice nursing and allied health payment ''pool'' according to the following steps:

(i) Determine the ratio of projected total Medicare+Choice direct GME payments made in accordance with the provisions of § 413.86(d)(3) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.

(ii) Multiply the ratio calculated in paragraph (e)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made across all hospitals in the current calendar year.

(2) The resulting product of the steps under paragraph (e)(1)(i) and (e)(1)(ii) of this section is the Medicare+Choice nursing and allied health payment pool for the current calendar year.

(3) The payment pool may not exceed $60 million in any calendar year.

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

D. Part 482 is amended as follows:

1. The authority citation for Part 482 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 482.66 [Amended]

2. Section 482.66 is amended by:

A. Removing paragraph (a)(3).

B. Redesignating paragraphs (a)(4) and (a)(5) as (a)(3) and (a)(4), respectively.

C. Removing paragraphs (a)(6) and (a)(7).

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

E. Part 485 is amended as follows:

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. Section 485.610 is amended by:

A. Revising paragraph (a).

B. Republishing the introductory text of paragraph (b).

C. Redesignating paragraph (b)(4) as paragraph (b)(5) and republishing newly designated paragraph (b)(5).

D. Adding a new paragraph (b)(4).

§ 485.610 Condition of participation: Status and location.

(a) *Standard:* Status. The facility is—

(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;

(2) A recently closed facility, provided that the facility—

(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) Meets the criteria for designation under this subpart as of November 29, 1999; or

(3) A health clinic or a health center (as defined by the State) that—

(i) Is licensed by the State as a health clinic or a health center;

(ii) Was a hospital that was downsized to a health clinic or a health center; and

(iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.

(b) *Standard: Location.* The CAH meets the following requirements:

* * * * *

(4) The CAH is being treated as being located in a rural area in accordance with § 412.103 of this chapter.

(5) 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.

3. Section 485.620 is amended by revising paragraph (b) to read as follows:

§ 485.620 Condition of participation: Number of beds and length of stay.

* * * * *

(b) *Standard: Length of stay.* The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: July 21, 2000.

Nancy Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 24, 2000.

Donna E. Shalala,

Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION

[Based on 1990 Census Data]

County	State
BALDWIN	ALABAMA.
MOBILE	ALABAMA.
TUSCALOOSA	ALABAMA.
ANCHORAGE	ALASKA.
COCONINO	ARIZONA.
MARICOPA	ARIZONA.
MOHAVE	ARIZONA.
PIMA	ARIZONA.
PINAL	ARIZONA.
YUMA	ARIZONA.
BUTTE	CALIFORNIA.
EL DORADO	CALIFORNIA.
FRESNO	CALIFORNIA.
KERN	CALIFORNIA.
LOS ANGELES	CALIFORNIA.
MADERA	CALIFORNIA.
MERCED	CALIFORNIA.
MONTEREY	CALIFORNIA.
PLACER	CALIFORNIA.
RIVERSIDE	CALIFORNIA.
SAN BERNARDINO	CALIFORNIA.
SAN DIEGO	CALIFORNIA.
SAN JOAQUIN	CALIFORNIA.
SAN LUIS OBISPO	CALIFORNIA.
SANTA BARBARA	CALIFORNIA.
SANTA CLARA	CALIFORNIA.
SHASTA	CALIFORNIA.
SONOMA	CALIFORNIA.
STANISLAUS	CALIFORNIA.
TULARE	CALIFORNIA.
VENTURA	CALIFORNIA.
ADAMS	COLORADO.
EL PASO	COLORADO.
LARIMER	COLORADO.
MESA	COLORADO.
PUEBLO	COLORADO.
WELD	COLORADO.
COLLIER	FLORIDA.
DADE	FLORIDA.
MARION	FLORIDA.
OSCEOLA	FLORIDA.
PALM BEACH	FLORIDA.
POLK	FLORIDA.
BUTLER	KANSAS.
RAPIDES	LOUISIANA.
TERREBONNE	LOUISIANA.
PENOBSCOT	MAINE.
WORCESTER	MASSACHUSETTS.
POLK	MINNESOTA.
ST. LOUIS	MINNESOTA.
STEARNS	MINNESOTA.
CASCADE	MONTANA.
MISSOULA	MONTANA.
YELLOWSTONE	MONTANA.
CLARK	NEVADA.
NYE	NEVADA.
WASHOE	NEVADA.
DONA ANA	NEW MEXICO.
SANDOVAL	NEW MEXICO.
SANTA FE	NEW MEXICO.
HERKIMER	NEW YORK.
BURLEIGH	NORTH DAKOTA.
CASS	NORTH DAKOTA.
GRAND FORKS	NORTH DAKOTA.
MORTON	NORTH DAKOTA.
OSAGE	OKLAHOMA.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION—Continued

[Based on 1990 Census Data]

County	State
CLACKAMAS	OREGON.
JACKSON	OREGON.
LANE	OREGON.
LYCOMING	PENNSYLVANIA.
PENNINGTON	SOUTH DAKOTA.
BEXAR	TEXAS.
BRAZORIA	TEXAS.
HARRIS	TEXAS.
HIDALGO	TEXAS.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION—Continued

[Based on 1990 Census Data]

County	State
TOM GREEN	TEXAS.
WEBB	TEXAS.
KANE	UTAH.
UTAH	UTAH.
BENTON	WASHINGTON.
FRANKLIN	WASHINGTON.
KING	WASHINGTON.
PIERCE	WASHINGTON.
SNOHOMISH	WASHINGTON.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION—Continued

[Based on 1990 Census Data]

County	State
SPOKANE	WASHINGTON.
WHATCOM	WASHINGTON.
YAKIMA	WASHINGTON.
DOUGLAS	WISCONSIN.
MARATHON	WISCONSIN.
LARAMIE	WYOMING.
NATRONA	WYOMING.

APPENDIX B.—HOSPITALS AS OF JANUARY 1, 2000 THAT MAY QUALIFY AS RURAL WITHIN A GOLDSMITH MODIFICATION AREA

[Based on 1990 Census Data]

Hospital name	County	State
North Baldwin Hospital	BALDWIN	ALABAMA.
South Baldwin Hospital	BALDWIN	ALABAMA.
Thomas Hospital	BALDWIN	ALABAMA.
Flagstaff Medical Center	COCONINO	ARIZONA.
Page Hospital	COCONINO	ARIZONA.
Wickenburg Regional Hospital	MARICOPA	ARIZONA.
Bullhead Community Hospital	MOHAVE	ARIZONA.
Havasu Samaritan Regional Hospital	MOHAVE	ARIZONA.
Kingman Regional Medical Center	MOHAVE	ARIZONA.
Mohave Valley Hospital and Medical Center	MOHAVE	ARIZONA.
Central Arizona Medical Center	PINAL	ARIZONA.
Casa Grande Regional Medical Center	PINAL	ARIZONA.
Biggs-Gridley Memorial Hospital	BUTTE	CALIFORNIA.
Feather River Hospital	BUTTE	CALIFORNIA.
Barton Memorial Hospital	EL DORADO	CALIFORNIA.
Coalinga Regional Medical Center	FRESNO	CALIFORNIA.
Kingsburg Medical Center	FRESNO	CALIFORNIA.
Sanger General Hospital	FRESNO	CALIFORNIA.
Selma District Hospital	FRESNO	CALIFORNIA.
Sierra Kings Health Care District	FRESNO	CALIFORNIA.
Delano Regional Medical Center	KERN	CALIFORNIA.
Kern Valley Hospital	KERN	CALIFORNIA.
Ridgecrest Community Hospital	KERN	CALIFORNIA.
Tehachapi Valley Hospital	KERN	CALIFORNIA.
Westside District Hospital	KERN	CALIFORNIA.
Avalon Municipal Hospital and Clinic	LOS ANGELES	CALIFORNIA.
Chowchilla District Memorial Hospital	MADERA	CALIFORNIA.
Madera Community Hospital	MADERA	CALIFORNIA.
Bloss Memorial Hospital	MERCED	CALIFORNIA.
Dos Palos Memorial Hospital	MERCED	CALIFORNIA.
Los Banos Community Hospital	MERCED	CALIFORNIA.
Sutter Auburn Faith Hospital	PLACER	CALIFORNIA.
Palo Verde Hospital	RIVERSIDE	CALIFORNIA.
San Gorgonio Memorial Hospital	RIVERSIDE	CALIFORNIA.
Santa Ynez Valley Cottage Hospital	SANTA BARBARA	CALIFORNIA.
Barstow Community Hospital	SAN BERNARDINO	CALIFORNIA.
Needles Desert Community Hospital	SAN BERNARDINO	CALIFORNIA.
Hi-Desert Medical Center	SAN BERNARDINO	CALIFORNIA.
Doctors Hospital of Manteca	SAN JOAQUIN	CALIFORNIA.
''St Dominic's Hospital''	SAN JOAQUIN	CALIFORNIA.
Tracy Community Memorial Hospital	SAN JOAQUIN	CALIFORNIA.
Twin Cities Community Hospital	SAN LUIS OBISPO	CALIFORNIA.
South Valley Hospital	SANTA CLARA	CALIFORNIA.
Petaluma Valley Hospital	SONOMA	CALIFORNIA.
Sonoma Valley Health Care District	SONOMA	CALIFORNIA.
Del Puerto Hospital	STANISLAUS	CALIFORNIA.
Emanuel Medical Center	STANISLAUS	CALIFORNIA.
Oak Valley District Hospital	STANISLAUS	CALIFORNIA.
Alta District Hospital	TULARE	CALIFORNIA.

APPENDIX B.—HOSPITALS AS OF JANUARY 1, 2000 THAT MAY QUALIFY AS RURAL WITHIN A GOLDSMITH MODIFICATION AREA—Continued

[Based on 1990 Census Data]

Hospital name	County	State
Sierra View District Hospital	TULARE	CALIFORNIA.
Tulare District Hospital	TULARE	CALIFORNIA.
Lindsay District Hospital	TULARE	CALIFORNIA.
Exeter Memorial Hospital	TULARE	CALIFORNIA.
Estes Park Medical Center	LARIMER	COLORADO.
McKee Medical Center	LARIMER	COLORADO.
Glades General Hospital	PALM BEACH	FLORIDA.
Bartow Memorial Hospital	POLK	FLORIDA.
Heart of Florida Hospital	POLK	FLORIDA.
Polk General Hospital	POLK	FLORIDA.
Lake Wales Medical Center	POLK	FLORIDA.
Susan B. Allen Memorial Hospital	BUTLER	KANSAS.
Millinocket Regional Hospital	PENOBSCOT	MAINE.
Penobscot Valley Hospital	PENOBSCOT	MAINE.
Harrington Memorial Hospital	WORCESTER	MASSACHUSETTS.
Heywood Hospital	WORCESTER	MASSACHUSETTS.
Athol Memorial Hospital	WORCESTER	MASSACHUSETTS.
Clinton Hospital	WORCESTER	MASSACHUSETTS.
First Care Medical Services	POLK	MINNESOTA.
Riverview Healthcare Association	POLK	MINNESOTA.
Ely-Bloomenson Community Hospital	ST. LOUIS	MINNESOTA.
Eveleth Health Services Park	ST. LOUIS	MINNESOTA.
Cook Hospital & Convalescent Center	ST. LOUIS	MINNESOTA.
University Medical Center—Mesabi	ST. LOUIS	MINNESOTA.
Virginia Regional Medical Center	ST. LOUIS	MINNESOTA.
White Community Hospital	ST. LOUIS	MINNESOTA.
Albany Area Hospital & Medical Center	STEARNS	MINNESOTA.
''St Michael's Hospital''	STEARNS	MINNESOTA.
Melrose Hospital & Pine Villa	STEARNS	MINNESOTA.
Paynesville Area Health Care	STEARNS	MINNESOTA.
Nye Regional Medical Center	NYE	NEVADA.
Lake Tahoe Medical Center	WASHOE	NEVADA.
Little Falls Hospital	HERKIMER	NEW YORK.
Northwood Deaconess Healthcare	GRAND FORKS	NORTH DAKOTA.
Fairfax Memorial Hospital	OSAGE	OKLAHOMA.
Pawhuska Hospital	OSAGE	OKLAHOMA.
Ashland Community Hospital	JACKSON	OREGON.
Cottage Grove Hospital	LANE	OREGON.
Peace Harbor Hospital	LANE	OREGON.
Jersey Shore Hospital	LYCOMING	PENNSYLVANIA.
Muncy Valley Hospital	LYCOMING	PENNSYLVANIA.
Angleton-Danbury General Hospital	BRAZORIA	TEXAS.
Brazosport Memorial Hospital	BRAZORIA	TEXAS.
Sweeny Community Hospital	BRAZORIA	TEXAS.
Kane County Hospital	KANE	UTAH.
Prosser Memorial Hospital	BENTON	WASHINGTON.
Providence Toppenish Hospital	YAKIMA	WASHINGTON.
Sunnyside Community Hospital	YAKIMA	WASHINGTON.

[FR Doc. 00–19107 Filed 7–31–00; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 412, 413, and 485

[HCFA–1118–F]

RIN 0938–AK09

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment system for operating costs to: implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Pub. L. 106–113); and implement changes arising from our continuing experience with the system. In addition, in the Addendum to this final rule, we describe changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for

operating costs and capital-related costs. These changes apply to discharges occurring on or after October 1, 2000. We also set forth rate-of-increase limits and make changes to our policy for hospitals and hospital units excluded from the prospective payment systems.

We are making changes to the policies governing payments to hospitals for the direct costs of graduate medical education, sole community hospitals and critical access hospitals.

We are adding a new condition of participation on organ, tissue, and eye procurement for critical access hospitals that parallels the condition of participation that we previously published for all other Medicare-participating hospitals.

Lastly, we are finalizing a January 20, 2000 interim final rule with comment period (65 FR 3136) that sets forth the criteria to be used in calculating the Medicare disproportionate share adjustment in reference to Medicaid expansion waiver patient days under section 1115 of the Social Security Act.

DATES: The provisions of this final rule are effective October 1, 2000. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to Congress on this rule on August 1, 2000.

FOR FURTHER INFORMATION CONTACT:
Steve Phillips, (410) 786–4531, Operating Prospective Payment, Diagnostic Related Groups, Wage Index, Reclassifications, and Sole Community Hospital Issues
Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education and Critical Access Hospital Issues

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8.00. As an alternative, you can view and photocopy the Federal Register document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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I. Background

A. Summary

Section 1886(d) of the Social Security Act (the Act) sets forth 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. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

Certain specialty hospitals are excluded from the prospective payment systems. Under section 1886(d)(1)(B) of the Act, the following hospitals and hospital units are excluded from the prospective payment systems: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit.

Under sections 1820 and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural nonprofit hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(i)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

Under section 1886(a)(4) of the Act, costs of approved educational activities programs are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The regulations governing the hospital inpatient prospective payment system are located in 42 CFR Part 412. The regulations governing excluded hospitals and hospital units are located in 42 CFR Parts 412 and 413, and the GME regulations are located in 42 CFR Part 413.

On November 29, 1999, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, Public Law 106–113, was enacted. Public Law 106–113 made a number of changes to the Act affecting prospective payments to hospitals for inpatient services and payments to excluded hospitals. This final rule implements amendments enacted by Public Law 106–113 relating to FY 2001 payments for GME costs, disproportionate share hospitals (DSHs), sole community hospitals (SCHs), and CAHs. These changes are addressed in sections IV and VI of this preamble.

Other related provisions of Public Law 106–113 that pertain to Medicare hospital inpatient payments with an effective date prior to October 1, 2000, are addressed in an interim final rule with comment period that is published elsewhere in this issue of the **Federal Register**.

Public Law 106–113 also amended section 1886(j) of the Act, which was added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105–33). Section 1886(j) of the Act provides for a fully implemented prospective payment system for inpatient rehabilitation hospitals and rehabilitation units, effective for cost reporting periods beginning on or after October 1, 2002, with payment provisions during a transitional period of October 1, 2000 to October 1, 2002 based on target amounts specified in section 1886(b) of the Act. We are issuing a separate notice of proposed rulemaking to implement the prospective payment system for inpatient rehabilitation hospitals and units.

B. Summary of the Provisions of the May 5, 2000 Proposed Rule

On May 5, 2000, we published a proposed rule in the **Federal Register** (65 FR 26282) that set forth proposed changes to the Medicare hospital inpatient prospective payment system for operating costs for FY 2001. In the proposed rule, we made no policy changes relating to payments for capital-related costs under the hospital inpatient prospective payment system in FY 2001. However, we did propose changes to the amounts and factors used in determining the rates for capital-related costs for FY 2001. The proposed rule also included changes relating to payments for GME costs and payments to excluded hospitals and units, SCHs, and CAHs.

The following is a summary of the major changes we proposed and the issues we addressed in the May 5, 2000 proposed rule:

- We proposed changes to the FY 2001 DRG classifications and relative weights, as required by section 1886(d)(4)(C) of the Act.
- We proposed an update to the FY 2001 hospital wage index, using FY 1997 wage data. We also proposed to implement the second year phaseout of Part A physician teaching-related costs, Part A certified registered nurse anesthetist (CRNA) costs and resident costs from the FY 2001 wage index calculation.
- We discussed the impact of our policy on post acute care transfers and set forth certain proposed changes concerning sole community hospitals (SCHs), rural referral centers (RRCs), the indirect medical education adjustment, the DSH adjustment and collection of data on uncompensated costs for services furnished in hospitals, the Medicare Geographic Classification Review Board (MGCRB) classifications, and payment for the direct costs of GME.
- We discussed FY 2001 as the last year of a 10-year transition established to phase-in the prospective payment system for capital-related costs for inpatient hospital services.
- We discussed a number of proposals concerning excluded hospital and hospital units and CAHs. The proposed changes addressed limits on and adjustments to the proposed target amounts for FY 2001; development of a prospective payment system for inpatient rehabilitation hospitals and units; continuous improvement bonus payments; clarification that the 5-percent threshold used in calculating an excluded hospital's cost per discharge is based only on Medicare inpatients discharged from the hospital-within-a-hospital; an all-inclusive payment rate option for CAHs; and adding a new condition of participation for CAHs relating to organ, tissue, and eye procurement.
- In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2001 prospective payment rates for operating costs and capital-related costs. We also addressed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2001 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 of the proposed changes on affected entities.
- In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 2001 capital cost model.
- In Appendix C of the proposed rule, as required by section 1886(e)(3) (B) of the Act, we set forth our report to Congress on our initial estimate of a recommended update factor for FY 2001 for payments to hospitals included in the prospective payment systems, and hospitals excluded from the prospective payment systems.
- In Appendix D of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we included our recommendation of the appropriate percentage change for FY 2001 for:

—Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs; and

—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 recommendations by the Medicare Payment Advisory Commission (MedPAC) concerning hospital inpatient payment policies and presented our responses to those recommendations. Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress that reviews and makes recommendations on Medicare payment policies no later than March 1 of each year. This year, MedPAC released a subsequent report in June containing additional recommendations. We respond to those recommendations in section IV.E. of this preamble.

C. Public Comments Received in Response to the Proposed Rule

We received a total of 290 timely items of correspondence containing multiple comments on the proposed rule. Major issues addressed by commenters included the creation of a new DRG for pancreas and kidney transplants, the adequacy of the DRG for heart assist devices, various aspects of the wage index calculation, rebasing of the SCH payment rates, and reclassification of hospitals.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate section heading.

D. Final Rule for the January 20, 2000 Interim Final Rule

On January 20, 2000, we published in the **Federal Register** an interim final rule with comment period (65 F 3136) to implement a change in the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. The interim final rule set forth the criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system. This final rule finalizes the policy in this interim final rule with comment period. We discuss this policy in detail in Section IV.E.2. 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 a rate per discharge basis that varies according to 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 at least 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. Changes to the DRG classification system and the recalibration of the DRG

weights for discharges occurring on or after October 1, 2000, 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 Revision, Clinical Modification (ICD–9–CM). Medicare fiscal intermediaries enter the information into their claims processing systems and subject 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.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate DRG by the Medicare GROUPER software program. 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.

In the July 30, 1999 final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for the use of particular data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with the next year's proposed rule, and as appropriate, in the recalibration in the final rule following the proposed rule.

Currently, cases are assigned to one of 501 DRGs (including one DRG for a diagnosis that is invalid as a discharge diagnosis and one DRG for ungroupable diagnoses) 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, cases are assigned to an MDC based on the principal diagnosis, before assignment to a DRG. However, there are presently five DRGs to which cases are directly assigned on the basis of procedure codes. These are the DRGs for liver, bone marrow, and lung transplants (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 (CC).

Generally, the 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 2001 and discussed other issues concerning DRGs. The proposed changes, the public comments we received concerning them, and the final DRG changes are set forth below. Unless otherwise noted, the changes we are implementing will be effective in the revised GROUPER software (Version 18.0) to be implemented for discharges on or after October 1, 2000. (Also unless otherwise specified, our DRG analysis is based on the full (100 percent) FY 1999 MedPAR file (bills received through December 31, 1999 for discharges in FY 1999).

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

In the August 29, 1997 final rule with comment period (62 FR 45974), we noted that, because of the many recent changes in heart surgery, we were considering conducting a comprehensive review of the MDC 5 surgical DRGs. In the July 31, 1998 final rule with comment period (63 FR 40956), we did adopt some changes to the MDC 5 surgical DRGs. Since that time, we have received inquiries on a continuing basis regarding these DRGs. We have continued to review Medicare claims data and, based on our analysis, we proposed several DRG changes in MDC 5 in the May 5, 2000 proposed rule.

a. Heart Transplant (DRG 103). As previously stated, cases are generally assigned to an MDC based on principal diagnosis and subsequently assigned to surgical or medical DRGs included in that MDC. However, cases involving liver, bone marrow, and lung transplants (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483) are directly assigned on the basis of procedure codes. Cases assigned to these DRGs before classification to an MDC are referred to as pre-MDC. However, cases involving heart transplants are currently assigned first to MDC 5 and then to DRG 103.

Currently, when a bone marrow transplant and a heart transplant are performed during the same admission, the case is assigned to DRG 481 (Bone Marrow Transplant). Because bone marrow transplant cases are first classified to pre-MDC, while heart transplants are first assigned to MDC 5, the bone marrow transplant assumes precedence in the assignment of the case to a DRG. However, payment for DRG 481 is substantially less than DRG 103. For FY 2000, the relative weight for DRG 103 is 19.5100, while the relative weight for DRG 481 is 8.7285.

To ensure appropriate DRG assignment of these cases, we proposed that the heart transplant DRG, which encompasses combined heart-lung transplantation (ICD–9–CM procedure code 33.6) and heart transplantation (ICD–9–CM procedure code 37.5) be assigned to pre-MDC. In this way, cases involving a bone marrow transplant and a heart transplant would be assigned to DRG 103 (DRG 103 would be reordered higher in the pre-MDC surgical hierarchy, as discussed in section II.B.5. of this preamble).

We received two comments in support of this proposed change and are adopting it as final.

b. Heart Assist Devices. We continue to review data in MDC 5 (Diseases and Disorders of the Circulatory System) to determine if cases are being assigned to the most appropriate DRG based on clinical coherence and similar resource consumption. At the December 1, 1994 ICD–9–CM Coordination and Maintenance Committee meeting, we recommended that new codes be created to capture single and bi-ventricular heart assist systems.

These codes, 37.65 (Implant of an external, pulsatile heart assist system) and 37.66 (Implant of an implantable, pulsatile heart assist system), were adopted for use for discharges occurring on or after October 1, 1995. However, code 37.66 was deemed investigational and was not considered a covered procedure. Effective May 5, 1997, we revised Medicare coverage of heart assist devices to allow coverage of a ventricular assist device (code 37.66) used for support of blood circulation postcardiotomy if certain conditions were met.

Due to some residual misunderstanding regarding this coverage policy, we emphasize that this device was and will continue to be listed as a noncovered procedure in the Medicare Code Editor (MCE), the front-end software product in the GROUPER program that detects and reports errors in the coding of claims data. The reason that this device is listed in the MCE, in spite of the fact that its implantation is covered, is because of the stringent conditions that must be met by hospitals in order to receive payment.

In the August 29, 1997 final rule (62 FR 45973), we moved procedure code 37.66 from DRGs 110 and 111 [1] (Major Cardiovascular Procedures with and without CCs, respectively) to DRG 108 (Other Cardiothoracic Procedures). As stated in the July 31, 1998 final rule (63 FR 40956), we moved procedure code 37.66 to DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures with and without CCs, respectively) for FY 1999.

In the July 30, 1999 final rule (64 FR 41498), we responded to a comment suggesting that heart assist devices be assigned to DRG 103. For the proposed rule we reviewed the 100 percent FY 1999 MedPAR file containing bills through December 31, 1999, and found that there were a total of 47 implantable heart assist system procedures performed on Medicare beneficiaries. Of these cases, 13 (approximately 28 percent) were assigned to DRG 103 (Heart Transplant) and four (approximately 9 percent) were assigned to DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses), and, therefore, were paid at significantly higher rates than the remaining 30 cases. All of the procedure code 37.66 cases have extremely high charges, which is consistent with past analysis, and all of these cases are subject to payment as cost outliers.

Our data analysis indicated that the most cases in any one hospital was 5, while 17 hospitals performed only one heart assist system implant each. We reiterate that only heart transplant cases can be properly assigned to the transplant DRG (August 29, 1997 final rule (62 FR 45974)). Since heart assist devices are used across DRGs, many not involving a transplant, we did not propose to assign procedure code 37.66 to DRG 103.

In addition to the review of 37.66, we also looked at procedure codes 37.62 (Implant of other heart assist system), 37.63 (Replacement and repair of heart assist system), and 37.65 (Implant of an external, pulsatile heart assist system). These cases are currently assigned to DRGs 110 and 111 (Major Cardiovascular Procedures). We believe that these procedures are similar both clinically and in terms of resource utilization to procedure code 37.66, which is already assigned to DRGs 104 and 105. Therefore, we proposed to move codes 37.62, 37.63, and 37.65 from DRGs 110 and 111 to DRGs 104 and 105.

Comment: We received four comments on this proposal.

Two comments in favor of our proposal were received from national associations concerned with health care delivery.

Two commenters requested reevaluation of the DRG assignment of mechanical heart assist devices, particularly procedure code 37.66, and suggested that a new DRG be created to classify this technology, or that these cases be assigned to DRG 103 (Heart Transplant). The commenters pointed out that the heart assist implantation procedure is typically performed in the same medical centers by the same surgical teams as the heart transplant procedure.

With respect to our past decision not to assign cases with procedure code 37.66 to DRG 103, one commenter acknowledged our analysis of 1996 MedPAR data showing the costs of these cases to be more similar to DRGs 104 and 105 than DRG 103, but suggested that we look at more recent data. The commenter also questioned our rationale for not assigning these cases to DRG 103 on the basis that heart assist devices are used across DRGs.

One commenter argued that, as all the cases with procedure code 37.66 were qualified as cost outliers, the misplacement of this procedure is evident. This commenter also noted that use of this procedure is likely to increase in the future and suggested that HCFA position itself ahead of the curve by increasing payment now in anticipation of this event. The commenter urged HCFA to examine the option of combining code 37.66 with other clinically similar low-volume procedures, and creating a new DRG that would more appropriately pay these cases. This recommended new DRG could conceivably include codes 37.62, 37.63, and 37.65, as they are similar both clinically and in terms of resource consumption.

Finally, one commenter expressed concern that the uncovered status of procedure code 37.66 in the MCE may be resulting in inappropriate payment denials. The commenter recommended that HCFA review the procedures employed by fiscal intermediaries to override the MCE edits.

Response: We are adopting our proposed change to assign procedure codes 37.62, 37.63, and 37.65 to DRGs 104 and 105.

With respect to the comments regarding procedure code 37.66, we have continually considered the issue of DRG assignment of heart assist devices since this technology was assigned an ICD–9–CM code in 1995, and became a Medicare covered procedure (if specific conditions were met) effective in 1997. As we noted in the proposed rule, these are costly cases that are currently spread across several DRGs. Although the outlier policy is intended to help hospitals offset unusually costly cases, we are concerned when a particular procedure always qualifies as an outlier case.

However, we do not believe it would be appropriate to redefine DRG 103 to include these cases at this time. The presently limited incidence of these cases, with very few cases occurring at any particular hospital over the course of a year, does not warrant disrupting the clinical coherence of DRG 103. The fact that these cases are spread across a number of DRGs indicates they do not represent a clinically cohesive group of patients in terms of their associated diagnoses or other procedures.

We will continue to monitor and evaluate these cases to determine whether a better approach might be

[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 with patients who are age 0–17. Occasionally, a pair of DRGs is split between age ≥17 and age 0–17.

identified, including the possibility of a new DRG for procedure codes 37.62, 37.63, 37.65, and 37.66. We note that the classification of patients into DRGs is a constantly evolving process. As there are changes in the coding system, data collection, medical technology, or medical practice, all DRG definitions will be reviewed and potentially revised.

Concerning the concept of HCFA positioning itself ''ahead of the curve'' by anticipating increased use of heart assist devices and raising payment accordingly, we are reluctant to attempt to predict future trends in medical practice, especially when such predictions would affect payments across all DRGs as a result of DRG recalibration. We appreciate the industry's continued interest in this system, and look forward to working together to arrive at equitable payments for this and other new technologies.

With respect to the comment concerning fiscal intermediary overrides of MCE edits listing procedure code 37.66 as noncovered, we will instruct our fiscal intermediaries to be aware of this issue. We are concerned that Medicare payment for this procedure be limited to those cases for which coverage is appropriate and that payment is not inappropriately denied.

c. Platelet Inhibitors. Effective October 1, 1998, procedure code 99.20 (Injection or infusion of platelet inhibitor) was created. The use of platelet inhibitors have been shown to significantly decrease the rate of acute vessel closure, as well as the rate of cardiac complications and death.[2] Platelet inhibitors are frequently administered to patients undergoing percutaneous transluminal coronary angioplasty (PTCA). In addition, patients admitted with unstable angina may also benefit from platelet inhibitors.[2] This procedure code is designated as a non-OR procedure that does not affect DRG assignment (platelet inhibitors are administered either through intravenous injection or infusion).

For the past 2 years, a manufacturer of platelet inhibitors has submitted data to support its position that cases involving platelet inhibitor therapy receiving angioplasty should be reclassified from DRG 112 (Percutaneous Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant). Using the 100 percent FY 1999 MedPAR file that contains discharges through September 30, 1999, we performed analysis for the proposed rule of the cases for which procedure code 99.20 was reported. There were a total of 37,222 cases spread across 123 DRGs.

The majority of the platelet inhibitor cases, 28,022 (75 percent of all platelet inhibitor cases), are already assigned to DRG 116. The average standardized charges for these cases are approximately $26,683, compared to approximately $25,251 for DRG 116 overall. In DRG 112, there were 4,310 platelet inhibitor cases (12 percent of all platelet inhibitor cases) assigned. The average standardized charge for these cases is approximately $22,786, compared to approximately $20,224 for DRG 112 overall. Although the platelet inhibitor therapy cases that are classified to DRG 112 do have somewhat higher charges than the average case assigned to this DRG (11 percent, or $2,563), we found several procedures in DRG 112 with average standardized charges higher than the platelet inhibitor cases. For example, there were 1,560 cases in which a single vessel PTCA or coronary atherectomy with thrombolytic agent (procedure code 36.02) was performed with an average standardized charge of approximately $25,181, and there were 4,951 cases in which a multiple vessel PTCA or coronary atherectomy was performed, with or without a thrombolytic agent (procedure code 36.05) with an average standardized charge of approximately $23,608.

We also noted that there are several procedures assigned to DRG 112 that have average standardized charges lower than the average charges for all cases in the DRG. For example, average charges for cases with procedure code 37.34 (Catheter ablation of lesion or tissues of heart) were $18,429.

There is always some variation in charges within a DRG. The difference in variations of charges in DRG 112 is within the normal range of charge variations.

Clinical homogeneity within DRGs has always been a fundamental principle considered when assigning codes to appropriate DRGs. Currently, DRG 116 includes cases involving the insertion of a pacemaker as well as the insertion of coronary artery stents with PTCA. On the other hand, cases assigned to DRG 112 involve less invasive operating room and, in some cases, nonoperating room procedures.

The basis for DRG assignment has generally been the diagnosis of the patient or the procedures performed. To the extent the use of a particular technology becomes prevalent in the treatment of a particular type of case, the DRG system is designed to account for any increases or decreases in costs through recalibration. Hospitals frequently benefit from this process while efficiency-enhancing technology is being introduced. We believe that the update factors established in section 1886(b)(3)(B)(i) of the Act, combined with the potential for continuing improvements in hospital productivity, and annual recalibration of the DRG weights, are adequate to finance appropriate care of Medicare patients.

We also discussed in the proposed rule our analysis of cases where platelet inhibitor therapy is targeted on acute coronary syndrome patients without coronary intervention. These cases are assigned to DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction with Cardiac Catheterization and Complex Diagnosis) or DRG 140 (Angina Pectoris). The concern is that both types of cases, those performed in conjunction with coronary intervention and those without, be given an equal focus in this evaluation.

Based on our analysis, we found 410 platelet inhibitor cases (1 percent) assigned to DRG 124. This is a small percentage of cases in comparison to the overall total of 134,759 cases assigned to this DRG. The platelet inhibitor cases had an average standardized charge of approximately $17,378 compared to approximately $14,730 for DRG 124 overall. As we have indicated, there is always some variation in charges within a DRG and this difference is within normal variation.

There were 66 platelet inhibitor cases (0.2 percent) assigned to DRG 140. The average standardized charge for these cases is higher than the overall DRG charge, approximately $8,992 and $5,657, respectively. However, it represents a small percentage of the total (76,913) cases assigned to DRG 140.

In summary, currently 75 percent of cases where code 99.20 is present are assigned to DRG 116. The next most common DRG where these cases are assigned is DRG 112 (12 percent). Cases assigned to DRG 116 generally involve implantation of a pacemaker or artery stent, while cases assigned to DRG 112 involve percutaneous cardiovascular procedures. Our analysis found a $3,897 difference between cases involving platelet inhibitor therapy that were assigned to DRG 116 and cases assigned to DRG 112, indicating a clinical distinction between the cases grouping to the two DRGs. Finally, among platelet

[2] Topol EJ and Serruys PW. ''Frontiers in Interventional Cardiology.'' Circulation.1998; 98: 1802. and Frishman W *et al.* ''Medical therapies for the Prevention of Restenosis after Percutaneous Coronary Interventions.'' Curr Probl Cardology. 1998; 23: 555.

inhibitor therapy cases that are assigned to DRG 112, our analysis found that the average charges are well within the normal variation around the overall average charges within the DRG. Based on these findings, we believe it would be inappropriate to assign all cases where procedure code 99.20 is present to DRG 116. Therefore, we did not propose to change our current policy that specifies that assignment of cases to this code does not affect the DRG assignment.

Comment: We received two comments on this issue. One commenter from a national hospital association supported not assigning code 99.20 to DRG 116. The other commenter argued that the analysis on which our position was based is flawed. This commenter believed that perhaps as many as five times the 37,222 cases we identified with ICD–9–CM procedure code 99.20 actually exist in the data but the procedure was not coded. To remedy this, the commenter suggested two options HCFA could pursue. The first option would be to reexamine the data file with the goal of excluding cases that appear to be miscoded. The commenter suggested that HCFA might check total pharmacy charges in MedPAR and exclude from the analysis cases without ICD–9–CM procedure code 99.20 that have pharmacy charges over a certain threshold (for example, a threshold of $500). The second option would be to use outside data to capture pharmacy information which would provide more reliable information than coding with procedure code 99.20.

The commenter recommended that HCFA make a concerted effort, perhaps through the Medicare fiscal intermediaries, to instruct hospitals to use ICD–9–CM procedure code 99.20 on the claim of any case that receives any of the three platelet inhibitors.

Response: We appreciate the support of the hospital association for our position on this issue.

In response to the comment that the MedPAR data underreport procedure code 99.20 because the data do not affect DRG assignment and payment, we believe it is in hospitals' best interest to submit accurate billing data that are utilized in the DRG reclassification and recalibration of the DRG relative weights process.

We disagree with the recommendation that we exclude from our analysis any bill with over $500 in pharmacy charges that does not report procedure code 99.20. We question the analytical validity of this approach, particularly given that many Medicare beneficiaries have multiple chronic conditions requiring multiple medications. It is simply not possible to determine coding accuracy by reviewing charge data submitted on bills. The only way to identify coding errors would be to review the actual medical records. To exclude cases with pharmacy charges exceeding a certain predetermined threshold would likely skew the results of any such analysis.

We remain open to considering and using non-MedPAR data to make DRG changes if the data are reliable and validated. In the July 31, 1999 final rule (64 FR 41499), we described the timetable and process for interested parties to submit non-MedPAR data.

With respect to the recommendation that we make a concerted effort to ensure that hospitals use procedure code 99.20 appropriately, from the inception of this procedure code, effective October 1, 1998, HCFA has collaborated with the American Hospital Association (AHA) to educate coders on platelet inhibitor therapy. An extensive article in AHA's publication, *Coding Clinic for ICD–9–CM*, Fourth Quarter 1998, identifies the platelet inhibitor drugs and includes instructions on the appropriate code assignment. Coding instructions for platelet inhibitors are also available via the 1998 regulatory updates teleconference sponsored by AHA.

d. Extracorporeal Membrane Oxygenation. Extracorporeal Membrane Oxygenation (ECMO) is a cardiopulmonary bypass technique that offers long-term cardiopulmonary support to patients who have reversible cardiopulmonary insufficiency that has not responded to conventional management. It involves passing a patient's blood through an extracorporeal membrane oxygenator that adds oxygen and removes carbon dioxide. The oxygenated blood then is passed through a heat exchanger to warm it to body temperature prior to returning it to the patient. The process and equipment are similar to those used in open heart surgery, but are continued over prolonged periods of time. ECMO attempts to provide the patient with artificial cardiopulmonary function while his or her own cardiopulmonary functions are incapable of sustaining life.

Since ECMO involves the use of a device that sustains cardiopulmonary function while the underlying condition is being treated, it is important to identify and treat underlying conditions leading to cardiopulmonary failure if the patient is to return to normal cardiopulmonary function.

ECMO is assigned to procedure code 39.65 (Extracorporeal membrane oxygenation (ECMO)). This code is not recognized as an OR procedure within the DRG system and, therefore, does not affect payment. To evaluate the appropriateness of payment under the current DRG assignment, we have reviewed a 10-percent sample of Medicare claims in the FY 1999 MedPAR file and found only 4 cases in which ECMO was used. The charges for these cases ranged from $16,006 to $198,014. Since medical literature indicates that ECMO is predominately used on newborns and pediatric cases, this low number of claims is not surprising. Only in recent years have some hospitals started to use ECMO on adults. It is reserved for cases facing almost certain mortality.

Because ECMO is a procedure clinically similar to a heart assist device, we proposed that procedure code 39.65 be classified as an OR procedure and be classified in DRGs 104 and 105 along with the heart assist system procedures (as discussed in section II.B.2.b. of this preamble). Those cases in which ECMO was provided, but for which the principal diagnosis is not classified to MDC 5, would then be assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This would be appropriate since it is possible that secondary conditions or complications may arise during hospitalization that would require the use of ECMO. The relatively high weight of DRG 468 would be appropriate for these cases.

Comment: We received two comments in support of the proposal to classify procedure code 39.65 as an OR procedure and then assign it to DRGs 104 and 105. One of the commenters stated that most of the adult patients receiving ECMO will fall within MDC 5 since ECMO is used for patients with severe, but reversible, heart or lung disorders that have not responded to the usual treatments of mechanical ventilation, medicines, and extra oxygen. The commenter further stated that these severely ill patients may continue on ECMO for a period of days or weeks until the heart or lungs recover, or until the treatment is no longer effective.

Response: We acknowledge the support of the commenters to classify 39.65 as an OR procedure and then assign it to DRGs 104 and 105 and are adopting our proposal as final.

3. MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period)

a. V05.8 (Vaccination for disease, NEC). DRG 390 (Neonate with Other Significant Problems) contains newborn or neonate cases with other significant

problems, not assigned to DRGs 385 through 389, DRG 391, or DRG 469. In order to be classified into DRG 391 (Normal Newborn), the neonate must have a principal diagnosis as listed under DRG 391 and either no secondary diagnosis or a secondary diagnosis as listed under DRG 391. Neonates with a secondary diagnosis of V05.8 (Vaccination for disease, NEC) are currently classified to DRG 390. Although it would seem that healthy newborns who receive vaccinations and have no other problems would be assigned to DRG 391, code V05.8 is not included as one of the secondary diagnoses under DRG 391, and therefore the case would not be classified as a normal newborn (DRG 391). Code V05.8 is assigned to DRG 390 as a default, since it is not included under another complicated neonate DRG or the normal newborn DRG.

In the proposed rule, we discussed our review of the appropriateness of including diagnosis code V05.8 on the list of acceptable secondary diagnoses under DRG 390 based on inquires that we had received. We pointed out that by including V05.8 on the acceptable secondary diagnosis list for DRG 390, newborns who receive vaccinations are classified as having significant health problems. The inquirers believed this incorrectly labels an otherwise healthy newborn as having a significant medical condition. Providing a vaccination to a newborn is performed to prevent the infant from contracting a disease.

We agreed with the inquirers that, absent any evidence of disease, a newborn should not be considered as having a significant problem simply because a preventative vaccination was provided. Therefore, we proposed that V05.8 be removed from the list of acceptable secondary diagnoses under DRG 390 and assigned as a secondary diagnosis under DRG 391. In doing so, these cases would no longer be classified to DRG 390.

Comment: We received two comments in support of our proposal to remove code V05.8 from the list of acceptable secondary diagnoses under DRG 390. These commenters agreed that a prophylactic vaccination should not be classified as a significant problem. Newborns who receive these prophylactic vaccinations should still be considered normal newborns. We received no comments in opposition to the proposal.

Response: We are adopting the proposal to include V05.8 on the list of acceptable secondary diagnoses under DRG 391 Normal Newborn. Codes V05.3 (Viral hepatitis vaccination) and V05.4 (Varicella vaccination) are already listed as acceptable secondary diagnoses under DRG 391.

b. Diagnosis code 666.02 (Third-stage postpartum hemorrhage, delivered with postpartum complication). Diagnosis code 666.02 is assigned to DRG 373 (Vaginal Delivery without Complicating Diagnoses). This DRG was created for uncomplicated vaginal deliveries. However, code 666.22 (Delayed and secondary postpartum hemorrhage, delivered with postpartum complication) is assigned to DRG 372 (Vaginal Delivery with Complicating Diagnoses). This means that mothers who have a delayed and secondary postpartum hemorrhage would be assigned to DRG 372, while mothers who have a third-stage postpartum hemorrhage would not be considered as a complicated delivery.

We believe a third-stage postpartum hemorrhage should be considered a complicating diagnosis and, in order to categorize these cases more appropriately, we proposed to move diagnosis code 666.02 from DRG 373 and assign it as a complicating diagnosis under DRG 372.

Comment: We received two comments supporting the proposal to classify 666.02 as a complicating diagnosis under DRG 372. The commenters agreed that a third-stage postpartum hemorrhage should be classified as a complicated delivery. There were no comments submitted in opposition to this change.

Response: We are adopting as final our proposal to classify 666.02 as a complication diagnosis under DRG 372.

c. Diagnosis Code 759.89 (Specified congenital anomalies, NEC) (Alport's Syndrome). Alport's Syndrome (also referred to as hereditary nephritis) is an inherited disorder involving damage to the kidney, blood in the urine, and, in some cases, loss of hearing. It may also include loss of vision. Patients who are not treated early enough or who do not respond to treatment may progress to renal failure. A kidney transplant is one treatment option for these cases. As with many of the congenital anomalies, there is no unique ICD–9–CM code for this condition. Alport's Syndrome, along with many other rare and diverse congenital anomalies, is assigned to the rather nonspecific diagnosis code 759.89 (Specific congenital anomalies, NEC). Examples include William Syndrome, Brachio-Oto-Renal Syndrome, and Costello's Syndrome. Each of these is a unique hereditary disorder affecting a variety of body systems.

Patients can be diagnosed and treated for congenital anomalies throughout their lives; treatment is not restricted to the neonatal period. In our GROUPER, however, each diagnosis code is assigned to just one MDC. In this case, diagnosis code 759.89 is assigned to MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) although the patient may be an adult.

In the proposed rule, we referred to a request from a physician concerning renal transplants for patients with Alport's Syndrome. The physician pointed out that when a patient with Alport's Syndrome is admitted for a kidney transplant, the case is assigned to DRG 390 (Neonate with Other Significant Problems). In these instances, when the principal diagnosis is code 759.89, the case is classified to MDC 15 although the patient may no longer be a newborn. The physician believed that these cases should be assigned to DRG 302 (Kidney Transplant).

The inquirer suggested moving diagnosis code 759.89 to MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract) so that when a kidney transplant is performed, it will be assigned to DRG 302. Although this seems quite appropriate for patients with Alport's Syndrome found in diagnosis code 759.89, it does not work well for the wide variety of patients also described by this code. Many others would be inappropriately classified to MDC 11.

Alport's Syndrome cases with code 759.89 as a principal diagnosis who receive a kidney transplant are assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This DRG has a FY 2000 relative weight of 3.6400. Also for FY 2000, DRG 302 (Kidney Transplant) has a relative weight of 3.5669. Therefore, the payment amounts are in fact comparable.

We discussed several options for resolving this issue:

(1) If the case is assigned a principal diagnosis code of renal failure with Alport's Syndrome as a secondary diagnosis, the case could be assigned to DRG 302. As this option would represent a change in the sequencing of congenital anomaly codes and related complications, it would have to be evaluated and subsequently approved by the Editorial Advisory Board for *Coding Clinic for ICD–9–CM.* The Editorial Advisory Board is comprised of representatives from the physician, coding, and hospital industry. Final decisions on coding policy issues are made by the representatives from the AHA, the American Health Information Management Association, the National Center for Health Statistics, and HCFA.

(2) A unique ICD–9–CM diagnosis code could be created for Alport's Syndrome that could then be evaluated for possible assignment within MDC 11. This issue has been referred to the National Center for Health Statistics for consideration as a future coding modification.

One difficulty with this option is the large number of congenital anomalies and the limited number of unused codes in this section of ICD–9–CM. Each new code must be carefully evaluated for appropriateness.

(3) A third option, which was already addressed, involves moving diagnosis code 759.89 to MDC 11. The problem with this approach is that many cases would then be misassigned to MDC 11 because the congenital anomaly would not involve diseases of the kidney and urinary tract.

(4) A fourth option would be to leave the coding and DRG assignment as they currently exist. Since few cases exist, the overall impact may be minimal.

To evaluate the impact of leaving the DRG assignment as it currently exists, in the proposed rule we examined data from a 10-percent sample of Medicare cases in the FY 1999 MedPAR file. There were 95 cases assigned to a wide range of DRGs with code 759.89 as a secondary diagnosis. There was only one case assigned to MDC 15 with a principal diagnosis of code 759.89.

In the proposed rule, we recommended that diagnosis code 759.89 remain in MDC 15, since it encompasses such a wide variety of conditions.

Comment: We received two comments in support of modifying the coding advice for this particular congenital anomaly so that renal failure is reported as the principal diagnosis and Alport's Syndrome is reported as a secondary diagnosis. One commenter pointed out that a distinction exists between those manifestations that are integral to the congenital anomaly (and thus, according to the official coding guidelines, would not be coded at all) and those that are not considered integral. This commenter also supported the recommendation for a change in guidelines that would allow sequencing a manifestation that is not integral to the congenital anomaly as the principal diagnosis. The other commenter indicated that while renal disease is usually present in Alport's Syndrome, it does not always lead to renal failure. The commenter also supported the reporting of renal failure as the principal diagnosis, with Alport's Syndrome as a secondary diagnosis.

Response: The coding and sequencing of Alport's Syndrome patients with renal failure who are admitted for renal transplant were addressed at the June 2000 meeting of the Editorial Advisory Board of Coding Clinic for ICD–9–CM. *Coding Clinic for ICD–9–CM* is a publication of the AHA. The issue specifically addressed was whether the code used for Alport's Syndrome or the code for renal failure should be sequenced first when the patient is admitted for a renal transplant for the renal failure. In cases where manifestations are a key aspect of the congenital anomaly, the congenital anomaly code is usually sequenced first.

After careful evaluation, the Board determined that, in this specific case, the code for renal failure would be sequenced first, followed by the code for Alport's Syndrome. The Board also determined that renal failure is not always present for patients with Alport's Syndrome. These patients may, in fact, develop renal failure as a result of other factors. Therefore, hospitals do not have to sequence the congenital anomaly code first. By reporting renal failure as the principal diagnosis, the case is appropriately assigned to DRG 302. The Board's advice will be published in the third quarter 2000 issue of *Coding Clinic for ICD–9–CM* and will be effective for discharges occurring on or after September 1, 2000.

4. MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasm)

Diagnosis code 273.8 (Disorders of plasma protein metabolism, NEC) is assigned to DRG 403 (Lymphoma and Nonacute Leukemia with CC) and DRG 404 (Lymphoma and Nonacute Leukemia without CC). A disorder of plasma protein metabolism does not mean one has a lymphoma with nonacute leukemia. An individual can have a disorder of plasma protein metabolism without having a lymphoma or leukemia.

In the proposed rule, we considered the appropriateness of including diagnosis code 273.8 in DRGs 403 and 404. Disorders of plasma protein metabolism are not lymphomas or leukemia, thus diagnosis code 273.8 is more closely related to DRG 413 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses with CC) and DRG 414 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses without CC).

We also examined charge data drawn from cases assigned to diagnosis code 273.8 in a 10-percent sample of Medicare cases in the FY 1999 MedPAR file and found that the average charges for these cases were also more closely related to DRGs 413 and 414 than to DRGs 403 and 404. We proposed to move diagnosis code 273.8 from DRGs 403 and 404 to DRGs 413 and 414.

We also noted that diagnosis code 273.8 is included in the following surgical DRGs that are performed on patients with lymphoma or leukemia:

- DRG 400 (Lymphoma and Leukemia with Major OR Procedure)
- DRG 401 (Lymphoma and Nonacute Leukemia with Other OR Procedure with CC)
- DRG 402 (Lymphoma and Nonacute Leukemia with Other OR Procedure without CC)

The same clinical issue would apply to these surgical DRGS performed on patients with lymphoma and leukemia. Code 273.8 should be assigned to the surgical DRGs for myeloproliferative disorders since the cases are clinically similar and, as stated before, code 273.8 is not clinically similar to lymphomas and leukemias. Therefore, we proposed to remove code 273.8 from the surgical DRGs related to lymphoma and leukemia (DRGS 400, 401, and 402) and assigned to the following myeloproliferative surgical DRGS, based on the procedure performed:

- DRG 406 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major OR Procedures with CC)
- DRG 407 (Myeloproliferative Disorders Or Poorly Differentiated Neoplasms with Major OR Procedures without CC)
- DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other OR Procedures)

Comment: We received two comments supporting our proposal to remove code 273.8 from the DRGs for lymphomas and leukemia (medical DRGs 403 and 404 as well as surgical DRGs 400 through 402). They supported moving 273.8 to the DRGs for other myeloproliferative disorders (medical DRGs 413 and 414 as well as surgical DRGs 406 through 408). One commenter also pointed out that code 273.9 (Unspecified disorder of plasma protein metabolism) is clinically similar to 273.8 and is also included with the DRGs for lymphomas and leukemia. The commenter asked if HCFA also planned to move 273.9 in a similar fashion to that proposed for code 273.8 since they appear to be companion codes. The commenter asserted that it was inappropriate to keep 273.9 in the DRGS for lymphoma and leukemia.

Response: We agree that code 273.8 should be moved out of the DRGs for lymphoma and leukemia and into the DRGs for other myeloproliferative disorders. Also, we agree with the commenter who stated that code 273.9

is clinically similar to 273.8 and should be treated in the same manner. Each code would be more appropriately assigned to the DRGS for other myeloproliferative disorders. Therefore, we are removing 273.9 from medical DRGS 403 and 404 and assigning it to DRGS 413 and 414. We are adopting as final our proposal to remove 273.8 from medical DRGs 403 and 404 and assign it to medical DRGs 413 and 414. We are also removing 273.8 and 273.9 from surgical DRGs 400, 401, and 402 and assigning them to surgical DRGs 406, 407, and 408.

5. 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. Therefore, it is 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 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). 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 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. Assume also 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 were unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights because the revised GROUPER software was unavailable at the time the proposed rule was completed. Rather, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification, then determined the average charge for each DRG. These average charges then served as our best estimate of relative resource use for each surgical class.

We proposed to revise the surgical hierarchy for the pre-MDC DRGs, MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), and MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders) as follows:

- In the pre-MDC DRGs, we proposed to move DRG 103 (Heart Transplant) from MDC 5 to pre-MDC. We proposed to reorder DRG 103 (Heart Transplant) above DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses).
- In the pre-MDC DRGs, we proposed to reorder DRG 481 (Bone Marrow Transplant) above DRG 495 (Lung Transplant).
- In MDC 8, we proposed to reorder DRG 230 (Local Excision and Removal of Internal Fixation Devices of Hip and Femur) above DRGs 226 and 227 (Soft Tissue Procedures).
- In MDC 10, we proposed to reorder DRG 288 (OR Procedures for Obesity) above DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders).

Comment: One commenter supported the surgical hierarchy proposals. Another commenter opposed the reordering of DRG 230 above DRGs 226 and 227 in MDC 8. The commenter stated that, if both procedures are performed during the same operative episode, reordering DRGs 226 and 227 above DRG 230 would more appropriately capture facility resources.

Response: Although local excision and removal of internal fixation devices of hip and femur procedures may be less resource intensive than many of the surgical procedures in DRGs 226 and 227, we proposed the surgical hierarchy change because our data indicated cases of local excision and removal of internal fixation devices of hip and femur are more resource intensive than cases in DRGs 226 and 227. At the time of our proposed surgical hierarchy change, the average standardized charges for cases in DRG 230 were approximately $1,000 more than the average standardized charges for cases in DRGs 226 and 227. We are adopting the proposed surgical hierarchy change as final so that cases with multiple procedures will be assigned to the higher-weighted DRG. We will continue to monitor the MDC 8 surgical hierarchy as part of our ongoing review.

Based on a test of the proposed revisions using the most recent MedPAR file and the final GROUPER software, we have found that all the proposed

revisions are still supported by the data and no additional changes are indicated. Therefore, we are adopting these changes in this final rule.

6. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, 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 for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative coding or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this standard list of diagnoses 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 May 5, 2000 proposed rule, we proposed no deletions of the diagnosis codes on the CC list.

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, 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 coexist, 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 only as 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 (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; and the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions. In the July 30, 1999 final rule (64 FR 41490), no modifications were made to the CC Exclusions List for FY 2000 because we made no changes to the ICD–9–CM codes for FY 2000.

In this final rule, we are making limited revisions 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, 2000. (See section II.B.8. below, for a discussion of ICD–9-CM changes.) These changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6F and 6G in section V. of the Addendum to this final rule contain the revised CC Exclusions List that is effective for discharges occurring on or after October 1, 2000. Each table shows the principal diagnoses along with 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 were added to the list appear in Table 6F—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that were deleted from the list are in Table 6G—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2000, 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, 1997, 1998, 1999, and those in Tables 6F and 6G of this document) must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2000. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

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 17.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 18.0 of this manual, which includes the final FY 2001 DRG changes, will be available in October 2000 for $225.00. 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.

We received no comments on the CC Exclusions List in the proposed rule.

7. 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) 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
60.94 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 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962), or in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496).

a. Moving Procedure Codes from DRGs 468 or 477 to MDCs. We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to determine the appropriateness of moving procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC. That is, using procedure code 57.49 (Other transurethral excision or destruction of lesion or tissue of bladder) as an example, we determined that this particular code accounted for the highest number of major operative procedures (162 cases, or 9.8 percent of all cases) reported in the sample of DRG 477. In addition, we determined that procedure code 57.49 appeared in MDC 4 (Diseases and Disorders of the Respiratory System) 28 times as well as in 9 other MDCs.

Using a 10-percent sample of the FY 1999 MedPAR file, we determined that the quantity of cases in DRG 477 totaled 1,650. There were 106 instances where the major operative procedure appeared only once (6.4 percent of the time), resulting in assignment to DRG 477.

Using the same 10-percent sample of the FY 1999 MedPAR file, we reviewed DRG 468. There were a total of 3,858 cases, with one major operative code causing the DRG assignment 311 times (or 8 percent) and 230 instances where the major operative procedure appeared only once (or 6 percent of the time).

Our medical consultants then identified 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 did not identify any necessary changes in procedures under either DRG 468 or 477 and, therefore, did not propose to move any procedures from either DRG 468 or DRG 477 to one of the surgical DRGs. We received no comments on our review results and, therefore, we will not move any procedures from these DRGs for FY 2001.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. We also conduct an annual review of a list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be moved from one of these DRGs to another of these DRGs based on average charges and length of stay. We analyze the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment inappropriate. If our medical consultants were to find these shifts, we would propose moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on this year's review, we proposed not to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476. We received no comments on this proposal, and therefore are not moving any procedures from the DRGs indicated.

c. Adding Diagnosis Codes to MDCs. It has been brought to our attention that an ICD–9–CM diagnosis code should be added to DRG 482 (Tracheostomy for Face, Mouth and Neck Diagnoses) to preserve clinical coherence and homogeneity of the system. In the case of a patient who has a facial infection (diagnosis code 682.0 (Other cellulitis and abscess, Face)), the face may become extremely swollen and the patient's ability to breathe might be impaired. It might be deemed medically necessary to perform a temporary tracheostomy (procedure code 31.1) on the patient until the swelling subsides enough for the patient to once again breathe on his or her own.

The combination of diagnosis code 682.0 and procedure code 31.1 resulted in assignment to DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses). The absence of diagnosis code 682.0 in DRG 483 forces the GROUPER algorithm to assign the case based solely on the procedure code, without taking this diagnosis into account. Clearly this was not the intent, as diagnosis code 682.0 should be included with other face, mouth and neck diagnosis. We believe that cases such as these would appropriately be assigned to DRG 482. Therefore, we proposed to add diagnosis code 682.0 to the list of other face, mouth and neck diagnoses already in the principal diagnosis list in DRG 482.

We received one comment in support of the proposed change, and are adopting as final the proposal to add diagnosis code 682.0 to DRG 482.

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

As described 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, co-chaired by the National Center for

Health Statistics (NCHS) and HCFA, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for 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 NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while HCFA has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

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 field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the 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 for FY 2000 at public meetings held on June 4, 1998 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we did not implement any changes to ICD–9–CM codes for FY 2000 because of our major efforts to ensure that all of the Medicare computer systems were compliant with the year 2000. Therefore, the code proposals presented at the public meetings held on June 4, 1998 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, were held for consideration for inclusion in the annual update for FY 2001.

The Committee also presented proposals for coding changes for implementation in FY 2001 at public meetings held on May 13, 1999 and November 12, 1999, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 7, 2000.

Copies of the Coordination and Maintenance Committee minutes of the 1999 meetings can be obtained from the HCFA Home Page by typing http://www.hcfa.gov/medicare/icd9cm.htm. Paper copies of these minutes are no longer available and the mailing list has been discontinued.

The ICD–9–CM code changes that have been approved will become effective October 1, 2000. 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 VI. of the Addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the May 5, 2000 proposed rule, we solicited comments only on the proposed DRG classification of these new codes.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or 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, 2000. For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A (New Diagnosis Codes). No procedure codes were replaced by expanded codes or other codes, and no procedure codes were deleted. Revisions to diagnosis code titles appear in Table 6D (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Revisions to procedure code titles appear in Table 6E (Revised Procedure Codes Titles).

Comment: One commenter questioned the DRG assignments in Table 6A for new ICD–9–CM codes V45.74, V45.76, V45.77, V45.78 and V45.79. The commenter pointed out that it has been HCFA's longstanding practice to assign a new code to the same DRG or DRGs as its predecessor code. The commenter had seen a draft conversion table prepared by the NCHS for codes being revised October 1, 2000, and indicated that the conversion table did not support the DRG assignments for these specific codes.

Response: The commenter is correct. HCFA bases DRG assignments on the DRG assignment of the predecessor code. Tables 6A through 6E in the proposed rule were prepared prior to NCHS' completion of the conversion table. The DRG assignments were based on a mapping of codes V45.74, V45.76, V45.77, and V45.78 from code V45.89. However, the correct mapping on the conversion table now shows the following predecessor codes:

New Code	Previous Code	Previous DRG
V45.74	593.89	331, 332, 333
	596.8	331, 332, 333
V45.76	518.89	101, 102
V45.77	602.8	352
	607.89	352
	608.89	352
	620.8	358, 359, 369
	621.8	358, 359, 369
	622.8	358, 359, 369
V45.78	360.89	46, 47, 48
V45.79	255.8	300, 301
	289.59	398, 399
	388.8	73, 74
	569.49	188, 189, 190
	577.8	204

New Code	Previous Code	Previous DRG
	V45.89	467

We have modified the DRG assignments for V45.74, V45.76, V45.77, and V45.78 in Table 6A of this final rule according to the mapping indicated in the third column in the preceding table. However, V45.79 has a number of predecessor codes appearing in multiple MDCs and, thus, would not relate to any specific MDC. After discussions with NCHS, we determined that this code should continue to use V45.89 as its predecessor code for purposes of DRG assignment, since it is not restricted to a specific body system. Therefore, the DRG assignment for V45.79 was not changed in Table 6A.

9. Other Issues

a. *Immunotherapy.* Effective October 1, 1994, procedure code 99.28 (Injection or infusion of biologic response modifier (BRM) as an antineoplastic agent) was created and designated as a non-OR procedure that does not affect DRG assignment. This cancer treatment involving biological response modifiers is also known as BRM therapy or immunotherapy.

In response to a comment on the May 7, 1999 proposed rule, for the FY 2000 final rule we analyzed cases for which procedure code 99.28 was reported using the 100 percent FY 1998 MedPAR file. The commenter requested that we create a new DRG for BRM therapy or assign cases in which BRM therapy is performed to an existing DRG with a high relative weight. The commenter suggested that DRG 403 (Lymphoma and Nonacute Leukemia with CC) would be an appropriate DRG.

For the proposed rule, we analyzed all cases for which procedure code 99.28 was reported. We identified 1,179 cases in 136 DRGs in 22 MDCs. No more than 141 cases were assigned to any one particular DRG.

Of the 1,179 cases, 141 cases (approximately 12 percent) were assigned to DRG 403 in MDC 17. We found approximately one-half of these cases had other procedures performed in addition to receiving immunotherapy, such as chemotherapy, bone marrow biopsy, insertion of totally implantable vascular access device, thoracentesis, or percutaneous abdominal drainage, which may account for the increased charges. There were 123 immunotherapy cases assigned to DRG 82 (Respiratory Neoplasms) in MDC 4 (Diseases and Disorders of the Respiratory System). We noted that, in some cases, in addition to immunotherapy, other procedures were performed, such as insertion of an intercostal catheter for drainage, thoracentesis, or chemotherapy.

There were 84 cases assigned to DRG 416 (Septicemia, Age >17) in MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)). The principal diagnosis for this DRG is septicemia and, in addition to receiving treatment for septicemia, immunotherapy was also given. There were 79 cases assigned to DRG 410 (Chemotherapy without Acute Leukemia as Secondary Diagnosis) in MDC 17.

The cost of immunotherapy is averaged into the weight for these DRGS and, based on our analysis, we did not believe a reclassification of these cases was warranted. Due to the limited number of cases that were distributed throughout 136 DRGs in 22 MDCs and the variation of charges, we concluded that it would be inappropriate to classify these cases into a single DRG.

Although there were 141 cases assigned to DRG 403, it would be inappropriate to place all immunotherapy cases, regardless of diagnosis, into a DRG that is designated for lymphoma and nonacute leukemia. We establish DRGs based on clinical coherence and resource utilization. Each DRG encompasses a variety of cases, reflecting a range of services and a range of resources. Generally, then, each DRG reflects some higher cost cases and some lower cost cases. To the extent a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, that is, additional payments over and above the standard prospective payment rate.

We did not receive any comments regarding payment for immunotherapy cases.

b. Pancreas Transplant. Effective July 1, 1999, Medicare covers whole organ pancreas transplantation if the transplantation is performed simultaneously with or after a kidney transplant (procedure codes 55.69, Other kidney transplantation, and V42.0, Organ or tissue replaced by transplant, Kidney) (Transmittal No. 115, April 1999). We noted that when we published the notification of this coverage in the July 30, 1999 final rule (64 FR 41497), we inadvertently made an error in announcing the covered codes. We cited the incorrect codes for pancreas transplantation as procedure code 52.80 (Pancreatic transplant, not otherwise specified) and 52.83 (Heterotransplant of pancreas). The correct procedure codes for pancreas transplantation are 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas). The Coverage Issues Manual was revised to reflect this change via Transmittal 124, April 2000, effective October 1, 2000.

Pancreas transplantation is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Pancreas transplantation for diabetic patients who have not experienced end-stage renal failure secondary to diabetes is excluded from coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells.

In the July 30, 1999 final rule (64 FR 41497), we indicated that we planned to review discharge data to determine whether a new DRG should be created, or existing DRGs modified, to further classify pancreas transplantation in combination with kidney transplantation.

Under the current DRG classification, if a kidney transplant and a pancreas transplant are performed simultaneously on a patient with chronic renal failure secondary to diabetes with renal manifestations (diagnosis codes 250.40 through 250.43), the case is assigned to DRG 302 (Kidney Transplant) in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). If a pancreas transplant is performed following a kidney transplant (that is, during a different hospital admission) on a patient with chronic renal failure secondary to diabetes with renal manifestations, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This is because pancreas transplant is not assigned to MDC 11, the MDC to which a principal diagnosis of chronic renal failure secondary to diabetes is assigned.

For the proposed rule, using 100 percent of the data in the FY 1999 MedPAR file (which contains hospital bills received for FY 1999 through

December 31, 1999), we analyzed the cases for which procedure codes 52.80 and 52.83 were reported. We identified a total of 79 cases in 8 DRGs, in 3 MDCs, and in 1 pre-MDC. Of the 79 cases identified, 49 cases were assigned to DRG 302, 14 cases were assigned to DRG 468, and 8 cases were assigned to DRG 191 (Pancreas, Liver and Shunt Procedures with CC). The additional 8 cases were distributed over 5 other assorted DRGs, and due to their disparity, were not considered in our evaluation.

We examined our data to determine whether it was appropriate to propose a new kidney and pancreas transplant DRG. We identified 49 such dual transplant cases in the FY 1999 MedPAR file. We do not believe this to be a sufficient sample size to warrant the creation of a new DRG. Furthermore, we noted that nearly half of these cases occurred at a hospital in Maryland, which is not paid under the prospective payment system. The rest of the cases are spread across multiple hospitals, with no single hospital having more than 5 cases in the FY 1999 MedPAR.

We received 261 comments on this issue, 244 of which were form letters.

We will continue to monitor these dual transplant cases to determine whether it may be appropriate in the future to establish a new DRG. However, we are not establishing a new DRG for these cases for FY 2001 and the current procedure code classification will remain in effect.

Comment: All commenters called for the establishment of a unique DRG recognizing the combined transplant of kidney and pancreas in the same operative episode. Some commenters cited increased utilization of hospital resources, especially operating-room time, recovery time, and immunosuppressive drugs as justification for a separate DRG for a combined pancreas-kidney transplant. One commenter forwarded to us facility-specific charge data for four dual-transplant patients seen at that center through December 1997.

Response: We stated in the proposed rule that there does appear to be a difference between the charges for dual kidney-pancreas transplant patients assigned to DRG 302 (Kidney Transplant) and those patients who received only a kidney transplant. However, the numbers of dual transplant cases in our database were insufficient to warrant establishing a new DRG for dual transplants.

We point out that, given the low volume of these cases and their infrequent occurrence in any particular hospital, we believe our outlier policy will provide adequate protection for any extraordinarily costly cases. Furthermore, there is always variation in terms of the costs for cases within a DRG relative to the payments under the prospective payment system for that DRG. Although examining these cases in isolation from other DRG 302 cases appears to suggest that dual transplants are more expensive, the nature of the prospective payment system is such that hospitals are expected to be able to offset cases where costs are greater than payments with those cases where payments exceed costs.

We further point out that additional Medicare coverage of a transplanted organ does not necessarily and immediately result in creation of a unique DRG. A specific example of not creating a unique DRG is the combined heart-lung transplant procedure. Effective for discharges occurring on or after October 1, 1990, Medicare was able to identify combined heart-lung transplant using ICD–9–CM code 33.6 (Combined heart-lung transplantation). Instead of assigning this new code to its own specific DRG, however, it was combined with heart transplant in DRG 103 (Heart Transplant). When DRG 495 (Lung Transplant) was created for cases discharged on or after October 1, 1994, review of our data revealed that assignment of code 33.6 was more clinically coherent with DRG 103 than DRG 495. Therefore, code 33.6 was not moved into the new lung transplant DRG. Although this does not indicate we will not create a distinct DRG for combined kidney and pancreas transplants, it does show a precedent for allowing a sufficient sample of cases to accumulate before deciding whether a new DRG is necessary.

Finally, one of the risks of establishing a new DRG based on few documentable cases is that a few extremely low-cost cases could dramatically reduce the average charges in a year, thereby lowering the relative weight and potentially underpaying cases in this DRG by a significant amount.

Comment: Several commenters argued that combined pancreas and kidney transplants are underpaid every time they are performed and expressed concern that this lack of funding provides limited access to this procedure for Medicare beneficiaries.

Response: We do not believe that beneficiaries' access will be limited by our decision. In addition, 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.

Comment: One commenter argued that the incremental cost of the pancreas transplant was insufficient to cause the claim to move into outlier status.

Response: Our data show covered charges submitted by hospitals ranging from a low of approximately $42,000 to a high in excess of $182,000 for cases in DRG 302. Outlier payments are meant to alleviate the financial effects of treating extraordinarily high-cost cases. Therefore, the commenter may be correct in saying that some of the cases with lower charges might not be further compensated by outlier payments. However, other cases are further compensated to mitigate losses experienced by hospitals.

Comment: One commenter stated we underrepresented the volume of future dual transplants under Medicare, citing mid-year approval of Medicare coverage for pancreas transplants, and noting that this is not enough time to accurately reflect the numbers of procedures since patients normally must accrue longer wait times before they receive organ offers for transplant.

Response: It is true that we did not attempt to project the future volume of combined kidney and pancreas transplant procedures. We reported the number of actual hospital claims in our MedPAR data base, submitted through December 1999, when we published the proposed rule in the May 5, 2000 **Federal Register** (65 FR 26294). DRG categories and payment are always based on actual historical hospital charge data, not projected data. What must also be considered, however, is that dual transplants would only appear in statistics concerning DRG 302, while HCFA also covers pancreas transplants performed in separate operative episodes, subsequent to kidney transplantation. Those pancreatic transplants occurring after kidney transplant would appear in DRG 468, or potentially other DRGs as well, depending on the principal diagnosis.

Comment: Several commenters noted that the 1998 Annual Report of United Network for Organ Sharing (UNOS) indicated there were 966 simultaneous kidney-pancreas transplants, and questioned HCFA's reported 49 cases appearing in DRG 302 as being too low. One commenter, citing the inability of HCFA to be able to identify cases of dual kidney-pancreas transplants, pointed out the need for a specific DRG for this category of patients. Another commenter noted that data were lost because of the incorrect publication of ICD–9–CM code 52.83 (Heterotransplant

of pancreas) as being a covered procedure.

Response: Most patients who are experiencing end-stage renal disease should be eligible for Medicare benefits. We note, however, that none of the commenters submitted specific evidence contrary to our finding that, outside of a single hospital in Maryland, no individual hospital had more than five Medicare dual transplant cases during FY 1999.

Obviously one issue is the timing of the creation of the coverage benefit, which was conferred for cases discharged on or after July 1, 1999. Cases transplanted prior to that date should not have appeared in our data as covered procedures.

We recognize that 52.83 is an incorrect code, and have corrected this typographical error in the Medicare Coverage Issues Manual, as noted above. Interestingly, the original data reported in the proposed notice contained 79 cases of pancreas transplant, but there were only 7 instances in which code 52.83 was reported. We believe that hospital coders recognized the error in the original coverage instruction, and chose to submit the less specific code 52.80 instead.

Comment: Several commenters asserted that it was contradictory for us to argue that 49 cases is too few to establish a DRG but we indicated in the May 5, 2000 proposed rule that there were 40 DRGs with fewer than 10 cases per year.

Response: These low-volume DRGs are not new, but in most cases were created very early during or even prior to the implementation of the prospective payment system. Many of these DRGs are related to patient categories that are rare in the Medicare population, such as age less than 17 or labor and delivery during childbirth. The DRG relative-weights for these DRGs are adjusted based on the overall change in the DRG weights rather than through normal recalibration.

We do not believe our policy not to establish a new dual transplant DRG for combined kidney and pancreas transplants is contradicted by the existence of these low-volume DRGs. As the commenters indicated, the number of combined kidney and pancreas transplants is likely to increase in the next few years, and therefore it is important to ensure an accurate and stable DRG payment is established.

Comment: Several commenters offered to work closely with HCFA to identify cases and costs associated with this category of patients.

Response: We appreciate these offers and the cooperative spirit in which they were presented. Our ability to evaluate and implement potential DRG changes depends on the availability of validated, representative data. We remain open to using non-MedPAR data if the data are reliable and validated and enable us to appropriately measure relative resource use. We will continue to monitor this category of patients, and will address this issue in the FY 2002 proposed rule.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 2001 recalibration as we did for FY 2000 (July 30, 1999 final rule (64 FR 41498)). That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1999 MedPAR file. (For the FY 2000 recalibration, we used the FY 1998 MedPAR file.) The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from FY 1999 MedPAR data (discharges occurring between October 1, 1998 and September 30, 1999), based on bills received by HCFA through March 2000, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1999 MedPAR file includes data for approximately 11.0 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1999 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed in section II.B. of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and 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 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 are eliminated.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be 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 1999 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, lung, and pancreas 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); DRG 480 (Liver Transplant); DRG 495 (Lung Transplant); and DRG 468 (Pancreas)). 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 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 the same case threshold in recalibrating the DRG weights for FY 2001. Using the FY 1999 MedPAR data set, there were 40 DRGs containing fewer than 10 cases. We computed the weights for these 40 low-volume DRGs by adjusting the FY 2000 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 DRG classification changes, resulted in an average case weight that differs from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor (1.45507) 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.

We received no comments on DRG recalibration.

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 make a budget neutrality adjustment to assure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

III. Changes to the Hospital Wage Index

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). The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising 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. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

We note that, effective April 1, 1990, the term Metropolitan Area (MA) replaced the term MSA (which had been used since June 30, 1983) to describe the set of metropolitan areas consisting 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.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. 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. As discussed below in section III.F of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

B. FY 2001 Wage Index Update

The FY 2001 wage index values in section VI of the Addendum to this final rule (effective for hospital discharges occurring on or after October 1, 2000 and before October 1, 2001) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1997 (the FY 2000 wage index was based on FY 1996 wage data).

The FY 2001 wage index includes the following categories of data associated with costs paid under the hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 2000 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology for FY 2000, the wage index for FY 2001 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of 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 that State.

Comment: One commenter believed that the FY 2001 wage calculation does not allow for inflationary effects or existing contractual increases, and recommended that we consider using a more recent Medicare cost reporting year and allow for inflationary wage adjustments.

Response: Due to the time period allowed for: (1) hospitals to complete and submit their cost reports to their intermediaries, (2) intermediaries to review and submit the cost reports to HCFA, (3) intermediaries to perform a separate, detailed review of all wage data and submit the results to HCFA, and (4) HCFA to compile a complete set of all hospitals' wage data from a given Federal fiscal year, we do not have available more recent reliable data to calculate the wage index. As described in the proposed rule (65 FR 26299) and section III.E. of this final rule, we adjust the wage data to a common period that reflects the latest cost reporting period for the filing year. Because the wage index is a relative measure, comparing area average hourly wages to a national average hourly wage, we believe the wage index is minimally impacted by inflationary effects beyond those accounted for by adjusting the data to a common period.

C. FY 2001 Wage Index

Because the hospital wage index is used to adjust payments to hospitals under the prospective payment system, it should, to the extent possible, reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. In response to concerns within the hospital community related to the removal from the wage index calculation costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), which are paid by Medicare separately from the prospective

payment system, in 1998 the AHA convened a workgroup to develop a consensus recommendation on this issue. The workgroup recommended that costs related to GME and CRNAs be phased out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we specified in the July 30, 1999 final rule (64 FR 41505) that we would phase-out these costs from the calculation of the wage index over a 5-year period, beginning in FY 2000. In keeping with the decision to phase-out costs related to GME and CRNAs, the final FY 2001 wage index is based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs.

Comment: We received one comment in support of our continued transition of removing GME and CRNA costs from the wage index calculation. We also received a comment from a national association representing nurse anesthetists expressing concern that, as a result of disparities in cost reporting systems and vague fiscal intermediary instructions, CRNA costs that should be paid under Part B might still be reported in hospitals' FY 1997 cost reports. The commenter also stated that removing CRNA costs from the wage index eliminates a payment mechanism for the indirect patient care activities performed by CRNAs, resulting in a disincentive for hospitals to employ CRNAs. To avoid any disruption in the ''continuous operations of hospitals,'' the commenter recommended that, prior to implementing any changes to the wage index calculation, HCFA should refine the Part A cost data collection and cost reporting process and instruct the fiscal intermediaries to provide all hospitals with ''explicit instructions as to the appropriate reporting of CRNA costs.'' The commenter believed this refinement to the cost data will identify and exclude only the CRNA salary costs related to the rural hospital cost pass-through provisions and allow Part A reimbursement for indirect patient care which are not reimbursed under Medicare Part B. In keeping with the general policy to exclude costs that are not paid through the Medicare prospective payment system, the commenter also recommended that HCFA exclude salaries reported under Medicare Part A for anesthesia assistants.

Response: We note that the FY 2001 wage index is the second year of the transition to eliminating Part A CRNA costs from the wage index. As evidenced in the impact analysis in the May 5, 2000 proposed rule (65 FR 26415), eliminating these CRNA and GME costs has an insignificant impact, with no category of hospitals impacted by more than 0.1 percent. Therefore, we do not believe it is necessary to delay further removal of CRNA costs.

Payment for CRNA services is made under a fee schedule under Medicare Part B (Supplementary medical insurance), with the sole exception of payments to hospitals under the rural pass-through provision. Although a hospital contracting for CRNA services would include the costs on its cost report, the fiscal intermediary forwards the information to the carrier for payment under the fee schedule. As the commenter noted, this payment structure has been in place since January 1, 1989. We believe that intermediaries and carriers are generally well informed and experienced in the handling of these costs. However, we will consider whether further clarification of our instructions is necessary.

The commenter also stated that Medicare does not specifically exclude anesthesia assistants, who are also reimbursed under Part B, from the wage index. The cost report instructions for Worksheet A, Line 20, refer to nonphysician anesthetists, which include both CRNAs and anesthesia assistants. We will consider whether our Worksheet S–3 instructions need to be revised to explicitly instruct hospitals to remove the Part B costs associated with anesthesia assistants as well.

1. Teaching Physician Costs and Hours Survey

As discussed in the July 30, 1999 final rule, because the FY 1996 cost reporting data did not separate teaching physician costs from other physician Part A costs, we instructed our fiscal intermediaries to survey teaching hospitals to collect data on teaching physician costs and hours payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospitals' cost report.

The FY 1997 cost reports also do not separately report teaching physician costs. Therefore, we once again conducted a special survey to collect data on these costs. (For the FY 1998 cost reports, we have revised the Worksheet S–3, Part II so that hospitals can separately report teaching physician Part A costs. Therefore, after this year, it will no longer be necessary for us to conduct this special survey.)

The survey data collected as of mid-January 2000 were included in the preliminary public use data file made available on the Internet in February 2000 at HCFA's home page (http://www.hcfa.gov). At that time, we had received teaching physician data for 459 out of 770 teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II. Also, in some cases, fiscal intermediaries reported that teaching hospitals did not incur teaching physician costs. In early January 2000, we instructed fiscal intermediaries to review the survey data for consistency with the Supplemental Worksheet A–8–2 of the hospitals' cost reports. Supplemental Worksheet A–8–2 is used to apply the reasonable compensation equivalency limits to the costs of provider-based physicians, itemizing these costs by the corresponding line number on Worksheet A.

When we notified the hospitals, through our fiscal intermediaries, that they could review the survey data on the Internet, we also notified hospitals that requests for changes to the teaching survey data had to be submitted by March 6, 2000. We instructed fiscal intermediaries to review the requests for changes received from hospitals and submit necessary data revisions to HCFA by April 3, 2000. We removed from the wage data the physician Part A teaching costs and hours reported on the survey form for every hospital that completed the survey. These data had been verified by the fiscal intermediary before submission to HCFA.

For the FY 2000 wage index, the AHA workgroup recommended that, if reliable teaching physician data were not available for removing teaching costs from hospitals' total physician Part A costs, HCFA should remove 80 percent of the costs and hours reported by hospitals attributable to physicians' Part A services. In calculating the FY 2000 wage index, if we did not receive survey data for a teaching hospital, we removed 80 percent of the hospital's reported total physician Part A costs and hours from the calculation. In the May 5, 2000 proposed rule, for the FY 2001 wage index, we proposed a different approach. In some instances, fiscal intermediaries had verified that teaching hospitals do not have teaching physician costs; for these hospitals, it is not necessary to adjust the hospitals' physician Part A costs. We conferred with the fiscal intermediaries to distinguish teaching hospitals that did not have teaching physician costs from teaching hospitals that had not identified the portion of their physician Part A costs associated with teaching physicians (that is, hospitals that did not complete the teaching survey).

In calculating the final FY 2001 wage index, we removed 100 percent of the physician Part A costs and hours (reported on Worksheet S–3, Lines 4, 10, 12, and 18) in the FY 2001 wage index calculation for those hospitals where the fiscal intermediary verifies that the hospital has otherwise unidentified teaching physician costs included in physician Part A costs and hours. For those teaching hospitals whose fiscal intermediaries identified as having costs attributable to teaching physicians but reported no physician Part A costs on the Worksheet S–3, we removed 100 percent of Worksheet A, Line 23, Column 1. To determine the hours to be removed, the costs reported on Line 23 of the Worksheet A, Column 1 are divided by the national average hourly wage for teaching physicians of $59.17 based upon the survey.

We note that Line 23 of Worksheet A, Column 1, flows directly into hospitals' total salaries on Worksheet S–3, Part II. Line 23 contains GME costs not directly attributable to residents' salaries or fringe benefits. Therefore, these costs tend to be costs associated with teaching physicians. To the extent a hospital fails to separately identify the proportion of its Line 23, Worksheet A costs associated with teaching physicians, we believe it is reasonable to remove all of these costs under the presumption that they are all associated with teaching physicians.

Thus, as we proposed in the May 5 proposed rule, for the FY 2001 wage index, we are either using the data submitted on the teaching physician survey (837 hospitals), or, in the absence of such data, removing 100 percent of physician Part A costs reported on Worksheet S–3 (287 hospitals), or removing the amount reported on Line 23 of Worksheet A, Column 1 (18 hospitals).

We received one comment in support of removing 100 percent of physician Part A costs and hours from teaching hospitals where the fiscal intermediary verifies that the hospital has otherwise unidentifiable teaching costs included in physician Part A costs and hours.

2. Nurse Practitioner and Clinical Nurse Specialist Costs

The current wage index includes salaries and wage-related costs for nurse practitioners (NPs) and clinical nurse specialists (CNSs) who, similar to physician assistants and CRNAs (unless at hospitals under the rural pass-through exception for CRNAs), are paid under the physician fee schedule. Over the past year, we have received several inquiries from hospitals and fiscal intermediaries regarding NP costs and how they should be handled for purposes of the hospital wage index. Because Medicare generally pays for NP and CNS costs under Part B outside the hospital prospective payment system, removing NP and CNS Part B costs from the wage index calculation would be consistent with our general policy to exclude, to the extent possible, costs that are not paid through the hospital prospective payment system. Because NP and CNS costs are not separately reported on the Worksheet S–3 for FYs 1997, 1998, and 1999, the FY 2000 Worksheet S–3 and cost reporting instructions will be revised to allow for separate reporting of NP and CNS Part A and Part B costs. We plan to exclude the Part B costs beginning with the FY 2004 wage index. These services are pervasive in both rural and urban settings. As such, because the wage index is a relative measure, we believe there will be no significant overall impact resulting from the removal of Part B costs for NPs and CNSs.

We did not receive any public comments on our plan to exclude NP and CNS Part B costs from the wage index calculation, beginning with the FY 2004 wage index.

3. Severance and Bonus Pay Costs

On October 6, 1999, we issued a memorandum to hospitals and fiscal intermediaries regarding our policy on treatment of severance and bonus pay costs in developing the wage index, effective beginning with the FY 2001 wage index. (The hospital cost report instructions also will be amended to reflect our policy on these costs.) We stated that severance pay costs may be included on Worksheet S–3 as salaries on Part II, Line 1, only if the associated hours are included. If the hospital has no accounting of the hours, or if the costs are not based on hours, the severance pay costs may not be included in the wage index. On the other hand, bonus pay costs may be included in the cost report on Line 1 of Worksheet S–3 with no corresponding hours. Due to the inquiries we continue to receive from hospitals regarding the inclusion of severance pay costs on cost reports, in the May 5 proposed rule, we clarified our policy in this area.

Hospitals vary in their accounting of severance pay costs. Some hospitals base the amounts to be paid on hours, for example, 80 hours worth of pay. Others do not; for example, a 15-year employee may be offered a $25,000 buyout package. Some hospitals record associated hours; others do not. The Wage Index Workgroup has suggested that we not include any severance pay costs in the wage index calculation, that these costs are for terminated employees, and, therefore, they should be considered an administrative rather than a salary expense.

Severance pay costs can be substantial amounts, particularly in periods of downsizing. In the proposed rule, we state our view that, if severance pay costs are included with no associated hours, the wage index, which is a relative measure of wage costs across labor market areas, would be distorted.

We included severance pay costs in the proposed FY 2001 wage index as a salary cost to the extent that associated hours also were reported. However, we solicited public comments on this issue. We received two comments on this issue.

Comment: Two national hospital associations disagree with our policy clarification that severance pay costs may be included on Worksheet S–3, Part II, Line 1 as salaries only if associated hours are included. These commenters argued that HCFA's wage index policy is that wages and benefits are to be determined in accordance with generally accepted accounting principles (GAAP) rather than Medicare cost reimbursement principles and that under GAAP severance pay is classified as salaries and wages. They also argued that, unless a terminated employee continues to work or is still considered to be employed by the provider after the last regular pay period that additional hours should not be reported for severance pay. Further, for employees receiving severance pay, ''there are no hours to report'' because ''their job has been eliminated and they are no longer employed by the provider.''

Response: As indicated in the proposed rule, we exclude severance pay costs from the wage index calculation if there are no associated hours because we believe that inclusion of such costs might lead to a distortion of the wage index. The wage index is a relative measure of average hourly wages across geographic areas, and we believe that severance pay costs (which might be significant) without associated hours might inappropriately inflate the average hourly wage for a given hospital or area for a given time period (which in turn would distort the relative measure of wages across areas). For example, if we included severance pay costs with no associated hours, then a hospital might be more likely to qualify for geographic reclassification for purposes of the wage index simply because it incurred significant severance pay costs in a given year. In light of the comments, we will continue to examine this issue to determine whether inclusion of severance pay costs with no

associated hours would lead to a better measure of relative wages as opposed to a distortion in the measure and to determine whether it is feasible and appropriate to revise our policy on severance pay costs in the future.

4. Health Insurance and Health-Related Costs

In the September 1, 1994 final rule (59 FR 45356), we stated that health insurance, purchased or self-insurance, is a core wage-related cost. Over the past year, we have received several inquiries from hospitals and hospital associations requesting that we define ''purchased health insurance costs.'' In response, in the May 5 proposed rule, we clarified that, for wage index purposes, we define ''purchased health insurance costs'' as the premiums and administrative costs a hospital pays on behalf of its employees for health insurance coverage. ''Self-insurance'' includes the hospital's costs (not charges) for covered services delivered to its employees, less any amounts paid by the employees, and less the personnel costs for hospital staff who delivered the services (these costs are already included in the wage index). For purchased health insurance and self-health insurance, the included costs must be for services covered in a health insurance plan.

Also, in the September 1, 1994 final rule (59 FR 45357), we addressed a comment about the inclusion of health-related costs in the calculation of the wage index. Such health-related costs include employee physical examinations, flu shots, and clinic visits, and other services that are not covered by employees' health insurance plans but are provided at no cost or at discounted rates to employees of the hospital. In the May 5 proposed rule, we proposed to clarify that the costs for these services may be included as an ''other'' wage-related cost if (among other criteria), when all such health-related costs are combined, the total of such costs is greater than one percent of the hospital's total salaries (less excluded area salaries). As discussed in the September 1, 1994 final rule, a cost may be allowable as an ''other wage-related cost'' if it meets certain criteria. Under one criterion, the wage-related cost must be greater than one percent of total salaries (less excluded area salaries). For purposes of applying this 1-percent test with respect to the health-related costs at issue here, we look at the combined total of the health-related costs (not charges) for services delivered to its employees, less any amounts employees paid, and less the personnel costs for hospital staff who delivered the services (as these costs are already included in the wage index).

Comment: We received several comments regarding our policy and definitions for health insurance and health-related costs. Some commenters interpreted the policy clarification in the proposed rule as stating that self-insurance will no longer be included as core wage-related costs. They believe that not including these costs is inconsistent with the fundamental concept of core wage-related costs. One commenter pointed to the 1994 HCFA/Industry workgroup which established the list of core wage-related costs still in use, and contended that ''(t)hese proposed changes are inconsistent with the agreements reached in those original workgroup meetings.''

Response: As noted in the May 5 proposed rule, we previously stated our policy regarding health insurance and health-related costs in the FY 1995 final rule. We emphasize again in this final rule that, health insurance costs, whether purchased or self-insured, is, and will continue to be, a core wage-related cost. We did not propose a change in this policy, nor are we implementing a change in this policy in this final rule.

Comment: Some commenters objected to our statement in the proposed rule that only health self-insurance costs (not charges, and exclusive of any amounts paid by covered employees and less the personnel costs for hospital staff who delivered the services) are allowable core wage-related costs, and also argued that health self-insurance costs should be determined in accordance with GAAP which would include charges and personnel costs. They suggested that excluding costs that are determined in accordance with GAAP would create major inconsistencies among hospitals and inevitably result in major swings in the wage index for individual MSAs.

Two commenters recommended that HCFA review this policy to avoid creating disincentives to hospitals that develop cost-effective health-insurance benefits; they asserted that there should be no differentiation between purchased health insurance and self-funded health insurance.

Response: We disagree with the commenters that we are unfairly and inconsistently treating hospitals that self-insure by not allowing as a wage-related cost the salary costs for employees who deliver the health services. The personnel costs of delivering health care to all of a hospital's patients are already included in the wage index through line 1 of Worksheet S–3, Part II. Accounting for these hospital personnel costs on lines 13 or 14 for wage-related costs would falsely overstate a hospital's average hourly wage. Unless a hospital actually incurs the personnel costs twice, it is inappropriate to include the costs twice. Our policy does not require the exclusion of staff personnel costs from the premium costs for hospitals that purchase health insurance. As defined above and in the proposed rule, purchased health insurance costs include the premiums and administrative costs a hospital pays on behalf of its employees for health insurance coverage. The commenters suggested that the premium costs may include a hospital's staff personnel costs. We believe it is appropriate to allow the entire premium cost to a hospital as a wage-related cost if the intermediary verifies that the amount is an actual cost to the hospital.

Nevertheless, we agree with the commenters that, overall, for ''wage-related costs'', the application of GAAP creates a more static wage index and a better measure of relative wages across areas. For the FY 2002 wage index, we will advise hospitals to apply GAAP for wage-related costs, including health insurance and health-related costs. However, for self-health insurance and health-related costs, personnel costs associated with hospital staff that deliver the services to the employees must continue to be excluded from wage-related costs, if the costs are already included in the wage data as salaries on Worksheet S–3, Part II, Line I.

Comment: One commenter recommended that the insurance plan requirements be eliminated from our definition of health insurance costs, stating that hospitals should be required to maintain adequate records in support of the services they provide to their employees at either no cost or below cost. In expressing the concern that employee health benefits are ever-changing, the commenter recommended that not only must HCFA's definition of insurance plans be specific but it should also be implemented prospectively with sufficient clarification to reduce inconsistency in interpretation by the fiscal intermediaries.

Response: We are concerned that adopting this recommendation would make it difficult for intermediaries to accurately track benefits provided to a hospital's employees, leading to greater disparity in the treatment of these costs across hospitals. We will give further consideration to the implications of this recommendation, however.

Comment: One commenter recommended that health-related costs, for such items as ''employee physicals,

flu shots, and clinic visits'' should be included as a core wage-related cost; therefore, the 1-percent threshold criteria for health related costs should be eliminated.

Response: In the September 1, 1994 final rule, when we published the list of core wage-related costs agreed upon by the workgroup, we responded to comments specifically suggesting that health-related services (as opposed to self-insured health services, which was clearly on the original core list) be added to the core list. In our response, we pointed out that the core list was developed in conjunction with the hospital industry, to establish a list of commonly recognized costs that contribute significantly to the wage costs of a hospital and are readily identifiable in the hospital's records. Health-related benefits was not included on the core list at that time. We continue to believe these health-related benefits do not fit the criteria established by the workgroup for identifying core wage-related costs.

5. Elimination of Wage Costs Associated With Rural Health Clinics and Federally Qualified Health Centers

The current hospital wage index includes the salaries and wage-related costs of hospital-based rural health clinics (RHCs) and federally qualified health centers (FQHCs). However, Medicare pays for these costs outside the hospital inpatient prospective payment system. Effective January 1, 1998, under section 1833(f) of the Act, as amended by section 4205 of Public Law 105–33, Medicare pays both hospital-based and freestanding RHCs and FQHCs on a cost-per-visit basis. Medicare cost reporting forms for RHCs and FQHCs were revised to reflect this legislative change, beginning with cost reporting periods ending on or after September 30, 1998 (the FY 1998 cost report). Other cost-reimbursed outpatient departments, such as ambulatory surgical centers, community mental health centers, and comprehensive outpatient rehabilitation facilities, are presently excluded from the wage index. Therefore, consistent with our wage index refinements that exclude, to the extent possible, costs associated with services not paid under the hospital inpatient prospective payment system, we believe it would be appropriate to exclude all salary costs associated with RHCs and FQHCs from the wage index calculation if we had feasible, reliable data for such exclusion.

Because RHC and FQHC costs are not separately reported on the Worksheet S–3 for FYs 1997, 1998, and 1999, we cannot exclude these costs from the FY 2001, FY 2002, or FY 2003 wage indexes. Therefore, we will revise the FY 2000 Worksheet S–3 to begin providing for the separate reporting of RHC and FQHC salaries, wage-related costs, and hours. We will evaluate the wage data for RHCs and FQHCs in developing the FY 2004 wage index.

We received no public comments on this issue.

D. Verification of Wage Data From the Medicare Cost Report

The data for the FY 2001 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1997 Medicare cost reports. The data file used to construct the wage index includes FY 1997 data submitted to HCFA as of mid-July 2000. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. The unresolved data elements that were included in the calculation of the proposed FY 2001 wage index have been resolved and are reflected in calculation of the final FY 2001 wage index. We note that, as part of this process to identify aberrant data and correct any errors prior to the calculation of the final FY 2001 wage index, we notified by letter those hospitals that were leading to large variations in the wage indexes of their labor market areas compared to the FY 2000 wage index. These hospitals were instructed to review their data to identify the reason for the large increases or decreases and notify their fiscal intermediary of any necessary corrections. This resulted in several revisions to the data.

Also, as part of our editing process, in the final wage index, we removed data for 15 hospitals that failed edits. For eight of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. Two hospitals had erroneous average hourly wages (negative and zero) after allocating overhead to their excluded areas and, therefore, were removed from the calculation. The data from the remaining five hospitals also failed the edits and were removed. As a result, the final FY 2001 wage index is calculated based on FY 1997 wage data for 4,950 hospitals.

E. Computation of the FY 2001 Wage Index

The method used to compute the FY 2001 wage index follows. We note one technical change to the formula used to calculate the proposed wage index. For the first time, in the proposed rule we subtracted line 13 of Worksheet S–3, Part III from total hours when determining the excluded hours ratio used to estimate the amount of overhead attributed to excluded areas. Although we continue to believe this is the correct formula for determining this ratio, it resulted in very large and inappropriate increases in the average hourly wages for some hospitals. Therefore, in calculating the final FY 2001 wage index, we are not subtracting line 13 of Worksheet S–3, Part III in the calculation.

Step 1—As noted above, we based the FY 2001 wage index on wage data reported on the FY 1997 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, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1996 and before October 1, 1997. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1996 and reported a cost reporting period exceeding 52 weeks. These data were included because they did not have a cost report begin during the period described above. However, we generally describe these wage data as FY 1997 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1997 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997), we included wage data from only one of the cost reporting periods, the longest, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the latest period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 60 percent of the hospital's average hourly wage including all GME and CRNA costs, and 40 percent of the hospital's average hourly wage after eliminating all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, including all GME and CRNA costs, we subtracted from Line 1 (total salaries) the Part B salaries reported on Lines 3 and 5, home office salaries reported on

Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Lines 2, 4, and 6. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, and physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, 16, 18, and 20).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for specific categories of employees (Lines 16, 18, and 20) are excluded if no corresponding salaries are reported for those employees (Lines 2, 4, and 6, respectively).

We then calculated a hospital's salaries plus wage-related costs by subtracting from total salaries the salaries plus wage-related costs for teaching physicians, Part A CRNAs (Lines 2 and 16), and residents (Lines 6 and 20).

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S-3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 3, 5, and 7). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Finally, we subtracted the computed overhead salaries and hours associated with excluded areas from the total salaries and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1996 through April 15, 1998 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust 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
10/14/96	11/15/96	1.02848
11/14/96	12/15/96	1.02748
12/14/96	01/15/97	1.02641
01/14/97	02/15/97	1.02521
02/14/97	03/15/97	1.02387
03/14/97	04/15/97	1.02236
04/14/97	05/15/97	1.02068
05/14/97	06/15/97	1.01883
06/14/97	07/15/97	1.01695
07/14/97	08/15/97	1.01520
08/14/97	09/15/97	1.01357
09/14/97	10/15/97	1.01182
10/14/97	11/15/97	1.00966
11/14/97	12/15/97	1.00712
12/14/97	01/15/98	1.00451
01/14/98	02/15/98	1.00213
02/14/98	03/15/98	1.00000
03/14/98	04/15/98	0.99798

For example, the midpoint of a cost reporting period beginning January 1, 1997 and ending December 31, 1997 is June 30, 1997. An adjustment factor of 1.01695 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 1997 and covers a period of less than 360 days or more 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 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 (with and without GME and CRNA costs) for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Because the FY 2001 wage index is based on a blend of average hourly wages, we then added 60 percent of the average hourly wage calculated without removing GME and CRNA costs, and 40 percent of the average hourly wage calculated with these costs excluded.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 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 same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $21.7702.

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. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) 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 $10.1902 for Puerto Rico.

For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific 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 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area may not be less than the area wage index applicable to hospitals located in rural areas in that State. 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 that would have been made in the year if this section did not apply. For FY 2001, this change affects 193 hospitals in 34 MSAs. The MSAs affected by this

provision are identified in Table 4A by a footnote.

F. 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. Applications for MGCRB reclassification are now on the internet at http://www.hcfa.gov/regs/appeals.

1. Provisions of Public Law 106–113

Under section 152(b) of Public Law 106–113, hospitals in certain counties are deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. In the May 5 proposed rule we calculated FY 2001 wage indexes for hospitals in the affected counties as if they were reclassified to the specified area.

For purposes of making payments under section 1886(d) of the Act for FY 2001, section 152(b) provides the following:

- Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA;
- Orange County, New York is deemed to be located in the New York, New York MSA;
- Lake County, Indiana and Lee County, Illinois are deemed to be located in the Chicago, Illinois MSA;
- Hamilton-Middletown, Ohio is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- Brazoria County, Texas is deemed to be located in the Houston, Texas MSA;
- Chittenden County, Vermont is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

Section 152(b) also requires that these reclassifications be treated for FY 2001 as though they are reclassification decisions by the MGCRB. Therefore, in the May 5 proposed rule, we proposed that the wage indexes for the areas to which these hospitals are reclassifying, as well as the wage indexes for the areas in which they are located, would be subject to all of the normal rules for calculating wage indexes for hospitals affected by reclassification decisions by the MGCRB, as described below.

In addition, we proposed that the reclassifications enacted by section 152(b) pertain only to the hospitals located in the specified counties, not to hospitals in other counties within the MSA or hospitals reclassified into the MSA by the MGCRB.

Under section 154(b) of Public Law 106–113, the Allentown-Bethlehem-Easton, Pennsylvania MSA wage index was calculated including the wage data for Lehigh Valley Hospital. Section 154(b) states that, for FY 2001, ''[n]otwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), in calculating and applying the wage indices under that section for discharges occurring during fiscal year 2001, Lehigh Valley Hospital shall be treated as being classified in the Allentown-Bethlehem-Easton Metropolitan Statistical Area.'' We stated in the proposed rule that this statutory language directs us to include Lehigh Valley Hospital's wage data in the wage index calculation for the Allentown-Bethlehem-Easton MSA for FY 2000 and FY 2001.

Section 1886(d)(8)(B) of the Act established that a hospital located in a rural county adjacent to one or more urban areas is treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an MSA (or NECMAs), if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. Through FY 2000, hospitals are required to use standards published in the Federal Register on January 3, 1980, by the Office of Management and Budget. For FY 2000, there were 27 hospitals affected by this provision.

Section 402 of Public Law 106–113 amended section 1886(d)(8)(B) of the Act to allow hospitals to elect to use the standards published in the **Federal Register** on January 3, 1980 (1980 decennial census data) or March 30, 1990 (1990 decennial census data) during FY 2001 and FY 2002. As of FY 2003, hospitals will be required to use the standards published in the **Federal Register** by the Director of the Office of Management and Budget based on the most recent available decennial population data.

We are in the process of working with the Office of Management and Budget to identify the hospitals that would be affected by this amendment. We will revise payments to hospitals in the affected counties as soon as data is available. Hospitals will have this option during FY 2001 and FY 2002. After FY 2002, hospitals will be required to use data based on the 2000 decennial census. We refer the reader to the September 30, 1988 final rule (53 FR 38499) for a complete discussion of our approach to identify the outlying counties using the standards published in the January 3, 1980 **Federal Register**.

Comment: We received three comments on our proposed policy to treat hospitals reclassifying into an area containing one of the counties reclassified by section 152(b) in a manner similar to any other situation where a hospital reclassifies into an area where hospitals in that area have been reclassified into another area. The commenters, all hospitals that have been granted a reclassification into an area containing a county reclassified by section 152(b), requested that they should be permitted to reclassify along with the county identified by section 152(b). They added that, in the event it was determined that their preferred solution was not permissible, the wage index of the area to which they were reclassified should be calculated by including the wage data for the hospitals reclassified by section 152(b).

The commenters noted that they would be at a competitive disadvantage by the section 152(b) reclassifications if they were treated similar to other decisions by the MGCRB. In addition, they believed that the Secretary has some discretion with respect to calculating the wage indexes for areas with hospitals that have been reclassified, noting that the legislation does not specifically direct the Secretary to exclude reclassified hospitals from the calculation for the area in which a hospital is actually located.

Response: We have reconsidered the methodology for calculating the wage index applicable to hospitals reclassified into the MSAs that contain the counties specified in section 152(b) of Public Law 106–113. We continue to believe that the hospitals located in the counties specified in section 152(b) should be distinguished from the hospitals that were reclassified by the MGCRB into the MSAs containing those counties. Congress provided special treatment for hospitals in the counties specified in the statute, but it did not provide special treatment for hospitals

reclassified to the MSAs that contain those counties. Moreover, under the MGCRB process, hospitals are reclassified into MSAs as a whole, not into specific counties within an MSA; for example, some hospitals were reclassified by the MGCRB into the Newburgh, NY–PA MSA, which contains Orange County, NY and one other county, but those hospitals were not reclassified into Orange County itself. Thus, the benefits of section 152(b) apply only to the hospitals located in the counties specified by Congress.

Consistent with one of the suggestions of the commenters, however, we are revising the methodology reflected in the proposed rule with respect to the calculation of the wage index values for the MSAs containing the counties specified in section 152(b). The proposed rule reflected our normally applicable policy with respect to reclassifications, under which the wages of hospitals reclassified out of an MSA would be excluded from the calculation of the wage index value for that MSA; application of our normal rules might lead to an unexpected decrease in the wage index value for an MSA arising from the provisions of section 152(b). To address the unexpected decrease that might otherwise occur, we believe that it is appropriate to calculate the wage index values for the MSAs that contain the counties specified in section 152(b) (e.g., the Newburgh MSA) by including the wages of hospitals that were reclassified out of the area by section 152(b). We believe that we should not exclude the wages of those hospitals because Congress has provided special treatment for those hospitals, and we believe that including the wages of the reclassified hospitals appropriately reconciles the provisions of section 152(b) of Public Law 106–113, the MGCRB statutory and regulatory scheme, section 1886(d)(3)(E) of the Act, as well as the expectations of the hospitals prior to the enactment of section 152(b).

Comment: We received one comment related to our proposed treatment of Lehigh Valley Hospital's wage data under section 154(b) of Public Law 106–113. For FY 2001, Lehigh Valley Hospital was reclassified by the MGCRB to the Philadelphia MSA. The commenter argued that it was not Congress' intent that Lehigh Valley Hospital should be precluded from reclassifying.

The commenter also contended that the statutory language of section 154(b) could allow HCFA to permit Lehigh Valley Hospital to reclassify to Philadelphia, while the hospital's wage data would still be used to calculate the Allentown-Bethlehem-Easton MSA wage index. The commenter stated that by indicating this provision that Lehigh Valley ''shall be treated'' as being in the Allentown MSA, Congress did not intend to prohibit Lehigh Valley from reclassifying. If this had been Congress' intent, it would have been stated as such.

Response: In the proposed rule, we included Lehigh Valley Hospital's wage data in the wage index calculation for the Allentown-Bethlehem-Easton MSA. We also indicated that we believed the statutory language of section 154(b) required us to apply the Allentown-Bethlehem-Easton MSA wage index to Lehigh Valley Hospital for payments during FY 2001. However, we note that, despite the language of section 154(b), the MGCRB did reclassify Lehigh Valley Hospital to the Philadelphia MSA for FY 2001, and the HCFA Administrator did not reverse that decision. This has the effect of leaving stand the decision by the MGCRB to reclassify Lehigh Valley Hospital into the Philadelphia MSA for purposes of calculating and applying the Philadelphia wage index.

With respect to calculating the Allentown-Bethlehem-Easton MSA wage index, section 154(b) requires that we include Lehigh Valley Hospital's wage data in calculating the wage index for this MSA. We note that the provision is effective ''(n)otwithstanding any other provision of section 1886(d) of the Social Security Act.'' Therefore, although our normal policy is to remove the wage data of a hospital reclassified out of an area when calculating that area's wage index, section 154(b) directs us to include Lehigh's wage data in calculating the wage index for the A–B–E MSA.

2. Effects of Reclassification

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, except as discussed above, 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 redesignated hospitals 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 in which 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 2001 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. 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 urban or rural hospital cannot be reduced below the wage index value for the rural area of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural area of the State in which the hospital is located, the redesignated hospital receives the higher wage index value; that is, the wage index value for the rural area 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, before the redesignation of hospitals, based on the FY 1997 wage data. In addition, Table 3C in the Addendum to this final rule includes the adjusted average hourly wage for each hospital based on the FY 1997 data as of July 2000 (reflecting the phase-out of GME and CRNA wages as described at section III.C of this preamble). The MGCRB will use the average hourly wage published in this final rule to evaluate a hospital's application for reclassification for FY 2002 (unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2)). We note that in adjudicating these wage index reclassifications the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2001 wage index.

We indicated in the proposed rule that, at the time the proposed wage index was constructed, the MGCRB had completed its review of FY 2001 reclassification requests. The final FY 2001 wage index values incorporate all 493 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act, and section 152(b) Public Law 106–113) for FY 2001). Since publication of the May 5 proposed rule, the number of reclassifications has changed because some MGCRB decisions were still under review by the Administrator and because some hospitals decided to withdraw their requests for reclassification.

Changes to the wage index that resulted from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process have been incorporated into the wage index values published in this final rule. The changes affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index value for the area to which they are redesignated, or a wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated is affected.

Comment: One commenter recommended that the average hourly wages shown in Tables 4D and 4E should be consistent with the values shown in Tables 4A and 4B. In support of this recommendation, the commenter suggested that, because our policy for computing the wage index values for urban areas excludes wages for hospitals that have reclassified to another area, the average hourly wages shown in Table 4D should be computed exclusive of the reclassified hospitals. The commenter believed the recommended change has the potential of impacting a hospital's efforts to reclassify because the hospital may not qualify based on the ''unadjusted'' hourly wage currently shown in Table 4D.

Response: As discussed above and in the May 5 proposed rule (65 FR 26301), the average hourly wages in Tables 4D and 4E reflect the labor market area average hourly wages before hospital redesignations. We provide the unadjusted rather than adjusted average hourly wages because the MGCRB must use unadjusted average hourly wages in determining a hospital's eligibility for reclassification. A hospital that wishes to apply for reclassification for the FY 2002 wage index (deadline is September 1, 2000) should use the average hourly wage data in Tables 3C, 4D, and 4E of the FY 2001 proposed and final rules to determine whether it meets the requirements for reclassification. With the exception of urban areas that receive the statewide rural wage index value, an urban area's adjusted average hourly wage may be calculated by multiplying the area wage index value in Table 4A by the national average hourly wage.

Comment: One commenter questioned whether the number of hospitals reclassified for the wage index for FY 2001 cited in the proposed rule (586) was accurate.

Response: The correct number of wage index reclassifications for FY 2001 at the time the proposed rule was published was 386. As stated above, the final number of wage index reclassifications is 490.

A. Wage Data Corrections

In the proposed rule, we stated that, to allow hospitals time to evaluate the wage data used to construct the proposed FY 2001 hospital wage index, we would make available in May 2000 a final public data file containing the FY 1997 hospital wage data.

The final wage data file was released on May 5, 2000. As noted above in section III.C. of this preamble, this file included hospitals' teaching survey data as well as cost report data. As with the file made available in February 2000, we made the final wage data file released in May 2000 available to hospital associations and the public (on the Internet). However, this file was made available only for the limited purpose of identifying any potential errors made by HCFA or the fiscal intermediary in the entry of the final wage data that the hospital could not have known about before the release of the final wage data public use file. It is not for the initiation of new wage data correction requests.

If, after reviewing the May 2000 final data file, a hospital believed that its wage data were incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and HCFA, outlining why the hospital believed an error exists and provide all supporting information, including dates. These requests had to be received by us and the intermediaries no later than June 5, 2000.

Changes to the hospital wage data were made 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 final wage data file. Specifically, neither the intermediary nor HCFA accepted the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCRIS on or before April 3, 2000.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 2000 wage data file.
- 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 June 5, 2000) are incorporated into the final wage index in this final rule, to be effective October 1, 2000.

We believe the wage data correction process provides hospitals with sufficient opportunity to bring errors in

their wage data to the intermediary's attention. Moreover, because hospitals had access to the final wage data by early May 2000, they had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2001 wage index and its implementation on October 1, 2000. If hospitals avail themselves of this opportunity, the FY 2001 wage index implemented on October 1 should be free of these errors. Nevertheless, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which 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 2001 (that is, by the June 5, 2000 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the intermediary notified 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.

Comment: One commenter expressed concern about the process used in preparing the final wage index data, especially teaching survey data. The commenter was concerned that errors would not be corrected before the publication of the final rule. Without providing specific information, the commenter further stated that it still believed that there were a number of ''omission errors in the data'' and that the situation would have been better handled if the data were corrected and reposted.

Response: We acknowledge the commenter's concern and reiterate that the purpose of making the wage data available for review on the Internet is to allow hospitals time to evaluate the wage data used in constructing the hospital wage index. We encourage hospitals to review their data and to address and resolve issues in dispute prior to the publication of the final wage index data file. We acknowledge that the teaching physician data submitted by several providers were not accurately reported in the public use wage index data file published on May 5, 2000. Once we became aware of the errors, we took the necessary steps to review and incorporate the appropriate data. The updated file was then made available on our Internet website at: http://www.hcfa.gov/medicare/ippsmain.htm.

IV. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating Costs and Graduate Medical Education Costs

A. Expanding the Transfer Definition to Include Postacute Care Discharges (§ 412.4)

In accordance with section 1886(d)(5)(I) of the Act, the prospective payment system distinguishes between ''discharges,'' situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and ''transfers,'' situations in which the patient is transferred to another acute care hospital for related care. Our policy, as set forth in the regulations at § 412.4, provides that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Effective with discharges on or after October 1, 1998, section 1886(d)(5)(J) of the Act required the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs (identified below) selected by the Secretary if the individuals are discharged to one of the following settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

Therefore, any discharge from a prospective payment hospital from one of the selected 10 DRGs that is admitted to a hospital excluded from the prospective payment system on the date of discharge from the acute care hospital, on or after October 1, 1998, would be considered a transfer and paid accordingly under the prospective payment systems (operating and capital) for inpatient hospital services. Similarly, a discharge from an acute care inpatient hospital paid under the prospective payment system to a skilled nursing facility on the same date would be defined as a transfer and paid as such. We consider situations in which home health services related to the condition or diagnosis of the inpatient admission are received within 3 days after the discharge as a transfer.

The statute specifies that the Secretary select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. We identified the following DRGs with the highest percentage of postacute care:

- DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack (Medical))
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe (Surgical))
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity (Surgical))
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age >17 with CC (Surgical))
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age >17 without CC (Surgical))
- DRG 236 (Fractures of Hip and Pelvis (Medical))
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC (Surgical))
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC (Surgical))
- DRG 429 (Organic Disturbances and Mental Retardation (Medical))
- DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses (Surgical))

Generally, we pay for transfers based on a per diem payment, determined by dividing the DRG payment by the average length of stay for that DRG. The transferring hospital receives twice the per diem rate the first day and the per diem rate for each following day, up to the full DRG payment. Of the 10 selected DRGs, 7 are paid under this method. However, three DRGs exhibit a disproportionate share of costs very early in the hospital stay. For these three DRGs, hospitals receive one-half of the DRG payment for the first day of the stay and one-half of the payment they would receive under the current transfer payment method, up to the full DRG payment.

As required by section 1886(d)(5)(J)(iv) of the Act, we included in the FY 2001 proposed rule published on May 5, 2000 (65 FR 26302), a description of the effect of the provision to treat as transfers cases that are assigned to one of the 10 selected DRGs and receive postacute care upon their discharge from the hospital. Under contract with HCFA (Contract No. 500–95–0006), Health Economics Research, Inc. (HER) conducted an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. The analysis sought to obtain information on four primary areas: How hospitals responded in terms of their transfer practices; a comparison of payments and costs for these cases; whether hospitals are attempting to circumvent the policy by delaying postacute care or coding the patient's discharge status as something other than a transfer; and what the next possible step is for expanding the transfer payment policy beyond the current 10 selected DRGs or the current postacute destinations.

In addition, in accordance with section 1886(d)(5)(J)(iv)(I) of the Act, we included in the May 5, 2000 proposed rule for FY 2001 a discussion of whether other postdischarge services should be added to this postacute care transfer provision. Since FY 1999 was the first year this policy was effective and because of pending changes to payment policies for other postacute care settings such as hospital outpatient departments, we have limited data to assess whether additional postacute care settings should be included. We will continue to closely monitor this issue as more data become available.

In its analysis, HER relied on HCFA's Standard Analytic Files containing claims submission data through September 1999. However, the second and third quarter submissions for calendar year 1999 were not complete. It was decided that transfer cases would be identified by linking acute hospital discharges with postacute records based on Medicare beneficiary numbers and dates of discharge from the acute hospital with dates of admission or provision of service by the postacute provider. This method was used rather than selecting cases based on the discharge status code on the claim even though this code is being used for payment to these cases because we wanted to also assess how accurately hospitals are coding this status. However, the need to link acute and postacute episodes further limited the analytic data, due to the greater time lag for collecting postacute records. Therefore, much of HER's analysis focused on only the first two quarters of FY 1999. The two preceding fiscal years served as a baseline for purposes of comparison.

Since the publication of the May 5, 2000 proposed rule for FY 2001, HER has updated the results of its study of the impact on hospitals and hospital payments of the postacute transfer provision. In its revised analysis, HER found that the volume of postacute transfers qualifying for the lower per diem payment during the first 6 months of FY 1999 fell from 28 percent of total discharges under the 10 DRGs before the implementation of the payment change to 18 percent. It appears this decline was largely the result of a drop in the geometric mean length of stay in two high-volume DRGs (DRGs 14 and 209) that reduced the number of days qualifying a case for the per diem payment. In FY 1998, the geometric mean length of stay was 5.1 days for DRG 14 and 5.3 days for DRG 209. The geometric mean length of stay for both DRGs in FY 1999 was 4.9 days. To qualify for a per diem payment, a case's length of stay must be less than the DRG's geometric mean length of stay minus one day. Therefore, cases in these two DRGs with lengths of stay of five days were counted as qualified for per diem payments under the postacute care transfer rules in FY 1998 but not in FY 1999. Because DRGs 14 and 209 account for approximately 65 percent of the cases in the 10 DRGs, the drop in the threshold for qualifying cases contributed significantly to the magnitude of the decline in qualifying cases overall.

Correspondingly, HER found an increase in the volume and share of postacute transfers that did not qualify for the lower per diem payment. The share of long-stay postacute transfers paid under the full DRG amount (*e.g.,* those with a length of stay equal to at least one day less than the geometric mean length of stay minus one day) increased from 35 percent during the first half of FY 1998 to 43 percent during the first 6 months of FY 1999. Again, some of this increase is attributable to the drop in the geometric mean lengths of stay in DRGs 14 and 209.

According to HER, to some extent, the shift in the distribution of postacute transfers from qualifying to nonqualifying cases may suggest that hospitals have responded to the policy change by holding patients longer before releasing them to a postacute care provider. Total postacute transfers fell by 13 percent between the two payment periods, suggesting that hospitals may also have responded by resuming the provision of services that were previously performed by postacute care providers, resulting in an elimination of some postacute transfers. However, additional analysis would be necessary to separate the effects of the drop in the geometric mean length of stay from the hospital behavioral effects.

The study shows that the average length of stay of qualifying postacute transfers rose slightly between the two payment periods, from 4.16 days before the policy change to 4.33 days after. In contrast, the average length of stay of long-stay transfers and nontransfers for the same set of DRGs fell between the two 6-month study periods, by 15.9 and 16.6 percent, respectively. This indicates that, overall, hospitals were keeping cases slightly longer prior to transfer.

The figures on the impact of ''delayed'' transfers (for example, those patients transferred to a postacute care provider beyond the 1 or 3 day qualifying time period) remain unchanged. HER found little evidence that hospitals are responding to the policy change by increasing the time interval between prospective payment system discharge and postacute care admission or visit.

The study also did not find evidence that changes in prospective payment system hospital treatment and discharge behavior are resulting in increased lengths of stay or numbers of visits during the subsequent postacute care episode. Average lengths of stay and number of visits at postacute care providers following provider payment system discharge actually fell between the two payment periods. It is likely that any adverse effects of hospital behavior on patient care would have manifested itself in greater postacute care lengths of stay and number of visits following the implementation of the payment reform. HER found no evidence of this.

The average cost of qualifying postacute transfers rose in real terms by 2.4 percent after the policy change. According to HER, average profits for qualifying postacute transfers fell from $3,496 per case prior to the transfer policy change to $2,255 following the implementation of the payment reform. Average payments with adjustments for IME, DSH and outliers declined in real terms by 9.6 percent.

HER found that the postacute transfer policy resulted in a reduction in expenditures of $239 million during the first half of FY 1999. Annualized over a 1-year period, the policy reform lowered annual payments by an estimated $478 million. (In our estimate of the impacts of this policy, we estimated the total impact to be $480

million (63 FR 40977).) The estimated annual savings resulting from the policy change is equivalent to a 4.5 percent reduction in program expenditures in the 10 pilot DRGs and a 0.5 percent reduction in overall prospective payment system expenditures. The ''price'' effect (for example, holding hospital treatment and admission patterns constant) resulted in a savings of $276 million during the first half of FY 1999 (or an estimated $552 million annually). However, the decline in the number of transfers qualifying for the lower per diem, as well as the longer lengths of stay of short-stay postacute transfer cases, resulted in an offsetting reduction in savings of $37 million during the first 6 months of FY 1999 (or $74 million annually). As stated above, the combination of the positive ''price'' effect and the negative ''volume'' effect led to a net savings of $239 million during the first half of FY 1999 (or an estimated $478 million annually).

The study also examined the discharge destination codes as reported on the acute care hospital claims against postacute care transfers identified on the basis of a postacute care claim indicating the patient qualifies as a transfer. This analysis found that, in 1998, only 74 percent of transfer cases had discharge destination codes on the acute care hospital claim that were consistent with whether there was a postacute care claim for the case matching the date of discharge. In FY 1999, the year the postacute care transfer policy went into effect, this rate rose to 79 percent. This indicates that hospitals are improving the accuracy of coding transfer cases.

Transfers to hospitals or units excluded from the prospective payment system must have a discharge destination code (Patient Status) of 05. Transfers to a skilled nursing facility must have a discharge destination code of 03. Transfers to a home health agency must have a discharge destination code of 06. If the hospital's continuing care plan for the patient is not related to the purpose of the inpatient hospital admission, a condition code 42 must be entered on the claim. If the continuing care plan is related to the purpose of the inpatient hospital admission, but care did not start within 3 days after the date of discharge, a condition code 43 must be entered on the claim. The presence of either of these condition codes in conjunction with discharge destination code 06 will result in full payment rather than the transfer payment amount. We intend to closely monitor the accuracy of hospitals' discharge destination coding in this regard and take whatever steps are necessary to ensure that accurate payment is made under this policy.

Section 1886(d)(5)(J)(iv)(II) of the Act authorized but did not require the Secretary to include as part of the proposed rule additional DRGs to include under the postacute care transfer provision. As part of ''The President's Plan to Modernize and Strengthen Medicare for the 21st Century'' (July 2, 1999), the Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, we did not propose any change to the postacute care settings or the 10 DRGs.

HER did undertake an analysis of how additional DRGs might be considered for inclusion under the policy. The analysis supports the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent choices based on the other criteria as well. Most have fairly high short-stay PAC [postacute care] rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

Extending the policy beyond these initial DRGs, however, may well require more extensive analysis and grouping of like-DRGs. One concern raised in the analysis relates to single DRGs including multiple procedures with varying lengths of stay. Because the transfer payment methodology only considers the DRG overall geometric mean length of stay for a DRG, certain procedures with short lengths of stay relative to other procedures in the same DRG may be more likely to be treated as transfers. The analysis also considers pairs of DRGs, such as DRGs 263 and 264, as well as larger bundles of DRGs (grouped by common elements such as trauma, infections, and major organ procedures). According to HER, ''[i]n extending the PAC transfer policy, it is necessary to go beyond the flawed concept of a single DRG to discover multiple DRGs with a common link that exhibit similar PAC statistics. Aggregation of this sort provides a logical bridge in expanding the PAC transfer policy that is easily justified to Congress and that avoids unintended inequities in the way DRGs-and potentially hospitals-are treated under this policy. Hospitals can be inadvertently penalized or not under the current implementation criteria due to systematic differences in the DRG mix.''

Finally, the HER report concludes with a discussion of the issues related to potentially expanding the postacute care transfer policy to all DRGs. On the positive side, HER points to the benefits of expanding the policy to include all DRGs:

- A simple, uniform formula-driven policy;
- Same policy rationale exists for all DRGs-the statutory provision requiring the Secretary to select only 10 DRGs was a political compromise;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive short-stay postacute care transfer policy for other DRGs.

According to HER, the negative implications of expanding the policy to all DRGs include:

- The postacute care transfer policy is irrelevant for many DRGs;
- Added burden for the fiscal intermediaries to verify discharge destination codes;
- Diluted program savings beyond the initial 10 DRGs;
- Difficulty in identifying ongoing postacute care that resumes after discharge; and
- Heterogeneous procedures within single DRGs having varying lengths of stay.

The HER report in final format may be obtained from the HCFA website at: http://www.hcfa.gov/medicare/ippsmain.htm

Comment: One commenter observed that in our discussion in the proposed rule (65 FR 26303) of postacute care transfers to a skilled facility, we stated that ''(t)his would include cases discharged from one of the 10 selected DRGs to a designated swing bed for skilled nursing facilities.'' The commenter believed that HCFA clearly excluded swing bed transfers from the postacute care transfer policy in the July 31, 1998 final rule and asked for clarification.

Response: The commenter is correct that we excluded swing bed transfers from the postacute care transfer policy in the July 31, 1998 final rule (63 FR 40977). We are not changing the policy to include swing beds at this time. The sentence in question was inadvertently included in the proposed rule.

Comment: One commenter believed the transfer policy is contrary to the

design of the prospective payment system and penalizes clinical decision making by physicians in discharging their patients to the appropriate level of care. The commenter suggested that the HER study shows that the net outcome of the policy has been to pay hospitals less and increase the complexity and administrative costs of the inpatient prospective payment system. The commenter cited the disadvantages of expanding the policy to all DRGs set forth in the HER report and recommended that the Administration revisit this policy in light of the findings of the researchers that care, not finances, is driving the length of stay in these cases.

Response: We disagree with the commenter that the postacute transfer policy penalizes clinical decisionmaking by physicians in discharging their patients to the appropriate level of care, but rather believe that the policy appropriately adjusts payments to hospitals to reflect the amount of care actually provided in the acute care setting. Furthermore, this policy does not require a change in physician clinical decisionmaking nor in the manner in which physicians and hospitals practice medicine. It simply addresses the appropriate level of payments once those decisions have been made.

With respect to whether the provision is contrary to the original intent of the prospective payment system, we believe it is entirely consistent with the following statement made in the **Federal Register** during the first year of the prospective payment system in response to a comment concerning the hospital-to-hospital transfer policy: ''(t)he rationale for per diem payments as part of our transfer policy is that the transferring hospital generally provides only a limited amount of treatment. Therefore, payment of the full prospective payment rate would be unwarranted'' (49 FR 244). We also note that in its earliest update recommendations, the Prospective Payment Assessment Commission (MedPAC's predecessor organization) included what it called a site-of-service substitution adjustment to account for the shifting of portions of inpatient care to other settings. We believe this provision is an appropriate and consistent response to the changing treatment practice of the hospital industry.

Though we are not expanding the policy to include all DRGs at this time, HER points to advantages as well as the disadvantages cited by the commenter of doing so, including:

- A simple, uniform formula-driven policy;
- Same policy rationale exists for all DRGs—the statutory provision requiring the Secretary to select only 10 DRGs was a political compromise;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive short-stay postacute care transfer policy for other DRGs.

Finally, we also believe that care, not finances, should drive the length of stay and all other clinical decisions in these cases, and that payments should be aligned with the care given in each provider setting.

Comment: One commenter agreed with our decision to not expand the number of DRGs subject to the postacute transfer policy. The commenter believed that the policy should be revoked because the cost savings have far exceeded the estimates relied on in developing the policy and, more fundamentally, because it violates the notion of averaging that is at the heart of an appropriate prospective payment system. The commenter also believed that the introduction of prospective payment in virtually all postacute settings obviates the need for this expansion of transfer policy.

The commenter stated that the use of the geometric mean length of stay to determine the payment amount does not fully consider the medical practice patterns of physicians in different regions of the country and appears to penalize those areas that already achieved a lower length of stay.

Response: Since updating its study after the proposed rule was published, HER reports that the policy resulted in savings of $478 million, remarkably close to our estimate of $480 million published in the July 31, 1998 final rule (63 FR 40977). Furthermore, as we stated in our previous response, we believe that the policy is entirely consistent with the original intent of the prospective payment system.

We disagree with the commenter's belief that the introduction of prospective payment systems to postacute settings obviates the need for the transfer policy. The purpose of the policy is to align payments with the care actually provided in the inpatient setting. The policy is particularly appropriate for areas of the country where care has been more aggressively shifted from acute to postacute settings.

B. Sole Community Hospitals (SCHs)(§§ 412.63, 412.73, and 413.75, proposed new § 412.77, and § 412.92)

Under the hospital inpatient prospective payment system, special payment protections are provided to sole community hospitals (SCHs). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as, among other things, a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria a hospital must meet to be classified as an SCH are located at § 412.92(a).

Currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: The Federal national rate applicable to the hospital; or the hospital's ''target amount''—that is, either the updated hospital-specific rate based on FY 1982 costs per discharge, or the updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113, which amended section 1886(b)(3) of the Act, provides that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 target amount (the hospital-specific rate as opposed to the Federal rate) may elect to receive payment under a methodology using a third hospital-specific rate based on the hospital's FY 1996 costs per discharge. This amendment to the statute means that, for cost reporting periods beginning on or after October 1, 2000, eligible SCHs can elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

We are aware that language in the Conference Report accompanying Public Law 106–113 indicates that the House bill (H.R. 3075) would have permitted SCHs that were being paid the Federal rate to rebase, not SCHs that were paid on the basis of either their FY 1982 or FY 1987 target amount (H.R. Conf. Rep. No. 106–479, 106th Cong., 1st Sess. at 890 (1999)). The language of the section 405 amendment to section 1886(b)(3) (which added new subparagraph (I)(ii)) clearly limits the option to substitute the FY 1996 base year to SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of the target amount applicable to the hospital under section 1886(b)(3)(C).

In the May 5 proposed rule, we proposed that, when calculating an eligible SCH's FY 1996 hospital-specific rate, we utilize the same basic methodology used to calculate FY 1982 and FY 1987 bases. That methodology is set forth in §§ 412.71 through 412.75 of the regulations and discussed in detail in several prospective payment system documents published in the **Federal Register** on September 1, 1983 (48 FR 3977); January 3, 1984 (49 FR 256); June 1, 1984 (49 FR 23010); and April 20, 1990 (55 FR 15150).

Since we anticipate that eligible hospitals will elect the option to rebase using their FY 1996 cost reporting periods, we proposed that our fiscal intermediaries would identify those SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of their target amounts. For these hospitals, fiscal intermediaries would calculate the FY 1996 hospital-specific rate as described below in this section IV.B. If this rate exceeds a hospital's current target amount based on the greater of the FY 1982 or FY 1987 hospital-specific rate, the hospital will receive payment based on the FY 1996 hospital-specific rate (based on the blended amounts described at section 1886(b)(3)(I)(i) of the Act) unless the hospital notifies its fiscal intermediary in writing prior to the end of the cost reporting period that it does not wish to be paid on the basis of the FY 1996 hospital-specific rate. Thus, if a hospital does not notify its fiscal intermediary before the end of the cost reporting period that it declines the rebasing option, we would deem the lack of such notification as an election to have section 1886(b)(3)(I) of the Act apply to the hospital.

We further proposed that an SCH's decision to decline this option for a cost reporting period will remain in effect for subsequent periods until such time as the hospital notifies its fiscal intermediary otherwise.

The FY 1996 hospital-specific rate will be based on FY 1996 cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996, that are 12 months or longer. If the hospital's last cost reporting period ending on or before September 30, 1996 is less than 12 months, the hospital's most recent 12-month or longer cost reporting period ending before the short period report would be utilized in the computations. If a hospital has no cost reporting period beginning in FY 1996, it would not have a hospital-specific rate based on FY 1996.

For each hospital eligible for FY 1996 rebasing, the fiscal intermediary will calculate a hospital-specific rate based on the hospital's FY 1996 cost report as follows:

- Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the FY 1996 cost report.
- Divide the total Medicare operating cost by the number of Medicare discharges in the cost reporting period to determine the FY 1996 base period cost per case. For this purpose, transfers are considered to be discharges.
- In order to take into consideration the hospital's individual case-mix, divide the base year cost per case by the hospital's case-mix index applicable to the FY 1996 cost reporting period. This step is necessary to standardize the hospital's base period cost for case-mix and is consistent with our treatment of both FY 1982 and FY 1987 base-period costs per case. A hospital's case-mix is computed based on its Medicare patient discharges subject to DRG-based payment.

We proposed that the fiscal intermediary will notify eligible hospitals of their FY 1996 hospital-specific rate prior to October 1, 2000. Consistent with our policies relating to FY 1982 and FY 1987 hospital-specific rates, we proposed to permit hospitals to appeal a fiscal intermediary's determination of the FY 1996 hospital-specific rate under the procedures set forth in 42 CFR part 405, subpart R, which concern provider payment determinations and appeals. In the event of a modification of base period costs for FY 1996 rebasing due to a final nonappealable court judgment or certain administrative actions (as defined in § 412.72(a)(3)(i)), the adjustment would be retroactive to the time of the intermediary's initial calculation of the base period costs, consistent with the policy for rates based on FY 1982 and FY 1987 costs.

Section 405 prescribes the following formula to determine the payment for SCHs that elect rebasing:

For discharges during FY 2001:

- 75 percent of the updated FY 1982 or FY 1987 former target (identified in the statute as the ''subparagraph (C) target amount''), plus
- 25 percent of the updated FY 1996 amount (identified in the statute as the ''rebased target amount'').

For discharges during FY 2002:

- 50 percent of the updated FY 1982 or FY 1987 former target, plus
- 50 percent of the updated FY 1996 amount.

For discharges during FY 2003:

- 25 percent of the updated FY 1982 or FY 1987 former target, plus
- 75 percent of the updated FY 1996 amount.

For discharges during FY 2004 or any subsequent fiscal year, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 amount.

We proposed to add a new § 412.77 and amend § 412.92(d) to incorporate the provisions of section 1886(b)(3)(I) of the Act, as added by section 405 of Public Law 106–113.

Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i)(XVI) of the Act to provide, for fiscal year 2001, for full market basket updates to both the Federal and hospital-specific payment rates applicable to sole community hospitals. In the May 5 proposed rule, we proposed to amend §§ 412.63, 412.73, and 412.75 to incorporate the amendment made by section 406 of Public Law 106–113.

We received several public comments on our proposal.

Comment: Several commenters discussed the difference between the language in the statutory provision, which limits the updated 1996-rebasing option to SCHs that were paid on the basis of their target amount (hospital specific rate) in 1999, and the language of the accompanying Conference report (H.R. Conf. Rep. No. 106–479, 106th Cong., 1st Sess. at 890 (1999)). The Conference report indicated that the House bill (H.R. 3075) would have permitted SCHs that were being paid the Federal rate to rebase rather than SCHs that were paid on the basis of either their FY 1982 or FY 1987 target amount. One commenter, in particular, believed that despite the clear statutory language, HCFA had the ability to allow leeway in determining which hospitals were eligible to elect 1996 rebasing. In support of this view, the commenter made the assertion that the Federal rate used in SCH payment computations included outlier and disproportionate share payments (DSH) as well as other special provisions. Therefore, the hospital-specific rate should be compared to the base Federal rate of the geographic area, without the add-ons, to determine which amount would yield the largest payment. Additionally, the total Federal payments on the hospital's cost report may exceed the hospital-specific payments in some years, while falling below them in other years because of the potential fluctuations of outliers and DSH payments. The commenter argued, therefore, that to determine whether an SCH is to be paid on the basis of the target amount, hospital-specific payments should be compared to the base Federal payments without the addition of outliers and DSH payments.

Response: We disagree with the commenter's argument. The commenter is correct in saying that in any one year, the target amount may be exceeded by calculations of the Federal rate. This is the reason why the calculation is done yearly, so that the hospital may receive the highest possible payment for that specific year based on a comparison of what each payment scheme would generate for the hospital. The statute clearly states the rebasing option is available to an SCH that, for its cost reporting period beginning on or after October 1, 2000, is paid on the basis of the target amount. As we stated in the proposed rule, we are aware of the difference between this rebasing plan set forth in section 405 of Public Law 106–113 and the one described in the Conference Report, but the unambiguous language of the statute controls over the language of the Conference Report.

Comment: One commenter pointed to an inconsistency between the text of proposed § 412.77 and the preamble to the proposed rule. The preamble stated that, in the absence of notification to the contrary from the hospital, the intermediary will base payment on the 1996 hospital specific rate, if this rate exceeds the 1982 or 1987 hospital-specific rate. The proposed regulation language at § 412.77(a) indicated that, in the absence of notification, the hospital payment would be based on the 1996 hospital specific rate without the qualification that this rate would need to exceed the 1982 or 1987 base year rates.

Response: We believe that the commenter's concern about inconsistency may stem from a typographical error that appeared in the text of proposed § 412.77 in the proposed rule, that incorrectly referenced § 412.72, rather than revised § 412.92. The payment determination formula used for SCHs is set forth in § 412.92(d), which has been revised to include the 1996 rebasing option. That formula clearly states that an SCH is paid based on whichever yields the greatest aggregate payment for the cost reporting period: the Federal payment rate, the 1982 or 1987 hospital-specific rate, or the 1996 hospital-specific rate. We have deleted the incorrect reference to § 412.72. In addition, for the sake of clarity, we have added a sentence to § 412.77(a)(1), further modified § 412.92(d)(1), and added a new § 412.92(d)(2) (the existing paragraph (d)(2) is redesignated as paragraph (d)(3)).

Comment: One commenter disagreed with the proposal that the intermediary should include the 1996 hospital specific rate in its payment calculations it if it is higher than either the 1982 or 1987 hospital specific rates, in the absence of notification to the contrary. Rather, the commenter suggested that an eligible hospital be required to state its choice to be paid on this basis.

Response: We believe that it is more efficient from an administrative standpoint to require a hospital to notify its fiscal intermediary if it chooses not to receive payment based on the (higher) FY 1996 hospital-specific rate. The only time that a hospital that is eligible for rebasing will be paid based on its 1996 amount is if that amount is higher than either the 1982 or 1987 hospital specific rates and also higher than the Federal rate. We do not know why a hospital would elect not to receive payment based on the highest of its possible choices. Therefore, rather than requiring a hospital to provide written notification to the fiscal intermediary when its FY 1996 hospital-specific rate is higher than its FY 1982 and FY 1987 hospital-specific rates, we deem the hospital to have made an election to be paid based on the FY 1996 hospital-specific rate, unless it notifies its fiscal intermediary otherwise.

Comment: Two commenters requested a clarification as to the proposed timing for a hospital that is eligible for payment based on its 1996 hospital-specific rate to notify its intermediary of its intention not to elect payment based on this rate.

Response: We agree that in the proposed rule the preamble and the proposed regulation language were contradictory. Accordingly, we are revising § 412.77(a)(2) to require that an eligible hospital must notify its intermediary of its intent not to elect payment based on its FY 1996 hospital-specific rate prior to the end of the cost reporting period for which the payments would otherwise be made. This schedule will allow hospitals an opportunity to consider their options.

C. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center (RRC). For discharges occurring before October 1, 1994, RRCs received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts were the same for discharges beginning with that date, RRCs would continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

As discussed in 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as an RRC for FY 1991 is to be classified as an RRC for FY 1998 and later years so long as that hospital continued to be located in a rural area and did not voluntarily terminate its RRC status. Otherwise, a hospital seeking RRC status must satisfy applicable criteria. One of the criteria under which a hospital may qualify as an RRC is to have 275 or more beds available for use. A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (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 referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as an RRC 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 per year, or if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we use to determine the national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value for FY 2001 in the May 5 proposed rule included all urban hospitals nationwide, and the 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 were based on discharges occurring during FY 1999 (October 1, 1998 through September 30, 1999) and include bills posted to HCFA's records through March 2000.

We proposed that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2000, must have a case-mix index value for FY 1999 that is at least—

- 1.3408; or
- 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 May 5, 2000 proposed rule at 65 FR 26306.)

Based on the latest data available (FY 1999 bills received through March 31, 2000), 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)	1.2289
2. Middle Atlantic (PA, NJ, NY)	1.2385
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3113
4. East North Central (IL, IN, MI, OH, WI)	1.2623
5. East South Central (AL, KY, MS, TN)	1.2661
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1822
7. West South Central (AR, LA, OK, TX)	1.2813
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3250
9. Pacific (AK, CA, HI, OR, WA)	1.3036

For the benefit of hospitals seeking to qualify as RRCs or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1999 case-mix index value in Table 3C in section VI. of the Addendum to this final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, in the May 5 proposed rule, we proposed to update the regional standards. The proposed regional standards were based on discharges for urban hospitals' cost reporting periods that began during FY 1998 (that is, October 1, 1997 through September 30, 1998). That is the latest year for which we have complete discharge data available.

Therefore, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2000, must have as the number of discharges for its cost reporting period that began during FY 1999 a figure that is at least—

- 5,000; or
- 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 May 5, 2000 proposed rule at 65 FR 26307.)

Based on the latest discharge data available for FY 1999, the final median number of discharges for urban hospitals by census region areas are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,725
2. Middle Atlantic (PA, NJ, NY)	8,736
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,911
4. East North Central (IL, IN, MI, OH, WI)	7,661
5. East South Central (AL, KY, MS, TN)	6,883
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,829
7. West South Central (AR, LA, OK, TX)	5,385
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,026
9. Pacific (AK, CA, HI, OR, WA)	6,268

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that an osteopathic hospital, if it is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2000, must have at least 3,000 discharges for its cost reporting period that began during FY 1999.

We did not receive any comments on the RRC criteria.

D. Indirect Medical Education (IME) Adjustment(§ 412.105)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

Section 111 of Public Law 106–113 modified the transition for the IME adjustment that was established by Public Law 105–33. We are publishing these changes in a separate interim final rule with comment period that appears elsewhere in this issue of the **Federal Register**. However, for discharges occurring during FY 2001, the adjustment formula equation used to calculate the IME adjustment factor is $1.54 \times [(1+r)^{.405} - 1]$. (The variable r represents the hospital's resident-to-bed ratio.)

In the proposed rule, we inadvertently omitted the revised transition for the IME adjustment for FYs 2002 and thereafter. Specifically, for discharges occurring on or after October 1, 2001, the adjustment formula equation used to calculate the IME adjustment factor is $1.35 \times [(1+r)^{.405} - 1]$. We are adding a new § 412.105(d)(3)(vi) to reflect this change.

In the July 30, 1999 final rule (64 FR 41517), we set forth certain policies that affected payment for both direct and indirect GME. These policies related to adjustments to full-time equivalent (FTE) resident caps for new medical residency programs affecting both direct and indirect GME programs; the adjustment to GME caps for certain hospitals under construction prior to August 5, 1997 (the enactment date of Public Law 105–33) to account for residents in new medical residency training programs; and the temporary adjustment to FTE caps to reflect residents affected by hospital closures. When we amended the regulations under § 413.86 for direct GME, we inadvertently did not make the corresponding changes in § 412.105 for IME. In the May 5 proposed rule, we proposed to make the following conforming changes:

- To amend § 412.105(f)(1)(vii) to provide for an adjustment to the FTE caps for new medical residency programs as specified under § 413.86(g)(6).
- To add a new § 412.105(f)(1)(viii) related to the adjustment to the FTE caps for newly constructed hospitals that sponsor new residency programs in effect on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, to conform to the provisions of § 413.86(g)(7).
- To add a new § 412.105(f)(1)(ix) to specify that a hospital may receive a

temporary adjustment to its FTE cap to take into account residents added because of another hospital's closure if the hospital meets the criteria listed under § 413.86(g)(8).

In addition, we proposed to add a cross-reference to ''§ 413.86(d)(3)(i) through (v)'' in § 412.105(g), and to correct the applicable period in both §§ 412.105(g) and 413.86(d)(3) by revising the phrase ''For portions of cost reporting periods beginning on or after January 1, 1998'' to read ''For portions of cost reporting periods occurring on or after January 1, 1998''.

We received one public comment on the proposed changes to the IME regulations.

Comment: One commenter recommended that the temporary adjustment allowed to a hospital's FTE cap under the proposed § 412.105(f)(1)(ix) to account for residents added because of another hospital's closure should be a permanent adjustment to maintain the current level of trainees.

Response: In the proposed rule, we were merely making a conforming change to the IME regulations based on a change in the GME regulations in the July 30, 1999 final rule. As indicated in the July 30, 1999 final rule (65 FR 41522), we continue to believe that, when a hospital assumes the training of additional residents because of another hospital's closure, an adjustment to the hospital's FTE cap should only be available for the period of time necessary to train those displaced residents. At that time we provided for the temporary adjustment because of hospitals' reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. We do not believe currently there is justification for a permanent adjustment because of the temporary training provisions for the displaced residents.

E. Payments to DSH Hospitals (§ 412.106)

1. Changes to the DSH Formula

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients (as defined in section 1886(d)(5)(F) of the Act) receive additional payments through the DSH adjustment. Section 4403(a) of Public Law 105–33 amended section 1886(d)(5)(F) of the Act to reduce the payment a hospital would otherwise receive under the current DSH 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 2002, and 0 percent for FY 2003 and each subsequent fiscal year. Subsequently, section 112 of Public Law 106–113 modified the amount of the reductions under Public Law 105–33 by changing the reduction to 3 percent for FY 2001 and 4 percent for FY 2002. The reduction continues to be 0 percent for FY 2003 and each subsequent fiscal year. In the May 5 proposed rule, we proposed to revise § 412.106(e) to reflect the changes in the statute made by Public Law 106–113.

Section 112 of Public Law 106–113 also directs the Secretary to require prospective payment system hospitals to submit data on the costs incurred by the hospitals for providing inpatient and outpatient hospital services for which the hospitals are not compensated, including non-Medicare bad debt, charity care, and charges for medical and indigent care to the Secretary as part of hospitals' cost reports. These data are required for cost reporting periods beginning on or after October 1, 2001. We will be revising our instructions to hospitals for cost reports for FY 2002 to capture these data.

Comment: Several commenters provided positive reinforcement concerning the impending collection of uncompensated care data via offers of assistance in this effort. Also, commenters made the point that, at this time, uncompensated care does not have a common national definition.

Response: We are aware that uncompensated care does not currently have a common national definition. One of our tasks will be to define the reporting parameters so that the data will be reported in a uniform manner. This is the main reason that we have not sought to use uncompensated care data in the Medicare DSH adjustment calculation in the past. We will keep these comments in mind as we proceed.

Comment: One commenter was concerned about the pending publication of the Report to Congress on the Medicare DSH formula. This commenter asked HCFA to complement its data collection efforts by issuing the report as required by Public Law 105–33.

Response: We are in the process of completing this report and intend to submit it to Congress in the near future.

2. DSH Adjustment Calculation: Change in the Treatment of Certain Medicaid Patient Days in States With Section 1115 Expansion Waivers

On January 20, 2000, we published in the **Federal Register** an interim final rule with comment period (65 FR 3136) to implement a change in the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. That interim final rule set forth criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system.

Under section 1886(d)(5)(F) of the Act, an adjustment is made to the hospital's inpatient prospective payment system payment for serving a disproportionate share of low-income or Medicaid and Medicare patients. The size of a hospital's Medicare DSH adjustment is based on the sum of the percentage of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI) and the percentage of patient days attributable to patients eligible for Medicaid but not Medicare Part A.

Some States provide medical assistance (Medicaid) under a demonstration project (also referred to as a section 1115 waiver).

Under policy in existence before the January 20, 2000 interim final rule, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

In the January 20, 2000 interim final rule with comment period, we revised the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment. This policy was reflected in a revision to § 412.106 of the regulations.

We received 11 public comments on the inclusion of Section 1115 waiver days in the Medicare disproportionate share adjustment calculation.

Comment: Several commenters were concerned with the inclusion in the January 20, 2000 interim final rule with comment period of expansion waiver days in the Medicaid portion of the Medicare DSH adjustment calculation. States without a Medicaid expansion waiver in place believed that States that did have a Medicaid expansion waiver in place received an unfair advantage. In addition, comments from Pennsylvania hospitals supported the continued inclusion of general assistance days in the Medicaid portion of the Medicare DSH adjustment calculation as well as expansion waiver days. Finally, some commenters urged HCFA to revise the

Medicare DSH adjustment calculation to include charity care days.

Response: While we initially determined that States under a Medicaid expansion waiver could not include those expansion waiver days as part of the Medicare DSH adjustment calculation, we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver days are utilized by patients whose care is considered to be an approved expenditure under Title XIX. While this does advantage States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.

Some States operate under a section 1115 waiver without an expansion (for example, Arizona). The days that are utilized by patients under the section 1115 waiver are already part of the Medicaid portion of the Medicare DSH adjustment calculation because the section 1115 waiver includes patients who otherwise would have been eligible for Medicaid Title XIX.

General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid-eligible under the State plan and are not considered Title XIX beneficiaries. Therefore, Pennsylvania, and other States that have erroneously included these days in the Medicare disproportionate share adjustment calculation in the past, will be precluded from including such days in the future. We would like to point out that these States were held harmless from adverse action in this matter for any cost reporting period beginning prior to December 31, 1999. We are in the process of preparing a Report to Congress on the Medicare DSH adjustment calculation which presents various options for calculating the adjustment.

Comment: One commenter was concerned about the inclusion of days in the Medicaid portion of the Medicare DSH adjustment calculation for additional States that are approved for expansion waivers in the future. Also, this commenter questioned whether or not the expenditures related to the expansion waiver days for Medicare DSH would be considered in the budget neutrality evaluation prior to approval of the expansion waiver application.

Response: As stated in the January 20, 2000 interim final rule with comment period, days utilized under section 1115 expansion waivers will be included in the Medicaid portion of the Medicare DSH adjustment calculation. As a result, the days utilized under any approved section 1115 expansion waiver in the future would be included in this calculation. However, the State will not be held accountable for the expenditures associated with Medicare DSH in the budget neutrality test for the section 1115 expansion waiver, as those payments are made from the Medicare program, not the Medicaid program.

Comment: Several commenters were concerned that the inclusion of section 1115 expansion waiver days was effective on January 20, 2000, rather than on January 1, 2000. These same commenters pointed out that the hold harmless provisions of Program Memorandum A–99–62 (December 1999) concern hospitals whose cost reporting periods begin on or prior to December 31, 1999. Therefore, many hospitals may be paid differently during different periods of the same cost report.

Response: We understand that discharges prior to January 20, 2000 will be handled one way, and discharges as of January 20, 2000 may be paid differently. While we can enforce an existing policy for a previous time period, we do not believe we can retroactively institute new policy.

F. Medicare Geographic Classification Review Board (§§ 412.256 and 412.276)

With the creation of the Medicare Geographic Classification Review Board (MGCRB), beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in Subpart L of Part 412 (§ 412.230 *et seq.*) set forth criteria and conditions for redesignations from rural to urban, rural to rural, or from an urban area to another urban area with special rules for SCHs and RRCs.

1. Provisions of Public Law 106–113

Section 401 of Public Law 106–113 amended section 1886(d)(8) of the Act by adding subparagraph (E), which creates a mechanism, separate and apart from the MGCRB, permitting an urban hospital to apply to the Secretary to be treated as being located in the rural area of the State in which the hospital is located. The statute directs the Secretary to treat a qualifying hospital as being located in a rural area for purposes of provisions under section 1886(d) of the Act. In addition, section 401 of Public Law 106–113 went on to provide for such reclassifications from urban to rural for purposes of Medicare payments to outpatient departments and to hospitals that would qualify to become critical access hospitals.

Regulations implementing section 1886(d)(8)(E) of the Act are included in an interim final rule with comment period implementing certain provisions of Public Law 106–111 published elsewhere in this issue of the **Federal Register**. The statutory language of section 1886(d)(8)(E) of the Act does not address the issue of interactions between changes in classification under section 1886(d)(8)(E) of the Act and the MGCRB reclassification process under section 1886(d)(10) of the Act. The Secretary has extremely broad authority under section 1886(d)(10) of the Act to establish criteria for reclassification under the MGCRB process. Section 401 of Public Law 106–113 does not amend section 1886(d)(10) of the Act to limit the agency's discretion under the provision in any way, nor does section 1886(d)(8)(E) of the Act (as added by section 401) refer to section 1886(d)(10) of the Act. However, we note that in the Conference Report accompanying Public Law 106–113, the language discussing the House bill (H.R. 3075, as passed) indicates that: ''[H]ospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the Medicare Geographic Reclassification Review Board for geographic reclassification to another area''.

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. That is, we were concerned that

some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

We received seven public comments on the interaction of urban to rural reclassification under section 1886(d)(8)(E) and reclassification under the MGCRB. Several additional comments were received regarding specific aspects of implementation of section 1886(d)(8)(E) of the Act (added by section 401 of Public Law 106–113). These issues are addressed in the interim final rule with comment period, published elsewhere in this issue of the **Federal Register**, that implements certain provisions of Public Law 106–113.

Comment: Several of our commenters urged HCFA to place no restrictions on access to MGCRB reclassification for urban hospitals that have elected to reclassify to rural under section 1886(d)(8)(E) of the Act, citing the Conference Report as evidence of the Congressional intent in enacting this provision. These commenters argued that these now-rural hospitals should receive the same treatment as geographically rural hospitals, noting that current Medicare policy permits geographically rural hospitals to reclassify, under the MGCRB, to urban areas for their wage index or standard payment amounts, or both. This means that geographically rural hospitals can take advantage of both rural as well as urban payment amounts. This same option, these commenters asserted, should be available to urban hospitals that petition for reclassification under section 1886(d)(8)(E).

Response: Under section 1886(d)(8)(E) of the Act, as added by section 401 of the Public Law 106–113, a hospital located in an urban area may file an application to be treated as being located in a rural area for purposes of payment under section 1886(d) of the Act. The issue here is whether a hospital that has been reclassified from an urban area to a rural area under section 1886(d)(8)(E) of the Act should be permitted to subsequently be reclassified under the MGCRB process from the rural area to another area. As discussed below, we believe that, for purposes of the MGCRB process, it is appropriate to distinguish between hospitals that are reclassified as rural under section 1886(d)(8)(E) of the Act and hospitals that are geographically rural. However, in light of our understanding of the intent underlying the language in the Conference Report for Public Law 106–113, we are revising a policy relating to RRCs so that certain urban hospitals that are not RRCs under current policy will be granted RRC status and can receive special treatment under the MGCRB process.

Section 1886(d)(8)(E) of the Act, as added by section 401 of Public Law 106–113, provides that, for purposes of section 1886(d) of the Act, if a hospital files an application and meets applicable criteria, the Secretary ''shall treat the hospital as being located in the rural area * * * of the State in which the hospital is located.'' As discussed above and in the proposed rule, a description of the House bill in the Conference Report for Public Law 106–113 indicates that hospitals reclassified as rural under section 1886(d)(8)(E) of the Act would be ''eligible to apply'' to the MGCRB for reclassification under the MGCRB process. Significantly, however, the terms of section 1886(d)(8)(E) of the Act do not refer to section 1886(d)(10) of the Act (which addresses the MGCRB reclassification process), and section 401 of Public Law 106–113 did not amend section 1886(d)(10) of the Act to limit the agency's discretion under that provision in any way. Put another way, section 1886(d)(8)(E) of the Act does not contain any language indicating that hospitals treated as rural under that provision can subsequently be treated as urban under section 1886(d)(10) of the Act, and section 1886(d)(10) does not contain language indicating that the Secretary must permit reclassification to an urban area of hospitals treated as rural under section 1886(d)(8)(E) of the Act. Thus, under the statute, the Secretary has broad discretion to determine when MGCRB reclassification is appropriate and, in enacting section 401 of Public Law 106–113, Congress did not enact any statutory amendments to limit that discretion in any way.

The statutory language of section 1886(d)(8)(E) of the Act directs the Secretary to treat qualifying hospitals, for purposes of section 1886(d) of the Act, ''as being located in the rural area * * * of the State in which the hospital is located''. Section 1886(d) of the Act encompasses the hospital wage index and the standardized amount. Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME,

which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

In addition, one of the criteria under section 1886(d)(8)(E) of the Act is that the hospital would qualify as an SCH or an RRC if it were located in a rural area. An SCH would be eligible to be paid on the basis of the higher of its hospital-specific rate or the Federal rate. On the other hand, the only benefit under section 1886(d) of the Act for an urban hospital to become an RRC would be waiver of the proximity requirements that are otherwise applicable under the MGCRB process, as set forth in § 412.230(a)(3).

We agree with the commenters that Congress contemplated that hospitals might seek to be reclassified as rural under section 1886(d)(E) of the Act in order to become RRCs so that the hospital would be exempt from the MGCRB proximity requirement and could be reclassified by the MGCRB to another urban area. -

Therefore, we sought a policy approach that would appropriately account for our concern that these urban to rural redesignations not be utilized inappropriately, but would benefit hospitals seeking to reclassify under the MGCRB process by achieving RRC status. We decided to reconsider our application of section 4202(b) of Public Law 105–33, which states, in part, ''Any hospital classified as a rural referral center by the Secretary * * * for FY 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.'' In the August 29, 1997 final rule with comment period, we reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban (62 FR 45999). Our rationale at that time for not reinstating RRC status for these hospitals was that a hospital had to be rural in order to qualify for reinstatement as an RRC, and these hospitals were no longer located in rural areas.

We are aware of several specific hospitals that were RRCs for FY 1991, but subsequently lost their status when the county in which they were located became urban, and have expressed their wish to be redesignated as an RRC in order to be eligible to reclassify. We believe that the language in the Conference Report accompanying Public Law 106–113 was intended to address these hospitals; that is, we believe that the intent underlying this language (a description of the House bill) was to allow certain urban hospitals to become RRCs (upon reclassifying from urban to rural under section 1886(d)(8)(E) of the Act) and then reclassify under the MGCRB process (as RRCs, the hospitals would be exempt from the MGCRB's proximity requirements). Accordingly, in light of section 1886(d)(8)(E) of the Act and the language in the Conference Report, we have decided to revisit our policy decision on section 4202(b) of Public Law 105–33. Effective as of October 1, 2000, hospitals located in what is now an urban area, if they were ever an RRC, will be reinstated to RRC status under section 4202(b) of Public Law 105–33. (In the August 27, 1997 final rule, we indicated that we recognized there were hospitals that qualified for RRC status after 1991 that lost their status in a subsequent year due to MGCRB reclassification. Therefore, we determined that we would permit any hospital that qualified as an RRC at any point that had lost its RRC status as a result of MGCRB reclassification to be reinstated, regardless of whether it was designated an RRC in 1991. Similarly, for purposes of this policy, we will permit hospitals that previously qualified as an RRC and that lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as an RRC.) Such hospitals would benefit from the waiver of the MGCRB's proximity requirements, as long as they are designated as RRCs at the time the MGCRB acts on their application.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

Comment: Several commenters suggested alternative policy options regarding the interaction of the distinct reclassification provisions found under sections 1886(d)(8)(E) and 1886(d)(10) of the Act. First, it was recommended that HCFA formulate a policy that would allow urban hospitals reclassifying to rural under section 1886(d)(8)(E) of the Act the same access to urban reclassification under the MGCRB process that the law makes available to geographically rural hospitals. One commenter posits two possible limitations on MGCRB reclassifications for these now-rural hospitals. One possibility is that an urban hospital that reclassifies to rural under section 1886(d)(8)(E) of the Act be permitted to reclassify only to another MSA, but be precluded from reclassifying back to the MSA in which it is situated. Second, the commenter suggested that reclassifications under the MGCRB process be restricted solely to the wage index for formerly urban hospitals that have elected to reclassify to rural under section 1886(d)(8)(E) of the Act.

Response: Although the alternatives suggested by the commenters would limit to some degree the possible inappropriate incentives for hospitals to become rural under section 1886(d)(8)(E) of the Act, we are concerned that they would still allow these hospitals to receive inappropriate payments, albeit on a more limited basis. Therefore, we have not selected these alternative approaches.

Comment: One health system argued that preventing an urban hospital that has reclassified to rural under section 1886(d)(8)(E) of the Act from reclassifying through restricting the MGCRB process would reduce the number of hospitals reclassifying as rural under section 1886(d)(8)(E) of the Act. The commenter further noted that even if we permitted an urban hospital that reclassified to a rural area under section 1886(d)(8)(E) of the Act to reclassify through the MGCRB process, the hospital would suffer financial losses during the period between when it was rural for all payment purposes and its reclassification back to urban.

Response: We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.

2. Revised Thresholds Applicable to Rural Hospitals for Wage Index Reclassifications

Existing §§ 412.230(e)(1)(iii) and (e)(1)(iv) provide that hospitals may obtain reclassification to another area for purposes of calculating and applying

the wage index if the hospital's average hourly wages are at least 108 percent of the average hourly wages in the area where it is physically located, and at least 84 percent of the average hourly wages in a proximate area to which the hospital seeks reclassification. These thresholds apply equally to urban and rural hospitals seeking reclassification.

Historically, the financial performance of rural hospitals under the prospective payment system has lagged behind that of urban hospitals. Despite an overall increase in recent years of Medicare inpatient operating profit margins, some rural hospitals continue to struggle financially (as measured by Medicare inpatient operating prospective payment system payments minus costs, divided by payments). For example, during FY 1997, while the national average hospital margin was 15.1 percent, it was 8.9 percent for rural hospitals. In addition, approximately one-third of rural hospitals continue to experience negative Medicare inpatient margins despite this relatively high average margin.

In response to the lower margins of rural hospitals and the potential for a negative impact on beneficiaries' access to care if these hospitals were to close, we considered potential administrative changes that could help improve payments for rural hospitals. One approach in that regard would be to make it easier for rural hospitals to reclassify for purposes of receiving a higher wage index. The current thresholds for applying for wage index reclassification are based on our previous analysis showing the average hospital wage as a percentage of its area wage was 96 percent, and one standard deviation from that average was equal to 12 percentage points (see the June 4, 1992 proposed rule (57 FR 23635) and the September 1, 1992 final rule (57 FR 39770)). Because rural hospitals' financial performance has consistently remained below that of urban hospitals, we now believe that rural hospitals merit special dispensation with respect to qualifying for reclassification for purposes of the wage index. Therefore, we proposed to change those average wage threshold percentages so more rural hospitals can be reclassified. Specifically, we proposed to lower the upper threshold for rural hospitals to 106 percent and the lower threshold to 82 percent. The thresholds for urban hospitals seeking reclassification for purposes of the wage index would be unchanged. We note that rural hospitals comprised nearly 90 percent of FY 2000 wage index reclassifications. Under the proposal, beginning October 1, 2000, rural hospitals would be able to reclassify for the wage index if, among other things, their average hourly wages are at least 106 percent of the area in which they are physically located, and at least 82 percent of the average hourly wages in the proximate area to which it seeks reclassification.

Although it is difficult to estimate precisely how many additional hospitals might qualify by lowering the thresholds because we do not have data indicating which hospitals meet all of the other reclassification criteria (e.g., proximity), our analysis indicated that, if we were to raise the 108 percent threshold to 109 percent, approximately 20 rural hospitals would no longer qualify. If the upper threshold were to be raised to 110 percent, another 16 hospitals would not qualify. On the other hand, increasing the lower threshold from 84 percent to 85 percent would result in only 2 rural hospitals becoming ineligible to reclassify. Only 1 additional hospital would be affected by raising the threshold to 86 percent. Based on this analysis, we anticipated approximately 50 rural hospitals are likely to benefit from the proposed change.

We believe this proposal, as adopted, achieves an appropriate balance between allowing certain hospitals that are currently just below the thresholds to become eligible for reclassification, while not liberalizing the criteria so much that an excessive number of hospitals begin to reclassify. Because these reclassifications are budget neutral, nonreclassified hospitals' payments are negatively impacted by reclassification.

We believe there are many factors associated with lower margins among rural hospitals. We note that section 410 of Public Law 106–113 requires the Comptroller General of the United States to ''conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices.'' In addition, section 411 of Public Law 106–113 requires MedPAC to conduct a study on the adequacy and appropriateness of the special payment categories and methodologies established for rural hospitals. We anticipate that the results of these studies will help identify other areas to help improve payments for rural hospitals, either through reclassifications or other means.

Comment: Commenters were unclear about the effective date for the change in wage index thresholds for rural hospitals applying for reclassification.

Response: The revised thresholds apply to applications submitted to the MGCRB (by September 1, 2000) for reclassification for FY 2002. These revised guidelines do not apply to decisions that have already been issued by the MGCRB for FY 2001.

G. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based on the number of residents trained by the hospital. Section 1886(h) of the Act, as amended by section 4623 of Public Law 105–33, caps the number of residents that hospitals may count for direct GME.

Section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) established a methodology for determining payments to hospitals for the costs of approved GME programs at section 1886(h)(2) of the Act. Section 1886(h)(2) of the Act, as implemented in regulations at § 413.86(e), sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not adjusted for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care/obstetrics and gynecology residents and non-primary care residents have two separate PRAs for FY 1994 and, thereafter, one for primary care and one for non-primary care. (Thus, for purposes of this proposed rule, when we refer to a hospital's PRA, this amount is inclusive of any CPI–U adjustments the hospital may have received since the hospital's base-year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/non-

primary care residents, as specified under existing § 413.86(e)(3)(ii)).

2. Use of National Average Per Resident Amount Methodology in Computing Direct GME Payments

Section 311 of Public Law 106–113 amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. Generally, section 311 establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be revised. Accordingly, in the May 5, 2000 proposed rule, we proposed to implement section 311 by setting forth the prescribed methodology for calculation of the weighted average PRA. We then discussed the proposed steps for determining whether a hospital's PRA will be adjusted based upon the proposed calculated weighted average PRA, in accordance with the methodology specified under section 311 of Public Law 106–113.

We proposed to calculate the weighted average PRA based upon data from hospitals' cost reporting periods ending during FY 1997 (October 1, 1996 through September 30, 1997), as directed by section 311 of Public Law 106–113. We accessed these FY 1997 cost reporting data from the Hospital Cost Report Information System (HCRIS) and also obtained the necessary data for those hospitals that are not included in HCRIS (because they file manual cost reports), from those hospitals' fiscal intermediaries. If a hospital had more than one cost reporting period ending in FY 1997, we proposed to include all of its cost reports ending in FY 1997 in our calculations. However, if a hospital did not have a cost reporting period ending in FY 1997, such as a hospital with a long cost reporting period beginning in FY 1996 and ending in FY 1998, the hospital is excluded from our calculations.

We have slightly revised the weighted average PRA in this final rule because of changes in the data that have come to our attention since the publication of the proposed rule. In the proposed rule, one hospital was excluded from our calculations because it was a new teaching hospital with no established PRA (the first year of training for a new teaching hospital is paid for by Medicare on a cost basis; a PRA is applied in calculating a hospital's payment beginning with the hospital's second year of residency training) even though it did have a cost reporting period ending during FY 1997. In the weighted average calculation in this final rule, we have excluded one more hospital because we learned that this hospital was also a new teaching hospital in FY 1997 with no established PRA. We also have added one hospital to the weighted average calculation because it was inadvertently excluded in the calculation in the proposed rule. In addition, we found that the data of two hospitals that were used in the weighted average calculation in the proposed rule were incorrect, and we have made the corrections for the weighted average calculation in this final rule. The total number of hospitals that we include in our calculation is unchanged from the proposed rule and remains at 1,235. Thirty-five of these hospitals are hospitals with more than one cost report.

In accordance with section 311 of Public Law 106–113, we proposed to calculate the weighted average PRA in the following manner:

Step 1: We determine each hospital's single PRA by adding each hospital's primary care and non-primary care PRAs, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

Step 2: We standardize each hospital's single PRA by dividing it by the 1999 geographic adjustment factor (GAF) (which is an average of the three geographic index values (weighted by the national average weight for the work component, practice expense component, and malpractice component)) in accordance with section 1848(e) of the Act and 42 CFR 414.26 (which is used to adjust physician payments for the different wage areas), for the physician fee schedule area in which the hospital is located.

Step 3: We add all the standardized hospital PRAs (as calculated in Step 2), each weighted by hospitals' respective FTEs, and then divide by the total number of FTEs.

Based upon this three-step calculation, we determined the weighted average PRA (for cost reporting periods ending during FY 1997) to be $68,464. (The weighted average PRA calculated for the proposed rule was $68,487.)

For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), the national average PRA is applied using the following three steps:

Step 1: Update the weighted average PRA for inflation. Under section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, the weighted average PRA is updated by the estimated percentage increase in the consumer price index for all urban consumers (CPI–U) during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001. Therefore, the weighted average standardized PRA ($68,464) would be updated by the increase in CPI–U for the period beginning with the midpoint of all cost reporting periods for hospitals with cost reporting periods ending during FY 1997 (October 1, 1996), and ending with the midpoint of the individual hospital's cost reporting period that begins during FY 2001.

For example, Hospital A has a calendar year cost reporting period. Thus, for Hospital A, the weighted average PRA is updated from October 1, 1996 to July 1, 2001, because July 1 is the midpoint of its cost reporting period beginning on or after October 1, 2000. Or, for example, if Hospital B has a cost reporting period starting October 1, the weighted average PRA is updated from October 1, 1996 to April 1, 2001, the midpoint of the cost reporting period for Hospital B. Therefore, the starting point for updating the weighted average PRA is the same date for all hospitals (October 1, 1996), but the ending date is different because it is dependent upon the cost reporting period for each hospital.

Step 2: Adjust for locality. In accordance with section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, once the weighted average PRA is updated according to each hospital's cost reporting period, the updated weighted average PRA (the national average PRA) is further adjusted to calculate a locality-adjusted national average PRA for each hospital. This is done by multiplying the updated national average PRA by the 1999 GAF (as specified in the October 31, 1997 **Federal Register** (62 FR 59257)) for the fee schedule area in which the hospital is located.

Step 3: Determine possible revisions to the PRA. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, the locality-adjusted national average PRA, as calculated in Step 2, is then compared to the hospital's individual PRA. Based upon the provisions of section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, a hospital's PRA is revised, if appropriate, according to the following:

• *Floor*—For cost reporting periods beginning in FY 2001, to determine which PRAs (primary care and non-primary care separately) are below the 70 percent floor, a hospital's locality-adjusted national average PRA is multiplied by 70 percent. This resulting number is then compared to the hospital's PRA that is updated for inflation to the current cost reporting period. If the hospital's PRA would be less than 70 percent of the locality-adjusted national average PRA, the individual PRA is replaced by 70 percent of the locality-adjusted national average PRA for that cost reporting period and would be updated for inflation in future years by the CPI–U.

We noted that there may be some hospitals with primary care and non-primary care PRAs where both PRAs are replaced by 70 percent of the locality-adjusted national average PRA. In these situations, the hospital would receive identical PRAs; no distinction in PRAs would be made for differences in inflation (because a hospital has both primary care and non-primary care PRAs, each of which is updated as described in § 413.86(e)(3)(ii)) as of cost reporting periods beginning on or after October 1, 2000.

For example, if the FY 2001 locality-adjusted national average PRA for Area X is $100,000, then 70 percent of that amount is $70,000. If, in Area X, Hospital A has a primary care FY 2001 PRA of $69,000 and a non-primary care FY 2001 PRA of $67,000, both of Hospital A's FY 2001 PRAs are replaced by the $70,000 floor. Thus, $70,000 is the amount that would be used to determine Hospital A's direct GME payments for both primary care and non-primary care FTEs in its cost reporting period beginning in FY 2001, and the $70,000 PRA would be updated for inflation by the CPI–U in subsequent years.

• *Ceiling*—For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), a ceiling that is equal to 140 percent of each locality-adjusted national average PRA is calculated and compared to each individual hospital's PRA. If the hospital's PRA is greater than 140 percent of the locality-adjusted national average PRA, the PRA would be adjusted depending on the fiscal year as follows:

a. FY 2001. For cost reporting periods beginning in FY 2001, each hospital's PRA from the preceding cost reporting period (that is, the PRA with which its direct GME payments were made in FY 2000) is compared to the FY 2001 locality-adjusted national average PRA. If the individual hospital's FY 2000 PRA exceeds 140 percent of the FY 2001 locality-adjusted national average PRA, the PRA is frozen at the FY 2000 PRA, and is not updated in FY 2001 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

For example, if the FY 2001 locality-adjusted national average PRA ''ceiling'' for Area Y is $140,000 (that is, 140 percent of $100,000, the hypothetical locality-adjusted national average PRA), and if, in this area, Hospital B has a FY 2000 PRA of $140,001, then for FY 2001, Hospital B's PRA is frozen at $140,001 and is not updated by the CPI–U for FY 2001.

b. FY 2002. For cost reporting periods beginning in FY 2002, the methodology used to calculate each hospital's individual PRA would be the same as described in section IV.G.2.a. above for FY 2001. Each hospital's PRA from the preceding cost reporting period (that is, the PRA with which its direct GME payments were made in FY 2001) is compared to the FY 2002 locality-adjusted national average PRA. If the individual hospital's FY 2001 PRA exceeds 140 percent of the FY 2002 locality-adjusted national average PRA, the PRA is frozen at the FY 2001 PRA, and is not updated in FY 2002 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

c. FY 2003, FY 2004, and FY 2005. For cost reporting periods beginning in FY 2003, FY 2004, and FY 2005, if the hospital's PRA for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period (for example, for the cost reporting period beginning in FY 2003, compare the hospital's PRA from the FY 2002 cost reporting period to the locality-adjusted national average PRA from FY 2002), then, subject to the limitation in section IV.G.2.d. of this preamble, the hospital's PRA is updated in accordance with section 1886(h)(2)(D)(i) of the Act, except that the CPI–U applied is reduced (but not below zero) by 2 percentage points.

For example, for purposes of Hospital A's FY 2003 cost report, Hospital A's PRA for FY 2002 is compared to Hospital A's locality-adjusted national average PRA ceiling for FY 2002. If, in FY 2002, Hospital A's PRA is $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000, then for FY 2003, Hospital A's PRA is updated with the FY 2003 CPI–U minus 2 percent. If, in this scenario, the CPI–U for FY 2003 is 1.024, Hospital A would update its PRA in FY 2003 by 1.004 (the CPI–U minus 2 percentage points). However, if the CPI–U factor for FY 2003 is 1.01 and subtracting 2 percentage points of 1.01 yields 0.99, the PRA for FY 2003 would not be updated, and would remain $100,001.

We note that, while the language in section 1886(h)(2)(D)(iv)(I) and in section 1886(h)(2)(D)(iv)(II) of the Act (the sections that describe the adjustments to PRAs for hospitals that exceed 140 percent of the locality-adjusted national average PRA) is very similar, the language does differ. Section 1886(h)(2)(D)(iv)(I) of the Act states that for a cost reporting period beginning during FY 2000 or FY 2001, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and period* * * *, the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for such preceding cost reporting period.'' (Emphasis added.) Section 1886(h)(2)(D)(iv)(II) of the Act states that for a cost reporting period beginning during FY 2003, FY 2004, or FY 2005, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and preceding period,* the approved FTE resident amount for the period involved shall be updated * * *.'' (Emphasis added.) Accordingly, for FYs 2001 and 2002, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA of the current cost reporting period. For FY 2003, FY 2004, or FY 2005, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA from the previous cost reporting period.

d. General rule for hospitals that exceed the ceiling. For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA exceeds 140 percent of the locality-adjusted national average PRA and it is adjusted under any of the above criteria, the current year PRA cannot be reduced below 140 percent of the locality-adjusted national average PRA.

For example, to determine the PRA of Hospital A, in FY 2003, Hospital A had a FY 2002 PRA of $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000. For FY 2003, applying an update of the CPI–U factor minus 2 percentage points (for example, 1.024 − .02 = 1.004 would yield an updated PRA of $100,401) while the locality-adjusted national average PRA (before calculation of the ceiling) is

updated for FY 2003 with the full CPI–U factor (1.024) so that the ceiling of $100,000 is now increased to $102,400 (that is, $100,000 x 1.024 = $102,400). Therefore, applying the adjustment would result in a PRA of $100,401, which is under the ceiling of $102,400 for FY 2003. In this situation, for purposes of the FY 2003 cost report, Hospital A's PRA equals $102,400.

We note that if the hospital's PRA does not exceed 140 percent of the locality-adjusted national average PRA, the PRA is updated by the CPI–U for the respective fiscal year. If a hospital's PRA is updated by the CPI–U because it is less than 140 percent of the locality-adjusted national average PRA for a respective fiscal year, and once updated, the PRA exceeds the 140 percent ceiling for the respective fiscal year, the updated PRA would still be used to calculate the hospital's direct GME payments. Whether a hospital's PRA exceeds the ceiling is determined before the application of the update factors; if a hospital's PRA exceeds the ceiling only because of the application of the update factors, the hospital's PRA would retain the CPI–U factors.

For example, if, in FY 2001, the locality-adjusted national average PRA ceiling for Area Y is $140,000, and if, in this area, Hospital B has a FY 2000 PRA of $139,000, then for FY 2001, Hospital B's PRA is updated for inflation for FY 2001 because the PRA is below the ceiling. However, once the update factors are applied, Hospital B's PRA is now $142,000 (that is, above the $140,000 ceiling). In this scenario, Hospital B's inflated PRA would be used to calculate its direct GME payments because Hospital B has only exceeded the ceiling after the application of the inflation factors.

• *PRAs greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA is greater than or equal to 70 percent and less than or equal to 140 percent of the locality-adjusted national average PRA, the hospital's PRA is updated using the existing methodology specified in § 413.86(e)(3)(i).

For cost reporting periods beginning in FY 2006 and thereafter, a hospital's PRA for its preceding cost reporting period would be updated using the existing methodology specified in § 413.86(e)(3)(i).

We proposed to redesignate the existing § 413.86(e)(4) as § 413.86(e)(5) and add the rules implementing section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, in the vacated § 413.86(e)(4). Because we proposed to apply the methodology for updating the PRA for inflation that is described in existing § 413.86(e)(3), we also proposed to amend § 413.86(e)(3) to make those rules applicable to the cost reporting periods (FY 2001 through FY 2005) specified in the proposed § 413.86(e)(4), and in subsequent cost reporting periods.

In addition, we proposed to make a conforming change by amending proposed redesignated § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base period and establish a PRA in a cost reporting period beginning on or after October 1, 2000. We believe there are two factors to consider when a new teaching hospital establishes its PRA under proposed redesignated § 413.86(e)(5). First, for example, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean of the PRAs in the hospital's census region (as specified in § 412.62(f)(1)(i)), the hospitals' PRAs used to calculate the weighted mean values are subject to the provisions of proposed § 413.86(e)(4), the national average PRA methodology. Second, the resulting PRA established under proposed redesignated § 413.86(e)(5) also would be subject to the national average PRA methodology specified in proposed § 413.86(e)(4).

We also proposed to make a clarifying amendment to the proposed redesignated § 413.86(e)(5)(i)(B) to account for an oversight in the regulations text when we amended our regulations on August 29, 1997 (62 FR 46004). In the preamble of the August 29, 1997 final rule, in setting forth our policy on the determination of per resident amounts for hospitals that did not have residents in the 1984 GME base period, we stated that we would use a ''weighted'' average of the per resident amounts for hospitals located in the same geographic area. However, we inadvertently did not include a specific reference to ''weighted'' in the language of the regulation text. Therefore, we are proposing to specify that the ''weighted mean value'' of per resident amounts of hospitals located in the same geographic wage area is used for determining the base period for certain hospitals for cost reporting periods beginning in the same fiscal years.

We received two public comments on the GME provisions included in the proposed rule.

Comment: One commenter supported the implementation of section 311 of Public Law 106–113. Another commenter suggested that there is ambiguity in our volunteer physician policy regarding the rotation of residents to nonhospital sites. The commenter requested that we explicitly state that, so long as the other criteria under the nonhospital policy are met, hospitals may receive direct GME payments for residents training in nonhospital sites when the hospitals do not incur supervisory costs, if the written agreement, which is signed by both the hospital and nonhospital site, indicates that the supervisory physician has agreed to volunteer his or her time in supervising activities.

Response: We did not propose to make any revisions to our policy regarding training residents in nonhospital sites. Any changes in policy regarding an adjustment for training at nonhospital sites would need to go through the notice and comment procedures. We will consider the merits of the commenter's recommendation for a change in policy for a future proposed rulemaking.

H. Outliers: Miscellaneous Change

Under the provisions of section 1886(d)(5)(A)(i) of the Act, the Secretary does not pay for day outliers for discharges from hospitals paid under the prospective payment systems that occur after September 30, 1997. In the May 5 proposed rule, we proposed to make a conforming change to § 412.2(a) by deleting the reference to an additional payment for both inpatient operating and inpatient capital-related costs for cases that have an atypically long length of stay. We did not receive any comments on this proposal and are adopting the change as final.

V. The Prospective Payment System for Capital-Related Costs: The Last Year of the Transition Period

Since FY 2001 is the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs, for the readers' benefit, we are providing a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals, and the policy for providing exceptions payments during the transition period.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we

established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The 10-year transition period established to phase in the prospective payment system for capital-related costs is effective for discharges occurring on or after October 1, 1991 (FY 1992) through discharges occurring on or before September 30, 2001. For FY 2001, hospitals paid under the fully prospective transition period methodology will be paid 100 percent of the Federal rate and zero percent of their hospital-specific rate, while hospitals paid under the hold-harmless transition period methodology will be paid 85 percent of their allowable old capital costs (100 percent for sole community hospitals) plus a payment for new capital costs based on the Federal rate. Fiscal year 2001 is the final year of the capital transition period and, therefore, the last fiscal year for which a portion of a hold-harmless hospital's capital costs per discharge will be paid on a cost basis (except for new hospitals). In the proposed rule, we stated that since fully prospective hospitals will be paid based on 100 percent of the Federal rate and zero percent of their hospital-specific rate, we did not determine a proposed hospital-specific rate update for FY 2001 in section IV of the Addendum of the proposed rule. However, it has come to our attention that an update to the hospital-specific rate is necessary on October 1, 2000, for hospitals with cost reporting periods that do not coincide with the Federal fiscal year. Therefore, the hospital-specific rate update for FY 2001 is shown in section IV of the Addendum of this final rule. For cost reporting periods beginning on or after October 1, 2001 (FY 2002), payment for capital-related costs will be determined based solely on the capital standard Federal rate. Hospitals that were defined as ''new'' for the purposes of capital payments during the transition period (§ 412.30(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324.

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with a base year hospital-specific rate lower than the Federal rate is paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate is paid under the hold-harmless payment methodology during the transition period. A hospital paid under the hold-harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate or (2) a payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated as of December 31, 1990, but put in use for patient care after December 31, 1990, also may be recognized as old capital if certain conditions are met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990. Beginning in FY 2001, at the conclusion of the transition period for the capital prospective payment system, capital payments will be based solely on the Federal rate for the vast majority of hospitals.

During the transition period, new hospitals are exempt from the prospective payment system for capital-related costs for their first 2 years of operation and are paid 85 percent of their reasonable cost during that period. The hospital's first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) beginning at least 1 year after the hospital accepts its first patient serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation, the hospital is paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the transition period.

The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, 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 + DSH Adjustment Factor + IME Adjustment Factor).

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.

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 for qualifying classes of hospitals. For up to 10 years after the conclusion of the transition period, a hospital may also receive an additional payment under a special exceptions process if certain qualifying criteria are met and its total inpatient capital-related payments are less than the 70 percent minimum percentage of its allowable Medicare inpatient capital-related costs.

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. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, under amendments to the Act enacted by section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are 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. In conjunction with this change to the

operating blend percentage, effective with discharges on or after October 1, 1997, we compute 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.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

In the August 30, 1991 final rule, we established a capital exceptions policy, which provides for exceptions payments during the transition period (§ 412.348). Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules. The minimum payment percentages for regular capital exceptions payments by class of hospitals for FY 2001 are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The provision for regular exceptions payments will expire at the end of the transition period. Payments will no longer be adjusted to reflect regular exceptions payments at § 412.348. Accordingly, for cost reporting periods beginning on or after October 1, 2001, hospitals will receive only the per discharge payment based on the Federal rate for capital costs (plus any applicable DSH or IME and outlier adjustments) unless a hospital qualifies for a special exceptions payment under § 412.348(g).

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals. The capital special exceptions process is budget neutral; that is, even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited special exceptions policy will allow for exceptions payments for 10 years beyond the conclusion of the 10-year capital transition period or through September 30, 2011.

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

A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§§ 413.40(b)(4) and (g))

1. Updated Caps

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105–33) establishes caps on the target amounts for certain existing excluded hospitals and 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 classes of excluded hospitals: Psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000), and the July 30, 1999 final rule (64 FR 41529). For purposes of calculating the caps on existing facilities, the statute required us to calculate the national 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage to the applicable fiscal year. In establishing the caps on the target amounts within each class of hospital for new hospitals, section 1886(b)(7)(C) of the Act, as amended by section 4416 of Public Law 105–33, explicitly instructed the Secretary to provide an appropriate adjustment to take into account area differences in wage-related costs. However, since the statutory language under section 4414 of Public Law 105–33 did not provide for the Secretary to account for area differences in wage-related costs in establishing the caps on the target amounts for existing hospitals, HCFA did not account for wage-related differences in establishing the caps on the target amounts for existing facilities in FY 1998.

Section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to direct the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. Elsewhere in this issue of the **Federal Register** we are publishing an interim final rule with comment period implementing this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. This final rule addresses the wage adjusted caps on the target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 2000.

For purposes of calculating the caps on the target amounts, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Furthermore, section 1886(b)(3)(H)(iii), as added by Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

For cost reporting periods beginning in FY 2000, we update the FY 1996 wage-neutralized national 75th percentile target amount for each class of hospital by the market basket increase through FY 2000. For cost reporting periods beginning during FY 2001 and FY 2002, we update the previous year's wage-neutralized national 75th percentile target amount for each class of hospital by the applicable market basket percentage increase. In determining the wage-neutralized 75th percentile target amount for each class of hospital and consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act (as added by Pub. L. 106–113) to determine the appropriate wage

adjustment, we accounted for differences in wage-related costs by adjusting the caps on the target amounts for each class of hospital (psychiatric, rehabilitation, and long-term care) using the methodology, which is described in detail in the interim final rule with comment period that implements the provisions of section 121 Public Law 106–113 that is published elsewhere in this issue of the **Federal Register.**

As stated in the May 5, 2000 proposed rule, we wage neutralized each hospital's FY 1996 target amount to account for area differences in wage-related costs. For each class of hospitals, we determined the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the most recent actuarial estimate of the labor-related portion of excluded hospital costs (or 0.71553). This actuarial estimate of the labor-related share of PPS-excluded hospital costs was revised in connection with other revisions to the PPS-excluded hospital market basket published in the August 29, 1997 final rule (62 FR 45996). Based on the relative weights of the labor cost categories (wages and salaries, employee benefits, professional fees, postal services, and all other labor intensive services), the labor-related portion is 71.553 percent. The remaining 28.447 percent is the nonlabor-related portion. Similarly, we determined the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, as we stated in the May 5 proposed rule, we wage neutralize each hospital's FY 1996 target amount by dividing the labor-related portion of each hospital's FY 1996 target amount by the hospital's FY 1998 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), as shown in Tables 4A and 4B of the August 29, 1997 final rule (62 FR 46070). Each hospital's wage-neutralized FY 1996 target amount was calculated by adding the nonlabor-related portion of its target amount and the wage-neutralized labor-related portion of its target amount. Then, the wage-neutralized target amounts for hospitals within each class were arrayed in order to determine the national wage-neutralized 75th percentile caps on the target amounts for each class of hospital.

As stated in the May 5 proposed rule, this methodology for wage-neutralizing the national 75th percentile of the target amounts is identical to the methodology we utilized for the wage index adjustment described in the August 29, 1997 final rule (62 FR 46020) to calculate the wage-adjusted 110 percent of the national median target amounts for new excluded hospitals and units. Again, we recognize that wages may differ for prospective payment hospitals and excluded hospitals, but we believe that the acute care hospital wage data utilized reflect area differences in wage-related costs. Moreover, in light of the short timeframe for implementing this provision, we used the wage data for acute hospitals since they are the most feasible data source. Reliable wage data for excluded hospitals and units are not available.

Comment: One commenter objected to our use of the FY 1998 hospital wage index, which is based on FY 1994 wage data from Medicare cost reports, to wage neutralize the labor-related portion of each hospital's FY 1996 target amount in establishing area wage adjustments to the caps on the target amounts for long-term care hospitals. The commenter favored using the most current wage data (the FY 2001 wage index, based on FY 1997 Medicare cost report data) to estimate wage adjustments to the caps on the target amounts for excluded hospitals and units.

Response: We reconsidered our methodology for wage-neutralizing each hospital's FY 1996 target amount used in determining the wage-neutralized national 75th percentile target amount for each class of hospital. In the May 5, 2000 proposed rule, the labor-related portion of each hospital's FY 1996 target amount was wage neutralized by dividing it by the FY 1998 hospital inpatient prospective payment system wage index. The FY 1998 hospital inpatient prospective payment system wage index was calculated using FY 1994 wage data due to the 4-year lag time in receiving the data used in the annual calculation of the wage index. We have reconsidered this methodology and believe it is appropriate to wage neutralize the labor-related portion of each hospital's FY 1996 target amount by the FY 2000 hospital inpatient prospective payment system wage index. The FY 2000 wage index is the most current wage data available to wage neutralize each hospital's FY 1996 target amount, and the FY 2000 wage index was calculated based on FY 1996 wage data and therefore reflects area differences in wage-related FY 1996 costs. The FY 2001 wage index will be applied to the wage-related portion of the cap to determine each hospital's FY 2001 wage-adjusted cap on its target amount.

In the May 5, 2000 proposed rule (65 FR 26314), we proposed the labor-related and nonlabor-related shares of the wage-neutralized national 75th percentile caps on the target amounts for FY 2001 as follows:

Class of excluded hospital or unit	FY 2001 proposed labor-related share	FY 2001 proposed nonlabor-related share
Psychiatric	$8,106	$3,223
Rehabilitation	15,108	6,007
Long-Term Care	29,312	11,654

Taking into account the national 75th percentile of the target amounts for cost reporting periods ending during FY 1996 (wage-neutralized using the FY 2000 acute care wage index), the wage adjustment provided for under Public Law 106–113, and the applicable update factor based on the market basket percentage increase to FY 2001, we are establishing the labor-related and nonlabor-related portions of the caps on the target amounts for FY 2001 using the methodology outlined above as follows:.

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Psychiatric	$8,131	$3,233
Rehabilitation	15,164	6,029
Long-Term Care	29,284	11,642

These caps on the target amounts for FY 2001 reflect the use of the FY 2000 wage index in determining the FY 1996 national wage-neutralized 75th percentile target amounts, updated to FY 2001 by the applicable market basket percentage increase. The market basket percentage increase for excluded hospitals and units for FY 2001 is currently forecast at 3.4 percent. At the time the proposed rule was issued, the market basket increase was forecast at 3.1 percent.

Finally, the cap on a hospital's FY 2001 target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile target amount to its wage-adjusted labor-related portion of the national 75th percentile target amount. A hospital's wage-adjusted labor-related portion of the target amount is calculated by multiplying the labor-related portion of the wage-neutralized national 75th percentile target amount for the hospital's class by the hospital's applicable wage index. For FY 2001, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system (see § 412.63). For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2001 as shown in Tables 4A and 4B of this final rule, a hospital's applicable wage index corresponds to the area in which the hospital or unit is physically

located (MSA or rural area) and is not subject to prospective payment system hospital reclassification under section 1886(d)(10) of the Act.

Comment: One commenter requested that HCFA provide long-term care hospitals the opportunity to redesignate to another rural or urban area under the standards outlined in § 412.230 for prospective payment system hospitals. The commenter believed that section 121 of Public Law 106–113 directs HCFA to make accurate area wage adjustments for excluded hospitals and that, in the interest of equity, HCFA should afford long-term care hospitals a process analogous to the MGCRB so that these providers would be able to redesignate their wage area to a rural or urban area. Additionally, the commenter recommended that long-term care hospitals located in ''close proximity'' (as defined in § 412.230(b)) to a prospective payment system hospital that has been allowed to reclassify its area wage index, should also be allowed to reclassify to that wage area.

Response: Section 121 of Public Law 106–113 directs the Secretary to make ''an appropriate adjustment'' to account for area wage-related differences. As we stated in the May 5 proposed rule, long-term care hospitals and psychiatric and rehabilitation hospitals and units which are exempt from the prospective payment system are not subject to prospective payment system hospital reclassification under section 1886(d)(10)(A) of the Act. This section establishes the MGCRB for the purpose of evaluating applications from short-term acute care providers. There is no equivalent statutory provision for HCFA to develop an alternative board for long-term care hospitals or for psychiatric and rehabilitation hospitals and units, or both.

While it would be feasible to allow units physically located in PPS hospitals that have been reclassified by the MGCRB to use the wage-index for the area to which that hospital has been reclassified, at the present time there is no process in place to make reclassification determinations for excluded free-standing providers. The wage-adjustment to the cap on the target amounts for existing excluded providers is only effective through FY 2002 and there is not enough time to develop and implement a process to determine reclassification for free-standing excluded providers. There are approximately 1000 free-standing excluded facilities (529 psychiatric, 196 rehabilitation and 242 long-term care). Therefore, in the interest of equity, we believe that in determining a hospital's wage-adjusted cap on its target amount, it is appropriate for excluded hospitals and units to use the wage index associated with the area in which it is physically located (MSA or rural area) and prospective payment system reclassification under section 1886(d)(10) of the Act is not applicable. This policy is consistent with the determination of the wage-adjusted caps on the target amounts for new excluded hospitals and units, which are not subject to reclassification when applying the wage index in the calculation of the cap. Additionally, skilled-nursing facility and ambulatory surgical center payment systems both use the acute-care inpatient hospital PPS wage index and do not allow for reclassifications since there is no analogous determination process to the MGCRB, which only has authority over PPS hospitals under section 1886(d)(10)(a) of the Act. Therefore, consistent with these policies regarding the application of the acute care wage index to other types of facilities, we are not implementing the commenter's recommendation to permit reclassification of an excluded hospital's or unit's wage index in determining the wage-adjusted cap on their target amount under § 41340(c)(4)(iii).

Comment: One commenter asserted that this is the first time HCFA has applied area wage adjustments to excluded hospitals and units. The commenter suggested that HCFA assess whether long-term care hospitals have a different mix of occupations compared to short-term acute care facilities and recommended that HCFA propose an appropriate adjustment to the acute care wage index to account for the relative wage-related costs for the occupational categories of long-term care hospitals or establish a long-term care hospital specific area wage index. The commenter noted that the acute care wage index includes some wage data derived from hospital-based psychiatric and rehabilitation units, but contains no data from long-term care hospitals. Also, the commenter argued that HCFA did not meet the statutory requirements of section 1886(b)(3)(H) of the Act as amended by section 121 of Public Law 106–113, which states that the Secretary shall provide for an appropriate adjustment ''to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs *within the same class of hospital*'' (emphasis added), since the acute care wage index data are based on data exclusively from short-term acute care hospitals.

Response: As stated in the May 5, 2000 proposed rule (65 FR 26314), we recognize that wages may differ for prospective payment system acute care hospitals and excluded hospitals, but we believe the acute care wage index data accurately reflects area differences in wage-related costs and they are the most feasible data source. For this reason the acute care hospital wage index is used for the Medicare prospective payment systems for outpatient facilities, skilled nursing facilities, and home health facilities.

Currently, there is hospital specific wage data available to develop a wage index based on data from excluded hospitals (or, as the commenter specifically requested, a long-term care hospital exclusive wage index). We may consider exploring the feasibility of developing a wage index for excluded hospitals and units in the future. However, the commenter has not presented any evidence that the acute care wage index inappropriately reflects the differences in wage-related costs for excluded hospital and units. We believe that the acute care wage index provides for an appropriate adjustment to account for wage-related costs in determining a hospital's wage-adjusted cap on its target amount.

In the interim final rule with comment period implementing certain provisions of Public Law 106–113 that we are publishing elsewhere in this issue of the **Federal Register** we revised §§ 413.40(c)(4)(i) and (c)(4)(ii) to incorporate the changes in the formula used to determine the limitation on the target amounts for excluded hospitals and units, as provided for by section 121 of Public Law 106–113.

In response to the May 5, 2000 proposed rule, we received two public comments relating to establishment of the wage-adjusted caps on the target amounts for excluded hospitals and units.

Comment: One commenter believed that the provision for a wage-adjustment to the national 75th percentile target amount cap placed on hospitals excluded from the prospective payment system provided HCFA with the broad authority to transition to a wage-adjusted cap over more than one period. The commenter suggested that the wage-adjusted caps on target amounts be phased-in over a period of time in a manner similar to the removal of teaching physician costs from the wage index calculation.

Response: Public Law 106–113, which was enacted November 29, 1999, directed us to retroactively provide for

a wage adjustment for the national 75th percentile target amounts for psychiatric and rehabilitation hospitals and units and for long-term care hospitals as of October 1, 1999. The purpose of the wage-adjustment to the 75th percentile cap on target amounts for excluded providers is to account for area differences in wage-related costs. We believe that the intent of this provision is to account for these wage differences beginning with cost reporting periods starting during FY 2000. Phasing-in the wage-adjustment to the caps on the target amounts would mitigate the purpose of the wage-adjustment because hospitals located in areas with wage index values greater than one would not receive the full intended benefit of the provision. Additionally, as we stated in the interim final rule with comment that we are publishing elsewhere in this issue of the **Federal Register** we estimate that most providers (93.3 percent of psychiatric hospitals and units, 97.5 percent of rehabilitation hospitals and units, and 93.5 percent of long-term care hospitals) are either not effected or are positively effected by the wage adjustment to the caps on the target amounts. Therefore, we believe it is inappropriate to phase in the wage-adjustment to the caps on the target amounts as the commenter recommended.

Additionally, the removal of the teaching physician costs on the wage index is set for a 5-year phase-out, while the wage-adjusted caps on national target amounts are only legislated to remain in effect from FY 2000 to FY 2002. As such, the remaining period of time for which these caps are in effect is too brief to warrant the administrative resources that would be involved in such a transition. The 5-year phase-out of the removal of teaching costs from the wage index was implemented based on the recommendation of an industry group made up of representatives from national and state hospital associations. While one commenter advocated the phase-in of the wage-adjustment to the caps on the target amounts, another commenter supported the complete implementation of the wage-adjustment to the caps on the target amounts effective FY 2000, since this adjustment reflects the higher cost incurred by providers located in areas with higher than the national average of labor expenditures.

Comment: One commenter commended the wage-adjustment to the caps on the target amounts for psychiatric and rehabilitation hospital and units and long-term care hospitals mandated by section 121 of Public Law 106–113. The commenter supported the application of the acute care wage index to the caps on the national target amounts since the wage adjustment aids providers who incur costs higher than the national average simply because they are located in marketplaces with higher labor prices. The commenter also noted that the target amounts for existing hospitals are now in line with the target amounts for new hospitals, which have been wage adjusted since their implementation in FY 1998 by Public Law 105–33. The commenter further suggested that, if the three classes of hospitals have not been transitioned to prospective payment systems by FY 2002, the wage adjustment to the national target amounts for both new and existing providers should remain in place.

Response: We agree with the comment and we believe that our implementation of the wage adjustment is consistent with the statutory provision in Public Law 106–113. However, regardless of whether the prospective payment systems for these classes of providers have been implemented, we will only be in a position to continue the use of the wage-adjusted caps on the target amounts beyond FY 2002 if Congress directs us to do so through additional legislation.

2. Updated Caps for New Excluded Hospitals and Units (§ 413.40(f))

Section 1886(b)(7) of the Act establishes a payment methodology for new 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 that first receives payment as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows:

For the first two 12-month 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 to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels. The amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2001. These figures are updated to reflect the market basket increase of 3.4 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$6,611	$2,630
Rehabilitation	13,002	5,169
Long-Term Care	16,757	6,662

3. Development of Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

Section 4421 of Public Law 105–33 added section 1886(j) to the Act. Section 1886(j) of the Act mandates the phase-in of a case-mix adjusted prospective payment system for inpatient rehabilitation services (freestanding hospitals and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The prospective payment system will be fully implemented for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) was amended by section 125 of Public Law 106–113 to require the Secretary to use the discharge as the payment unit under the prospective payment system for inpatient rehabilitation services and to establish classes of patient discharges by functional-related groups.

We will issue a separate notice of proposed rulemaking in the **Federal Register** on the prospective payment system for inpatient rehabilitation facilities. That document will discuss the requirements in section 1886(j)(1)(A)(i) of the Act for a transition phase covering the first two cost reporting periods under the prospective payment system. During this transition phase, inpatient rehabilitation facilities will receive a payment rate comprised of a blend of the facility specific rate (the TEFRA percentage) based on the amount that would have been paid under Part A with respect to these costs if the prospective payment system would not be implemented and the inpatient rehabilitation facility prospective payment rate (prospective payment percentage). As set forth in sections 1886(j)(1)(C)(i) and (ii) of the Act, the TEFRA percentage for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, is 66⅔ percent; the prospective payment percentage is 33⅓ percent. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the TEFRA percentage is 33⅓

percent and the prospective payment percentage is 66⅔ percent.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the average inpatient operating and capital costs of rehabilitation facilities and units. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, outlier status and any other factors the Secretary determines necessary. We will propose to set the prospective payment amounts in effect during FY 2001 so that total payments under the system are projected to equal 98 percent of the amount of payments that would have been made under the current payment system. Outlier payments in a fiscal year may not be projected or estimated to exceed 5 percent of the total payments based on the rates for that fiscal year.

4. Continuous Improvement Bonus Payment

Under § 413.40(d)(4), for cost reporting periods beginning on or after October 1, 1997, an ''eligible'' hospital may receive continuous improvement bonus payments in addition to its payment for inpatient operating costs plus a percentage of the hospital's rate-of-increase ceiling (as specified in § 413.40(d)(2)). An eligible hospital is a hospital that has been a provider excluded from the prospective payment system for at least three full cost reporting periods prior to the applicable period and the hospital's operating costs per discharge for the applicable period are below the lowest of its target amount, trended costs, or expected costs for the applicable period. Prior to enactment of Public Law 106–113, the amount of the continuous improvement bonus payment was equal to the lesser of—

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

(b) 1 percent of the ceiling.

Section 122 of Public Law 106–113 amended section 1886(b)(2) of the Act to provide, for cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, for an increase in the continuous improvement bonus payment for long-term care and psychiatric hospitals and units. Under section 1886(b)(2) of the Act, as amended, a hospital that is within one of these two classes of hospitals (psychiatric hospitals or units and long-term-care hospitals) will receive the lesser of 50 percent of the amount by which the operating costs are less than the expected costs for the period, or the increased percentages mandated by statute as follows:

(a) For a cost reporting period beginning on or after October 1, 2000 and before September 30, 2001, 1.5 percent of the ceiling; and

(b) For a cost reporting period beginning on or after

October 1, 2001, and before September 30, 2002, 2 percent of the ceiling.

We did not receive any public comments on our proposed revision of § 413.40(d)(4) to incorporate this provision of the statute and, therefore, are adopting it as final.

5. Changes in the Types of Patients Served or Inpatient Care Services That Distort the Comparability of a Cost Reporting Period to the Base Year Are Grounds for Requesting an Adjustment Payment in Accordance With Section 1886(b)(4) of the Act

Section 4419(b) of Public Law 104–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units in the subsequent year's final rule published in the **Federal Register**.

The process of requesting, adjudicating, and awarding an adjustment payment for a given cost reporting period occurs over a 2-year period or longer. An excluded hospital or unit must first file its cost report for the previous fiscal year with its intermediary within 5 months after the close of the previous fiscal year. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) in approximately 2 months. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or HCFA, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in a final rule on adjustments granted for cost reports ending in the previous Federal fiscal year, since those adjustments have not even been requested by that time. However, in an attempt to provide interested parties at least some relevant data on adjustments, we are publishing data on requests for adjustments that were processed by the fiscal intermediaries or HCFA during the previous Federal fiscal year.

The table below includes the most recent data available from the fiscal intermediaries and HCFA on adjustment payments that were adjudicated during FY 1999. By definition these were for cost reporting periods ending in years prior to FY 1998. The total adjustment payments awarded to excluded hospitals and units during FY 1999 are $73,532,146. The table depicts for each class of hospital, in aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment payment
Psychiatric	198	$100,861,663	$49,986,012
Rehabilitation	53	32,690,736	16,798,634
Long-term care	4	3,239,164	2,577,455
Children's	7	3,311,758	1,470,670
Cancer	2	4,849,093	2,699,375

B. Responsibility for Care of Patients in Hospitals-Within-Hospitals (§ 413.40(a)(3))

Effective October 1, 1999, for hospitals-within-hospitals, we implemented a policy that allows for a 5-percent threshold for cases in which a patient discharged from an excluded hospital-within-a-hospital and admitted to the host hospital was subsequently readmitted to the excluded hospital-within-a-hospital. With respect to these cases, if the excluded hospital exceeds the 5-percent threshold, we do not include any previous discharges to the prospective payment hospital in calculating the excluded hospital's cost per discharge. That is, the entire stay is considered one Medicare ''discharge'' for purposes of payments to the excluded hospital. The effect of this rule, as explained more fully in the May 7, 1999 proposed rule (64 FR 24716) and in the July 30, 1999 final rule (64 FR 41490), is to prevent inappropriate Medicare payment to hospitals having a large number of such stays.

In the existing regulations at § 413.40(a)(3), we state that the 5-percent threshold is determined based on the total number of discharges from the hospital-within-a-hospital. We have received questions as to whether, in determining whether the threshold is met, we consider Medicare patients only or all patients (Medicare and non-Medicare). To avoid any further misunderstanding, in the May 5, 2000 proposed rule, we indicated our intent to clarify the definition of ''ceiling'' in § 413.40(a)(3) by specifying that the 5-percent threshold is based on the Medicare inpatients discharged from the hospital-within-a-hospital in a particular cost reporting period, not on total Medicare and non-Medicare inpatient discharges.

We did not receive any public comments on our proposed clarification of the definition of ''ceiling'' in § 413.40(a)(3) and, therefore, are adopting the revision as final.

C. Critical Access Hospitals (CAHs)

1. Election of Payment Method (§ 413.70)

Section 1834(g) of the Act, as in effect before enactment of Public Law 106–113, provided that the amount of payment for outpatient CAH services is the reasonable costs of the CAH in providing such services. However, the reasonable costs of the CAH's services to outpatients included only the CAH's costs of providing facility services, and did not include any payment for professional services. Physicians and other practitioners who furnished professional services to CAH outpatients billed the Part B carrier for these services and were paid under the physician fee schedule in accordance with the provisions of section 1848 of the Act.

Section 403(d) of Public Law 106–113 amended section 1834(g) of the Act to permit the CAH to elect to be paid for its outpatient services under another option. CAHs making this election would be paid amounts equal to the sum of the following, less the amount that the hospital may charge as described in section 1866(a)(2)(A) of the Act (that is, Part A and Part B deductibles and coinsurance):

(1) For facility services, not including any services for which payment may be made as outpatient professional services, the reasonable costs of the CAH in providing the services; and

(2) For professional services otherwise included within outpatient CAH services, the amounts that would otherwise be paid under Medicare if the services were not included in outpatient CAH services.

Section 403(d) of Public Law 106–113 added section 1834(g)(3) to the Act to further specify that payment amounts under this election are be determined without regard to the amount of the customary or other charge.

The amendment made by section 403(d) is effective for cost reporting periods beginning on or after October 1, 2000.

In the May 5, 2000 proposed rule, we proposed to revise § 413.70 to incorporate the provisions of section 403(d) of Public Law 106–113. The existing § 413.70 specifies a single set of reasonable cost basis payment rules applicable to both inpatient and outpatient services furnished by CAHs. As section 403(d) of Public Law 106–113 provides that, for outpatient CAH services, CAHs may elect to be paid on a reasonable cost basis for facility services and on a fee schedule basis for professional services, we proposed to revise the section to allow for separate payment rules for CAH inpatient and outpatient services.

We proposed to place the provisions of existing § 413.70(a) and (b) that relate to payment on a reasonable cost basis for inpatient services furnished by a CAH under proposed § 413.70(a). Proposed § 413.70(a)(2) also stated that payment to a CAH for inpatient services does not include professional services to CAH inpatients and is subject to the Part A hospital deductible and coinsurance determined under 42 CFR Part 409, Subpart G.

We proposed to include under § 413.70(b) the payment rules for outpatient services furnished by CAHs, including the option for CAHs to elect to be paid on the basis of reasonable costs for facility services and on the basis of the physician fee schedule for professional services. Under proposed § 413.70(b)(2), we would retain the existing provision that unless the CAH elects the option provided for under section 403 of Public Law 106–113, payment for outpatient CAH services is on a reasonable cost basis, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in Parts 413 and 415 (except for certain payment principles that do not apply; that is, the lesser of costs or charges, RCE limits, any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7), and blended payment amounts for ambulatory surgical center services, radiology services, and other diagnostic services).

Under proposed § 413.70(b)(3), we specified that any CAH that elects to be paid under the optional method must make an annual request in writing, and deliver the request for the election to the fiscal intermediary at least 60 days before the start of the affected cost reporting period. In addition, proposed § 413.70(b)(3)(ii) stated that if a CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following two amounts:

- For facility services, not including any outpatient professional services for which payment may be made on a fee schedule basis, the amount would be the reasonable costs of the services as determined in accordance with applicable principles of cost reimbursement in 42 CFR Parts 413 and 415, except for certain payment principles that would not apply as specified above; and
- For professional services, otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts would be those amounts that would otherwise be paid for the services if the CAH had not elected payment under this method.

We also proposed in § 413.70(b)(3)(iii) that payment to a CAH for outpatient services would be subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161. In proposed § 413.70(c), we stated that final payment to the CAH for its facility services to inpatients and outpatients furnished during a cost reporting would be based on a cost report for that period, as required under § 413.20(b).

Comment: One commenter expressed concern about several CAH payment issues on which we did not propose to change existing policy. These comments related to payment for costs attributable to Medicare bed debts, counting of beds toward the 15- and 25-bed maximums, and payment for swing-bed services in CAHs.

Response: Because these comments dealt with matters beyond the scope of the proposed rule, we have received them with interest and will consider whether any changes in policy are needed at a later date.

We are adopting the proposed revisions to § 413.70 as final. The revised § 413.70 includes at paragraph (b)(2)(iii) the text of a paragraph (c) that was added in the interim final rule with comment period that implemented certain provisions of Public Law 106–33 published elsewhere in this issue of the **Federal Register**. We did not revise the text of this paragraph (c); we merely changed the paragraph coding to fit it into the scheme of coding of the revised § 413.70.

2. Condition of Participation: Organ, Tissue, and Eye Procurement (§ 485.643)

Sections 1820(c)(2)(B) and 1861(mm) of the Act set forth the criteria for designating a CAH. Under this authority, the Secretary has established in regulations the minimum requirements a CAH must meet to participate in Medicare (42 CFR Part 485, Subpart F).

Section 1905(a) of the Act provides that Medicaid payments may be made for any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary. The Secretary has specified CAH services as Medicaid services in regulations. Specifically, the regulations at 42 CFR 440.170(g)(1)(i), define CAH services under Medicaid as those services furnished by a provider meeting the Medicare conditions of participation (CoP).

Section 1138 of the Act provides that a CAH participating in Medicare must establish written protocols to identify potential organ donors that: (1) Assure that potential donors and their families are made aware of the full range of options for organ or tissue donation as well as their rights to decline donation; (2) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of those families; and (3) require that an organ procurement agency designated by the Secretary be notified of potential organ donors.

On June 22, 1998, as part of the Medicare hospital conditions of participation under Part 482, subpart C, we added to the regulations at § 482.45, a condition that specifically addressed organ, tissue, and eye procurement. However, Part 482 does not apply to CAHs, as CAHs are a distinct type of provider with separate CoP under Part 485. Therefore, in the proposed rule, we proposed to add a CoP for organ, tissue, and eye procurement for CAHs at a new § 485.643 that generally parallels the CoP at § 482.45 for all Medicare hospitals with respect to the statutory requirement in section 1138 of the Act concerning organ donation. CAHs are not full service hospitals and therefore are not equipped to perform organ transplantations. Therefore, we did not propose to include the standard applicable to Medicare hospitals that CAHs must be a member of the Organ Procurement and Transplantation Network (OPTN), abide by its rules and provide organ transplant-related data to the OPTN, the Scientific Registry, organ procurement agencies, or directly to the Department on request of the Secretary.

The proposed CoP for CAHs included several requirements designed to increase organ donation. One of these requirements is that a CAH must have an agreement with the Organ Procurement Organization (OPO) designated by the Secretary, under which the CAH will contact the OPO in a timely manner about individuals who die or whose death is imminent. The OPO will then determine the individual's medical suitability for donation. In addition, the CAH must have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes, as long as the agreement does not interfere with organ donation. The proposed CoP would require a CAH to ensure, in collaboration with the OPO with which it has an agreement, that the family of every potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The CAH may choose to have OPO staff perform this function, have CAH and OPO staff jointly perform this function, or rely exclusively on CAH staff. Research indicates that consent to organ donation is highest when the formal request is made by OPO staff or by OPO staff and hospital staff together. While we require collaboration, we also recognize that CAH staff may wish to perform this function and may do so when properly trained. Moreover, the CoP would require the CAH to ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as designated requestors.

Finally, we proposed that the CoP would require the CAH to work with the OPO and at least one tissue bank and one eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of organs and tissues is underway.

Because we were sensitive to the possible burden the proposed CoP could place on CAHs, we invited public comments and information concerning the following requirements: (1) Developing written protocols for donations; (2) developing agreements with OPOs, tissue banks, and eye banks; (3) referring all deaths to the OPO; (4) working cooperatively with the designated OPO, tissue bank, and eye bank in educating staff on donation issues, reviewing death records, and maintaining potential donors. We note that the proposed requirement allowed some degree of flexibiilty for the CAH. For example, the CAH would have the option of using an OPO-approved education program to train its own employees as routine requestors or deferring requesting services to the OPO, the tissue bank, or the eye bank to provide requestors.

We did not receive any public comments on the proposed CAH CoP on organ, tissue, and eye procurement. We are adopting § 485.643 as final.

VII. MedPAC Recommendations

On March 1, 2000 the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress, including several recommendations related to the inpatient operating payment system. Those related to the inpatient prospective payment systems were: Congress should establish a single set of payment adjustors for both the operating and capital systems; HCFA should expand the definition of transfers which applies a transfer policy to patients transferred to postacute settings; and, Congress should reformulate the Medicare DSH adjustment. In the proposed rule, we responded to these recommendations.

In addition, this year MedPAC published another report in June with additional recommendations. Among the recommendations were: FY 2001 updates to the operating and capital payment rates; moving to refined DRGs to better capture variations in patient severity; adopting DRG-specific outlier offsets; Congress should provide the Secretary the authority to adjust the

base payment amounts for anticipated coding changes; and, Congress should fold inpatient direct GME into the prospective payment system through a revised teaching hospital adjustment. A discussion of MedPAC's update recommendation can be found in Appendix D of this final rule.

A. Combined Operating and Capital Prospective Payment Systems (Recommendation 3J: March Report)

Recommendation: The Congress should combine prospective payment system operating and capital payment rates to create a single prospective rate for hospital inpatient care. This change would require a single set of payment adjustments—in particular, for indirect medical education and disproportionate share hospital payments—and a single payment update.

Response: We responded to a similar comment in the July 30, 1999 final rule (64 FR 41552), the July 31, 1998 final rule (63 FR 41013), and the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. However, we have not yet developed such a single framework as the actual operating system update has been determined by Congress through FY 2002. In the meantime, we intend to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We maintain our goal of combining the update frameworks at the end of the 10-year capital transition period (the end of FY 2001) and may examine combining the payment systems post-transition. Because of the similarity of the update frameworks, we believe that they could be combined with little difficulty.

In the discussion of its recommendation, MedPAC notes that it ''is examining broad reforms to the prospective payment system, including DRG refinement and modifications of the graduate medical education payment and the IME and DSH adjustments. The Commission believes that a combined hospital prospective payment rate should be established whether or not broader reforms are undertaken. However, if the Congress acts on any or all of the Commission's recommendations, it should consider combining operating and capital payments as part of a larger package.''

We agree that ultimately the operating and capital prospective payment systems should be combined into a single system. However, we believe that, because of MedPAC's ongoing analysis and the Administration's pending DSH report to Congress, any such unification should occur within the context of other system refinements.

B. Continuing Postacute Transfer Payment Policy (Recommendation 3K: March Report)

Recommendation: The Commission recommends continuing the existing policy of adjusting per case payments through an expanded transfer policy when a short length of stay results from a portion of the patient's care being provided in another setting.

Response: As noted in section IV.A. of this preamble, we have undertaken (through a contract with HER) an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. That analysis (based on preliminary data covering only approximately 6 months of discharge data) showed a minimal impact on the rate of short-stay postacute transfers after implementation of the policy. However, average profit margins as measured by HER declined from $3,496 prior to implementation of the policy to $2,255 after implementation. We believe these preliminary findings demonstrate that the postacute transfer provision has had only marginal impact on existing practice patterns while more closely aligning the payments to hospitals for these cases with the costs incurred. Therefore, we agree with MedPAC's recommendation that the policy should be continued.

C. Disproportionate Share Hospitals (DSH) (Recommendations 3L and 3M: March Report)

Recommendation: To address longstanding problems and current legal and regulatory developments, Congress should reform the disproportionate share adjustment to: Include the costs of all poor patients in calculating low-income shares used to distribute disproportionate share payments, and use the same formula to distribute payments to all hospitals covered by prospective payment.

Response: As we noted in section IV.E. of this preamble, Public Law 106–113 directed the Secretary to require subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Act) to submit data on costs incurred for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care. These data must be reported on the hospital's cost reports for cost reporting periods beginning on or after October 1, 2001, and will provide information that will enable MedPAC and us to evaluate potential refinements to the DSH formula to address the issues referred to by MedPAC.

Medicare fiscal intermediaries will audit these data to ensure their accuracy and consistency. Our experience with administering the current DSH formula leads us to believe that this auditing function would necessarily be extensive, because the non-Medicare data that would be collected have never before been collected and reviewed by Medicare's fiscal intermediaries. The data would have to be determined to be accurate and usable, and corrected if necessary.

We agree that the current statutory payment formula could be improved, largely because of different threshold levels and different formula parameters applicable to different groups of hospitals. We are in the process of preparing a report to Congress on the Medicare DSH adjustment that includes options for amending the statutory formula.

Comment: We received one comment regarding MedPAC's recommendation. The commenter expressed the concern that any unrecoverable costs from certified registered nurse anesthetist services in providing anesthesia and related care to indigent patients may not be included in the bad debt costs of hospitals.

Response: One of the difficulties in collecting uncompensated care and non-Medicare bad debt data is defining exactly the types of data being sought, particularly when there are no existing cost reporting guidelines to follow. We will be working closely with the hospital industry to identify and collect these data.

Recommendation: To provide further protection for the primarily voluntary hospitals with mid-level low-income shares, the minimum value, or threshold, for the low-income share that a hospital must have before payment is made should be set to make 60 percent of hospitals eligible to receive disproportionate share payments.

Response: Currently, fewer than 40 percent of all prospective payment system hospitals receive DSH payments. Therefore, this recommendation would entail significant redistributions of existing DSH payments if implemented in a budget neutral manner. We are particularly concerned about the effect of this recommendation on hospitals receiving substantial DSH payments currently, including major teaching hospitals and public hospitals. The analysis by MedPAC demonstrates that

these hospitals would be negatively impacted, if more hospitals were made eligible for DSH payments.

D. Severity-Adjusted DRGs (Recommendation 3A: June Report)

Recommendation: The Secretary should improve the hospital inpatient prospective payment system by adopting, as soon as practicable, DRG refinements that more fully capture differences in severity of illness among patients. At the same time, she should make the DRG payment rates more accurate by basing the DRG relative weights on the national average of hospitals' relative values in each DRG.

Response: For its analysis, MedPAC used the severity classifications from the all patient refined diagnosis related groups (APR–DRG) system. According to MedPAC, under this system each patient is initially assigned to 1 of 355 APR–DRGs. Each APR–DRG is broken into four severity classes: minor, moderate, major or extreme. Assignment to these classes within the APR–DRG is based on specific combinations of secondary diagnoses, age, procedures, and other factors. This process yields 1,420 distinct groups, compared with fewer than 500 DRGs. The MedPAC points out that ''to avoid creating refined DRGs that might have unstable relative weights, the Secretary should be selective in adopting clinical distinctions similar to those reflected in the APR–DRGs. This will require carefully weighing the benefits of more accurate clinical and economic distinctions against the potential for instability in relative weights based on small numbers of cases (p. 64).''

The MedPAC's predecessor, the Prospective Payment Assessment Commission, made a similar recommendation in 1995. In the June 2, 1995 proposed rule (60 FR 29246), we agreed with the Commission's judgment that adopting the severity DRGs would tend to reduce discrepancies between payments and costs for individual cases and thereby improve payment equity among hospitals. In the same rule, we also agreed with the Commission that basing DRG weights on standardized charges results in weights that are somewhat distorted as measures of the relative costliness of treating a typical case in each DRG, and that the hospital-specific relative value method of setting weights may reduce or eliminate distortions present in the current system.

However, in our discussion on DRG refinements in the same rule (60 FR 29209) we reiterated our position published in the final rule on September 1, 1992 (57 FR 39761) that we would not propose to make significant changes to the DRG classification system, unless we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG changes may have on coding behavior, or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments. In addition, we would need specific legislative authority to offset, through adjustments to the standardized amounts, any significant anticipated increase in payments attributable to changes in coding practices caused by significant changes to the DRG classification system. Because we have not been granted this authority, we do not believe it would be appropriate to adopt revised severity-adjusted DRGs at this time.

E. DRG-Specific Outlier Offsets (Recommendation 3B: June Report)

Recommendation: Congress should amend the law to change the method now used to finance outlier payments under the hospital inpatient prospective payment system. Projected outlier payments in each DRG should be financed through an offsetting adjustment to the relative weight for the category, rather than the current flat adjustment to the national average base payment amounts.

Response: Under this recommendation, outlier payments would be financed through an offset to the relative weight of each DRG based on the proportion of outlier cases in that DRG, rather than an overall offset to the standardized amounts as is done currently. This would more directly relate payments under each DRG to the proportion of outlier cases occurring within that DRG.

Because the effects on DRG weights of implementing severity refinements, changing the method used to calculate DRG relative weights, and adopting DRG-specific outlier financing are interactive, we believe that we should make appropriate changes concurrently. Therefore, as stated in our response to recommendation 3A, we would not recommend that Congress implement this recommendation until we are able to offset, through adjustments to the standardized amounts, any significant anticipated increase in payments attributable to changes in coding practices caused by significant changes to the DRG classification system.

In addition, we are concerned that any benefits of adopting the Commission's recommendation would not outweigh the additional complexity and variation it would add to the already complex process of calculating outlier thresholds so that outlier payments are projected to equal a certain percentage between 5 and 6 of DRG payments.

F. Gradual Implementation of DRG Refinement and DRG-Specific Outlier Offsets (Recommendation 3C: June Report)

Recommendation: To avoid imposing extraordinary financial burdens on individual providers, the Congress should ensure that the case-mix measurement and outlier financing policies recommended earlier are implemented gradually over a period of several years. Further, the Congress should consider including protective policies, such as exemptions or hold-harmless provisions, for providers in circumstances in which vulnerable populations' access to care might be disrupted.

Response: The Commission's analyses show that implementing its case-mix measurement and outlier financing recommendations would substantially change PPS payments for many hospitals and may impose heavy burdens on individual hospitals. The Commission believes that many of these hospitals could accommodate the changes in an orderly way under traditional phase-in mechanisms. The Commission also states that some hospitals, including some groups of rural hospitals, may need longer term relief from the financial impact of these changes. The Commission suggests that this relief might include such approaches as targeted additional payments, hold-harmless provisions, and temporary or permanent exemptions.

We are concerned that implementing the Commission's recommendations may increase the need for special payment exceptions for various categories of hospitals to ensure continued access to care for many Medicare beneficiaries. Before recommending implementation of these refinements to the payment system, they must be examined to determine how the changes would impact hospitals financially and strategies would need to be developed for countering effects that could endanger beneficiaries' access to quality health care.

G. Congress Should Grant the Secretary the Authority to Offset Payments for Anticipated Coding Changes (Recommendation 3D: June Report)

Recommendation: The Congress should give the Secretary explicit authority to adjust the hospital inpatient base payment amounts if anticipated

coding improvements in response to refinements in case-mix measurement are expected to increase aggregate payments by a substantial amount during the forthcoming year. This adjustment should be separate from the annual update. Further, the Congress should require the Secretary to measure the extent of actual coding improvements based on the bills providers submit for payment and make a timely adjustment to correct any substantial forecast error.

Response: In the past, whenever significant refinements to the DRGs have been implemented, there have been unanticipated payment increases as hospitals have responded with changes to their coding practices, resulting in more cases being assigned to higher-weighted DRGs than estimated when the DRG relative weights were calculated. We anticipate that a similar effect would occur following implementation of refined DRGs.

Therefore, we agree with MedPAC's recommendation that Congress give the Secretary explicit authority to adjust the hospital inpatient base payment amounts if anticipated coding improvements in response to refinements in case-mix measurement are expected to increase aggregate payments by a substantial amount during the forthcoming year. We also agree that adjustments to correct substantial forecast errors would be appropriate.

H. Fold Inpatient Direct GME Costs Into the Prospective Payment System (Recommendation 3E: June Report)

Recommendation: Congress should fold inpatient direct graduate medical education costs into prospective payment system payment rates through a revised teaching hospital adjustment. The new adjustment should be set such that the subsidy provided to teaching hospitals would be added to the IME adjustment. This recommendation should be implemented with a reasonable transition to limit the impact on hospitals of substantial changes in Medicare payments and to ensure that beneficiaries have continued access to the services that teaching hospitals provide.

Response: MedPAC cites two primary reasons for its recommendation: to improve payment equity among teaching hospitals by eliminating the wide variation in current hospital-specific GME payment amounts, and to establish that GME payments are a part of patient care costs. MedPAC proposes three options for folding direct GME costs into PPS in terms of its impact on total payments: fold inpatient direct GME costs into the prospective payment rates, holding aggregate payments and special payments to teaching hospitals constant; fold inpatient direct GME costs into the prospective payment rates, holding aggregate payments constant, and redistributing teaching hospital subsidies across all hospitals; and fold inpatient direct GME costs into prospective payment rates with no constraint on aggregate payments and no teaching hospital subsidy. The commission recommends the first option. While we do not disagree with MedPAC's objectives, we believe that there are still some significant issues related to these recommendations.

First, Congress has already taken steps towards addressing the direct GME payment variation. Section 311 of the BBRA of 1999 established a 70 percent floor and a 140 percent ceiling based on a national average per resident amount for direct GME payment purposes for FYs 2001 through 2005. While we agree with the objective of decreasing the variation in the current per resident amounts, the same objective can be achieved by moving to a national, rather than hospital-specific, per resident amount.

Second, MedPAC asserts that folding the direct GME payments into the prospective payment system will establish that GME payments are payments to account for the increased costs of inpatient care due to residency training. However, we would note the current direct GME payments are distributed on the basis of Medicare's patient share, based on the percentage of total Medicare inpatient days to total hospital inpatient days. It is unclear exactly how MedPAC's recommendation would better associate GME payments with the increased costs of patient care without rebasing the current IME adjustment to more appropriately reflect the empirical estimate of those increased costs, both direct and indirect. Furthermore, the current distribution of IME payments is not directly linked to the involvement of residents providing patient care, but instead is based on each Medicare discharge, adjusted for the other payment factors. In addition, if the recommended teaching adjustment is a mechanism for accounting for the extra costs of inpatient training, it seems inappropriate to include residents not training in inpatient settings in a payment for inpatient care costs.

Third, MedPAC estimates show that the IME adjustment for operating payments would be only 3.2 percent, if it were based on the empirical relationship between costs and the ratio of residents to hospital beds. This is significantly less than the adjustment of 5.5 percent, which is the adjustment set for the end of the phase-in under current law. MedPAC asserts that approximately $1.5 billion of the IME payments to teaching hospitals result from paying more than the empirical estimate suggests. Under MedPAC's recommendation, the direct GME payments would essentially be added to current IME payments. However, we feel that it is inappropriate to revise the teaching adjustment in such a way that would constitute a further add-on to the current IME payments which MedPAC believes are excessive. Before such a change is adopted, Congress should determine a more accurate level at which to set the IME adjustment.

In addition, we note that MedPAC recommends folding the direct GME costs into the prospective payment system based on the most recent cost reports. The costs associated with GME, however, are no longer routinely audited by the fiscal intermediaries. Any reconstitution of the direct GME payment methodology based on recent cost reports would require further extensive audit work by the fiscal intermediaries.

VIII. 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 or cartridge format; however, some files are available on diskette as well as on the Internet at http://www.hcfa.gov/stats/pubfiles.html. In our May 5, 2000 proposed rule, we published a list of data files that are available for purchase (65 FR 26318 through 26320).

B. Information Collection Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the May 5, 2000 proposed rule, we solicited public comment on each of the information collection requirements in §§ 412.77, 412.92, and 485.643 described below.

Section 412.77, Determination of the hospital-specific rate for inpatient operating costs for certain sole community hospitals based on a Federal fiscal year 1996 base period, and § 412.92, Special treatment: sole community hospitals.

Sections 412.77(a)(2) and 412.92(d)(1)(ii) state that an otherwise eligible hospital that elects not to receive payment based on its hospital-specific rate as determined under § 412.77 must notify its fiscal intermediary of its decision prior to the beginning of its cost reporting period beginning on or after October 1, 2000.

We estimate that it will take each hospital that notifies its intermediary of its election not to receive payments based on its hospital-specific rate as determined under § 412.77 an hour to draft and send its notice. However, we are unable at this time to determine how many hospitals will make this election and, therefore, will need to notify their intermediaries of their decision.

Section 485.643, Condition of participation: Organ, tissue, and eye procurement.

It is important to note that because of the inherent flexibility of this final regulation, the extent of the information collection requirements is dependent upon decisions that will be made either by the CAH or by the CAH in conjunction with the OPO or the tissue and eye banks, or both. Thus, the paperwork burden on individual CAHs will vary and is subject, in large part, to their decisionmaking.

The burden associated with the requirements of this section include: (1) The requirement to maintain protocol documentation demonstrating that the five requirements of this section have been met; (2) the requirement for a CAH to notify an OPO, a tissue bank, or an eye bank of any imminent or actual death; and (3) the time required for a hospital to document and maintain OPO referral information.

We estimate that, on average, the requirement to maintain protocol documentation demonstrating that the requirements of this section have been met will impose one hour of burden on each CAH (on 161 CAHs) on an annual basis, resulting in a total of 161 annual burden hours.

The CoP in this section will require CAHs to notify the OPO about every death that occurs in the CAH. The average Medicare hospital has approximately 165 beds and 200 deaths per year. However, by statute and regulation, CAHs may use no more than 15 beds for acute care services. Assuming that the number of deaths in a hospital is related to the number of acute care beds, there should be approximately 18 deaths per year in the average CAH. We estimate that the average notification telephone call to the OPO takes 5 minutes. Based on this estimate, a CAH would need approximately 90 minutes per year to notify the OPO about all deaths and imminent deaths.

Under the CoP, a CAH may agree to have the OPO determine medical suitability for tissue and eye donation or may have alternative arrangements with a tissue bank and an eye bank. These alternative arrangements could include the CAH's direct notification of the tissue and eye bank of potential tissue and eye donors or direct notification of all deaths. If a CAH chose to contact both a tissue bank and an eye bank directly on all deaths, it could need an additional 180 minutes per year (that is, 5 minutes per call) in order to call both the tissue and eye bank directly. Again, the impact is small, and this regulation permits the CAH to decide how this process will take place. We note that many communities already have a one-phone call system in place. In addition, some OPOs are also tissue banks or eye banks, or both. A CAH that chooses to use the OPO's tissue and eye bank services in these localities would need to make only one telephone call on every death.

We estimate that additional time would be needed by the CAH to annotate the patient record or fill out a form regarding the disposition of a call to the OPO, the tissue bank, or the eye bank, or all three. This recordkeeping should take no more than 5 minutes to record each disposition or call. Therefore, all of the paperwork burden associated with the call(s) could add up to an additional 270 minutes per year per CAH.

In summary, the information collection requirements of this section would be a range of 3 to 6 hours per CAH annually.

We did not receive any comments on the proposed information collection and recordkeeping requirements.

These new information collection and recordkeeping requirements have been submitted to the Office of Management and Budget (OMB) for review under the authority of PRA. These requirements will not be effective until they have been approved by OMB.

The requirements associated with a hospital's application for a geographic redesignation, codified in Part 412, are currently approved by OMB under OMB approval number 0938–0573, with an expiration date of September 30, 2002.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

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 485

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

42 CFR Chapter IV is amended as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

A. 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).

§ 410.152 [Amended]

2. In § 410.152, paragraph (k)(2), the cross-reference ''§ 413.70(c)'' is removed and ''§ 413.70(b)(2)(iii)(B)'' is added in its place.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

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).

2. Section 412.2 is amended by revising the last sentence of paragraph (a) to read as follows:

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* * * * An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

* * * * *

§ 412.4 [Amended]

3. In § 412.4(f)(3), the reference to ''§ 412.2(e)'' is removed and ''§ 412.2(b)'' is added in its place.

4. Section 412.63 is amended by:

A. Revising paragraph (s).

B. Redesignating paragraphs (t), (u), (v), and (w) as paragraphs (u), (v), (w), and (x) respectively.

C. Adding a new paragraph (t).

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

* * * * *

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas.

(t) *Applicable percentage change for fiscal year 2002.* The applicable percentage change for fiscal year 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.

* * * * *

5. Section 412.73 is amended by:

A. Revising paragraph (c)(12).

B. Adding paragraphs (c)(13), (c)(14), and (c)(15).

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

* * * * *

(c) *Updating base-year costs*—* * *

(12) *For Federal fiscal years 1996 through 2000.* For Federal fiscal years 1996 through 2000, the update factor is the applicable percentage change for other prospective payment hospitals in each respective year as set forth in §§ 412.63(n) through (r).

(13) *For Federal fiscal year 2001.* For Federal fiscal year 2001, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(14) *For Federal fiscal year 2002.* For Federal fiscal year 2002, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.1 percentage points.

(15) *For Federal fiscal year 2003 and for subsequent years.* For Federal fiscal year 2003 and subsequent years, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

* * * * *

§ 412.75 [Amended]

6. In § 412.75(d), the cross reference ''§ 412.73 (c)(5) through (c)(12)'' is removed and ''§ 412.75(c)(15)'' is added in its place.

§ 412.76 [Redesignated]

7. Section 412.76 is redesignated as a new § 412.78.

8. A new § 412.77 is added to read as follows:

§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for certain sole community hospitals based on a Federal fiscal year 1996 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92, that received payment for its cost reporting period beginning during 1999 based on its hospital-specific rate for either fiscal year 1982 under § 412.73 or fiscal year 1987 under § 412.75, and that elects under paragraph (a)(2) of this section to be paid based on a fiscal year 1996 base period. If the 1996 hospital-specific rate exceeds the hospital-specific rates for either fiscal year 1982 or 1987, unless the hospital elects to the contrary, this rate will be used in the payment formula set forth under § 412.92(d)(1).

(2) Hospitals that are otherwise eligible for but elect not to receive payment on the basis of their Federal fiscal year 1996 updated costs per case must notify their fiscal intermediary of this decision prior to the end of their cost reporting period beginning on or after October 1, 2000, for which such payments would otherwise be made. If a hospital does not make the notification to its fiscal intermediary before the end of the cost reporting period, the hospital is deemed to have elected to have section 1886(b)(3)(I) of the Act apply to the hospital.

(3) This section applies only to cost reporting periods beginning on or after October 1, 2000.

(4) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 1996 rebasing.* (1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1997 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and does have a cost reporting period beginning on or after October 1, 1995 and before October 1, 1996, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 1996, the hospital will not have a hospital-specific rate based on fiscal year 1996.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1996, the update factor is determined using the methodology set forth in § 412.73(c)(12) through (c)(15).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount

(target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1996 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(i) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

9. Section 412.92 is amended by:

A. Revising paragraph (d)(1).

B. Redesignating paragraph (d)(2) as paragraph (d)(3).

C. Adding a new paragraph (d)(2).

§ 412.92 Special treatment: sole community hospitals.

* * * * *

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals*—(1) *General rule.* For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(i) The Federal payment rate applicable to the hospitals as determined under § 412.63.

(ii) The hospital-specific rate as determined under § 412.73.

(iii) The hospital-specific rate as determined under § 412.75.

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section), if the sole community hospital was paid for its cost reporting period beginning during 1999 on the basis of the hospital-specific rate specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section, unless the hospital elects otherwise under § 412.77(a)(1).

(2) *Transition of FY 1996 hospital-specific rate.* The intermediary calculates the hospital-specific rate determined on the basis of the fiscal year 1996 base period rate as follows:

(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the hospital-specific rates specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the hospital-specific rates specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section plus 50 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the hospital-specific rates specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section, plus 75 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(iv) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

* * * * *

10. Section 412.105 is amended by:

A. Revising paragraph (d)(3)(v).

B. Adding a new paragraph (d)(3)(vi).

C. Republishing paragraph (f)(1) introductory text and revising paragraph (f)(1)(vii).

D. Adding new paragraphs (f)(1)(viii) and (f)(1)(ix).

E. Revising paragraph (g).

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(d) *Determination of education adjustment factor.* * * *

(3) * * *

(v) For discharges occurring during fiscal year 2001, 1.54.

(vi) For discharges occurring on or after October 1, 2001, 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:

* * * * *

(vii) If a hospital establishes a new medical residency training program, as defined in § 413.86(g)(9) of this subchapter, the hospital's full-time equivalent cap may be adjusted in accordance with the provisions of §§ 413.86(g)(6)(i) through (iv) of this subchapter.

(viii) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on

or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its full-time equivalent cap in accordance with the provisions of § 413.86(g)(7) of this subchapter.

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in § 413.86(g)(8) of this subchapter.

* * * * *

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods occurring 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, according to the applicable payment percentages described in §§ 413.86(d)(3)(i) through (d)(3)(v) of this subchapter.

11. In § 412.106, the introductory text of paragraph (e) is republished and paragraphs (e)(4) and (e)(5) are revised to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(e) *Reduction in payment for FYs 1998 through 2002.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

* * * * *

(4) For FY 2001, 3 percent.

(5) For FY 2002, 4 percent.

* * * * *

12. Section 412.230 is amended by:

A. Adding a new paragraph (a)(5)(iv).

B. Republishing the introductory text of paragraph (e)(1).

C. Revising paragraph (e)(1)(iii) and (e)(1)(iv).

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

(a) General. * * *

(5) *Limitations on redesignation.* * * *

(iv) An urban hospital that has been granted redesignation as rural under § 412.103 cannot receive an additional reclassification by the MGCRB based on this acquired rural status as long as such redesignation is in effect.

* * * * *

(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:

* * * * *

(iii) One of the following conditions apply:

(A) With respect to redesignations for Federal fiscal year 1994 through 2001, the hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; or

(B) With respect to redesignations for Federal fiscal year 2002 and later years, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent, and, in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; and

(iv) One of the following conditions apply:

(A) 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.

(B) With respect to redesignations for fiscal year 1994 through 2001, the hospital's average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(C) With respect to redesignations for fiscal year 2002 and later years, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

C. Part 413 is amended as follows:

1. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. In § 413.40, paragraph (a)(3) is amended by revising paragraph (B) of the definition of ''ceiling'' and paragraph (d)(4) is revised, to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction.* * * *

(3) *Definitions.* * * *

Ceiling. * * *

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of Medicare inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

* * * * *

(d) *Application of the target amount in determining the amount of payment.* * * *

(4) *Continuous improvement bonus payments.* (i) For cost reporting periods beginning on or after October 1, 1997 and ending before October 1, 2000, 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—

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

(B) 1 percent of the ceiling.

(ii) For cost reporting periods beginning on or after October 1, 2000, and ending before September 30, 2001, eligible psychiatric hospitals and units and long-tern care 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—

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

(B) 1.5 percent of the ceiling.

(iii) For cost reporting periods beginning on or after October 1, 2001, and before September 30, 2002, eligible psychiatric hospitals and units and long-term care hospitals receive payments in addition to those in paragraph (d)(5) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the periods; or

(B) 2 percent of the ceiling.

* * * * *

3. Section 413.70 is revised to read as follows:

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH.* (1) Payment for inpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its inpatients, 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, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs; and

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers.

(2) Payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(b) *Payment for outpatient services furnished by a CAH*—(1) *General.* Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is the amount determined under paragraph (b)(2) of this section.

(2) *Reasonable costs for facility services.* (i) Payment for outpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its outpatients, 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, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of costs or charges;

(B) RCE limits;

(C) Any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7); and

(D) Blended payment amounts for ambulatory surgical services, radiology services, and other diagnostic services;

(ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients, and is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

(iii) The following payment principles are used when determining payment for outpatient clinical diagnostic laboratory tests.

(A) The amount paid is equal to 100 percent of the least of—

(*1*) Charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act;

(*2*) The limitation amount for that test determined under section 1833(h)(4)(B) of the Act or the amount of the charges billed for the test; or

(*3*) A negotiated rate established under section 1833(h)(6) of the Act.

(B) Payment for outpatient clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts, as specified in § 410.152(k) of this chapter.

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.* (i) A CAH may elect to be paid for outpatient services in any cost reporting period under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section. This election must be made in writing, made on an annual basis, and delivered to the intermediary at least 60 days before the start of each affected cost reporting period. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following amounts:

(A) For facility services, not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts that otherwise would be paid for the services if the CAH had not elected payment under this method.

(iii) Payment to a CAH is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161 of this chapter.

(c) *Final payment based on cost report.* Final payment to the CAH for CAH facility services to inpatients and outpatients furnished during a cost reporting is based on a cost report for that period, as required under § 413.20(b).

4. Section 413.86 is amended by:

A. Revising the first sentence of paragraph (d)(3).

B. Revising the introductory text of paragraph (e)(3).

C. Redesignating paragraph (e)(4) as paragraph (e)(5).

D. Adding a new paragraph (e)(4).

E. Revising newly designated paragraph(e)(5)(i)(B).

F. Adding a new paragraph (e)(5)(iv).

§ 413.86 Direct graduate medical education payments.

* * * * *

(d) *Calculating payment for graduate medical education costs.* * * *

(3) *Step Three.* For portions of cost reporting periods occurring 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. * * *

(e) *Determining per resident amounts for the base period.* * * *

(3) *For cost reporting periods beginning on or after July 1, 1986.* Subject to the provisions of paragraph (e)(4) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

* * * * *

(4) *For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(i) *General provisions.* For purposes of § 413.86(e)(4)—

(A) *Weighted average per resident amount.* The weighted average per resident amount is established as follows:

(*1*) Using data from hospitals' cost reporting periods ending during FY 1997, HCFA calculates each hospital's single per resident amount by adding each hospital's primary care and non-primary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

(*2*) Each hospital's single per resident amount calculated under paragraph (e)(4)(i)(A)(*1*) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under § 414.26 of this chapter) in which the hospital is located.

(*3*) HCFA calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (e)(4)(i)(A)(*2*) of this section. The resulting amount is the weighted average per resident amount.

(B) *Primary care/obstetrics and gynecology and non-primary care per resident amounts.* A hospital's per resident amount is an amount inclusive of any CPI–U adjustments that the hospital may have received since the hospital's base year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and non-primary care residents as specified under paragraph (e)(3)(ii) of this section.

(ii) *Adjustment beginning in FY 2001 and ending in FY 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount is adjusted in accordance with paragraphs (e)(4)(ii)(A) through (e)(4)(ii)(C) of this section, in that order:

(A) *Updating the weighted average per resident amount for inflation.* The weighted average per resident amount (as determined under paragraph (e)(4)(i)(A) of this section) is updated by the estimated percentage increase in the CPI–U during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(B) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (e)(4)(ii)(A) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician Fee schedule area in which each hospital is located, established in accordance with § 414.26 of this subchapter.

(C) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (e)(4)(ii)(B) of this section, is compared to the hospital's per resident amount is revised, if appropriate, according to the following three categories:

(*1*) *Floor.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001. For subsequent cost reporting periods, the hospital's per resident amount is updated using the methodology specified under paragraph (e)(3)(i) of this section.

(2) *Ceiling.* If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2005:

(*i*) *FY 2001.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (e)(4)(ii)(B) of this section), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI–U factor.

(*ii*) *FY 2002.* For cost reporting periods beginning on or after October 1, 2001 and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI–U factor.

(iii) *FY 2003 through FY 2005.* For cost reporting periods beginning on or after October 1, 2002 and on or before September 30, 2005, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph (e)(3)(i) of this section, except that the CPI–U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(*iv*) *General rule for hospitals that exceed the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria (e)(4)(ii)(C)(*2*)(*i*) through (*iii*) of this section, the current year per resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(*3*) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per esident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (e)(3)(i) of this section.

(5) *Exceptions*—(i) *Base period for certain hospitals.* * * *

(B) The weighted 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 weighted 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) of his chapter.

* * * * *

(iv) Effective October 1, 2000, the per resident amounts established under paragraphs (e)(5)(i) through (iii) of this section are subject to the provisions of paragraph (e)(4) of this section.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

1. The authority citation for part 485 continues to read as follows:

Authority: Sec. 1820 of the Act (42 U.S.C. 1395i–1114), unless otherwise noted.

2. A new § 485.643 is added to subpart F to read as follows:

§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or

who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term ''Organ'' means a human kidney, liver, heart, lung, or pancreas.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare-Hospital Insurance)

Dated: July 24, 2000.

Nancy Ann Min DeParle,

Administrator, Health Care, Financing Administration

Dated: July 24, 2000.

Donna E. Shalaa,

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, 2000 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2000

I. Summary and Background

In this Addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth 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, 2000, 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 yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 25 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus 75 percent of the updated FY 1982 or FY 1987 hospital-specific rate. Section 405 of Public Law 106–113 amended section 1886(b)(3) of the Act to allow a sole community hospital that was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate to elect to rebase its hospital-specific ate based on its FY 1996 cost per discharge.

Section 404 of Public Law 106–113 amended section 1886(d)(5)(G) of the Act to extend the special treatment for Medicare-dependent, small rural hospitals. 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 Federal national rate.

As discussed below in section II of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2001. The changes, to be applied prospectively, affect the calculation of the Federal rates. In section III of this Addendum, we finalize our proposal to discontinue listing updates to the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. In section IV of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2001. Section V of this Addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2001. The tables to which we refer in the preamble to this final rule are presented at the end of this Addendum in section VI.

II. Changes to Prospective Payment Rates For Inpatient Operating Costs for FY 2001

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the 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, 2000. 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 2001.

In summary, the standardized amounts set forth in Tables 1A and 1C of section VI of this Addendum reflect—

- Updates of 2.3 percent for all areas (that is, the market basket percentage increase of 3.4 percent minus 1.1 percentage points);
- 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 2000 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 2000 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 table 1E of section VI of this Addendum, which apply to sole community hospitals, reflect updates of 3.4 percent (that is, the full market basket percentage increase) as provided for in section 406 of Public Law 106–113, 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 us to determine the Medicare target amounts

for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

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 (d)(2)(C) of the Act required us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, a 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, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are revising the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1999 MedPAR file.

Comment: One commenter asserted that our labor share of 71.1 percent is overstated and particularly disadvantageous to small rural hospitals. The commenter questioned how we arrived at this percentage when their informal survey of 300 hospitals found none with salaries and benefits in excess of 56 percent of total operating costs. The commenter proposed that HCFA should only recognize costs that are included in the wage index survey on the cost report when recalculating the labor share.

Response: We set forth the latest revision of the labor share calculation in the August 29, 1997 final rule (62 FR 45993) after considering comments in response to our proposal set forth in the June 2, 1997 proposed rule (62 FR 29920). We feel that our current methodology accurately captures, on average, the operating costs faced by hospitals that are affected by local labor markets. It should also be noted that the wage and benefit shares of the prospective payment system's market basket are determined using the wage index survey data provided in the Medicare Cost Reports. However, we will take these comments into consideration when we perform our next periodic revision of the hospital operating market basket.

2. Computing Large Urban and Other Area Averages

Sections 1886(d)(2)(D) and (d)(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 (d)(9)(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 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 million. 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 1998 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 2001. These areas are identified by a footnote in Table 4A.

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 areas' and the other areas' average standardized amounts for FY 2001 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVI) of the Act specifies an update factor for the standardized amounts for FY 2001 equal to the market basket percentage increase minus 1.1 percentage points for hospitals, except sole community hospitals, in all areas. The Act, as amended by section 406 of Public Law 106–113, specifies an update factor equal to the market basket percentage increase for sole community hospitals.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2001 is 3.4 percent. Thus, for FY 2001, the update to the average standardized amounts equals 3.4 percent for sole community hospitals and 2.3 percent for other hospitals.

As in the past, we are adjusting the FY 2000 standardized amounts to remove the effects of the FY 2000 geographic reclassifications and outliner payments before applying the FY 2001 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliners. We then apply the new offsets to the standardized amounts for outliners and geographic reclassifications for FY 2001.

Although the update factors for FY 2001 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY2001 for both prospective payment hospitals and hospitals excluded from the prospective payment system. We have included our final recommendations in Appendix C 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 requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index 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 2000 relative weights and wage index to aggregate payments using the FY 2001 relative weights and wage index. The same methodology was used for the FY 2000 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 0.997225. We also adjusted the Puerto Rico-specific standardized amounts to adjust for the effects of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999649. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2000 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 these same adjustment factors to the hospital-specific rates that are effective for cost

reporting periods beginning in on or after October 1, 2000. (See the discussion in the September 4, 1990 final rule (55 FR 6073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment. Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the Medicare Georgraphic 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 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. Section 152(b) of Public Law 106–113 requires reclassifications under that subsection to be treated as reclassifications under section 1886(d)(10) of the Act. 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. In the May 5, 2000 proposed rule, based on these simulations, we applied an adjustment factor of 0.994270 to ensure that the effects of reclassification are budget neutral. The final budget neutrality adjustment factor is 0.993187.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2000 budget neutrality adjustment factor. We note that the proposed FY 2001 adjustment reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 29, 2000. The effects of any additional reclassification changes that occurred as a result of appeals and reviews of MGCRB decisions for FY 2001 or hospitals' withdrawal of reclassification requests are reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in this final rule.

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). 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.

i. FY 2001 outlier thresholds. For FY 2000, the fixed loss cost outlier threshold was equal to the prospective payment for the DRG plus $14,050 ($12,827 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) was 80 percent. We applied an outlier adjustment to the FY 2000 standardized amounts of 0.948859 for the large urban and other areas rates and 0.9402 for the capital Federal rate.

For FY 2001, we proposed to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $17,250 ($15,763 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. In setting the final FY 2001 outlier thresholds, we used updated data. In this final rule, we are establishing a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $17,550 ($16,036 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we are maintaining the marginal cost factor for cost outliers at 80 percent. As we have explained in the past, to calculate outlier thresholds we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 1999, we used a cost inflation factor of minus 1.724 percent (a cost per case decrease of 1.724 percent). For FY 2000, we used a cost inflation factor of zero percent. To set the proposed FY 2001 outlier thresholds, we used a cost inflation factor of 1.0 percent. We are using a cost inflation actor of 1.8 percent to set the final FY 2001 outlier thresholds. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1999 is higher than we projected before the beginning of FY 1999, and that the percentage of actual outlier payments for FY 2000 will likely be higher than we projected before the beginning of FY 2000. The calculations of ''actual'' outlier payments are discussed below.

ii. Other changes concerning outliers. 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 2001 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 established 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 thresholds for FY 2001 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.9 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 2001 were as follows:

	Operating standardized amounts	Capital federal rate
National	0.948865	0.9416
Puerto Rico	0.975408	0.9709

The final outlier adjustment factors applied to the standardized amounts for FY 2001 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948908	0.9409
Puerto Rico	0.974791	0.9699

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 2000 outlier adjustment factors on the standardized amounts.

Table 8A in section VI 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 fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios replace the ratios published in the July 30, 1999 final rule (64 FR 41620). Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios will be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.200265 or greater than 1.298686 and capital cost-to-charge ratios lower than 0.01262 greater than 0.16792. 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 during FY 2001 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. FY 1999 and FY 2000 outlier payments. In the July 30, 1999 final rule (64 FR 41547), we stated that, based on available data, we estimated that actual

FY 1999 outlier payments would be approximately 6.3 percent of actual total DRG payments. This was computed by simulating payments using the March 1998 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1999 bills but instead reflected the application of FY 1999 rates and policies to available FY 1998 bills. Our current estimate, using available FY 1999 bills, indicates that actual outlier payments for FY 1999 were approximately 7.6 percent of actual total DRG payments. We note that the MedPAR file for FY 1999 discharges continues to be updated. Thus, the data indicate that, for FY 1999, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1999 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1999). In fact, the data indicate that the proportion of actual outlier payments for FY 1999 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1999.

We currently estimate that actual outlier payments for FY 2000 will be approximately 6.2 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 2000. This estimate is based on simulations using the March 2000 update of the provider-specific file and the March 2000 update of the FY 1999 MedPAR file (discharge data for FY 1999 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2000 by applying FY 2000 rates and policies to available FY 1999 bills.

Comment: Several commenters opposed the proposed change in the cost outlier fixed loss amount from $14,050 to $17,250. The commenters stated that our rationale for this change is that outlier payments were approximately 7.5 percent of total actual DRG payments in FY 1999 and are anticipated to be 6.1 percent in FY 2000. The commenters observed that no additional payments were made in previous years when outlier payments fell below 5.1 percent. The commenters stated that cost outlier thresholds were adjusted as a result of changes made by Public Law 105–33 and that the reason current payments exceed the 5.1 percent target was due to these changes. The commenters also noted that the majority of hospitals did not reap windfall profits on outlier cases, merely mitigated their losses. The commenters characterized these losses as particularly devastating as they come at a time when MedPAC's analyses show that hospitals' financial performance is deteriorating. One commenter suggested that the Secretary consider acting independently of Congress by lowering the FY 2001 outlier threshold without further reducing the standardized payment amount.

Response: We believe the commenters misunderstood the methodology for calculating the FY 2001 outlier fixed loss amount. Under section 1886(d)(5)(A)(iv) of the Act, we are required to set the outlier threshold at a level such that outlier payments are projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates. That FY 2000 outlier payments are now anticipated to exceed 5.1 percent of total payments is an indication that costs are rising faster than we predicted when setting the outlier fixed loss amount prior to the beginning of FY 2000. This was one of several factors taken into consideration when we estimated FY 2001 costs to model projected outlier payments for FY 2001. The outlier fixed loss amount is set to meet the aforementioned statutory requirement. Each year we set the outlier thresholds for the upcoming fiscal year by making projections based on the best available data; we do not make the thresholds more stringent simply because current data indicate that, in a previous year, actual outlier payments turned out to be more than we projected when we set the outlier thresholds for that year. Thus, the change in the outlier fixed loss amount from $14,050 (for FY 2000) to $17,250 (proposed FY 2001) reflects estimates and projections about costs in FY 2001. We did not increase the outlier fixed loss amount simply because we now expect that actual outlier payments exceed 5.1 percent of actual total DRG payments for FY 1999 and FY 2000 respectively.

We do not concur with the commenters' assertion that changes to the outlier methodology made by Public Law 105–33 caused current outlier payments to exceed 5.1 percent. Public Law 105–33 did not change the statutory requirement that projected outlier payments be between 5 percent and 6 percent of projected total payments based on DRG prospective payment rates. Again, we believe that current outlier payments are greater than expected in part because actual hospital costs may be higher than reflected in the methodology used to set the outlier threshold.

Finally, we believe in the concept of outlier payments as a protection against the financial effects of treating extraordinarily high-cost cases through an offsetting adjustment to the standardized amounts according to the statutory requirements set forth as required in sections 1886(d)(5)(A)(iv) and 1886(d)(3)(E) of the Act. These sections of the Act require that outlier thresholds be calculated so that outlier payments are projected to equal between 5 and 6 percent of total payments based on DRG prospective payment rates and the standardized amounts are to be reduced by the same percentage to account for the projected proportion of payments paid to outliers.

5. FY 2001 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A (Table 1E for sole community hospitals) contains the two national standardized amounts that are applicable to all hospitals, except 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 Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A, 1C and 1E, 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 we make an adjustment 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 this preamble, we discuss the data and methodology for the FY 2001 wage index. 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 2001, we are adjusting 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	1.25
County of Hawaii	1.15
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 VI of this Addendum contains the relative weights that we will use for discharges occurring in FY 2001. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2001

General Formula for Calculation of Prospective Payment Rates for FY 2001

The prospective payment rate for all hospitals located outside of Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

The prospective payment rate for sole community hospitals = whichever of the following rates yields the greatest aggregate payment: The Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if the sole community hospital was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate and elects rebasing, 25 percent of its updated hospital-specific rate based on FY 1996 cost per discharge plus 75 percent of its updated FY 1982 or FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate, or, 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, 100 percent of the Federal rate plus 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 Federal national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 2000 and before October 1, 2001, 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.

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 Table 1A or 1E1 in section VI 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 VI 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 VI of this Addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals)

Section 1886(b)(3)(C) of the Act, as amended by section 405 of Public Law 106–113, provides that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if the sole community hospital was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate and elects rebasing, 25 percent of its updated hospital-specific rate based on FY 1996 cost per discharge plus 75 percent of the updated FY 1982 or FY 1987 hospital-specific rate.

Section 1886(d)(5)(G) of the Act, as amended by section 404 of Public Law 106–113, provides 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 either the FY 1982 cost per discharge, the FY 1987 cost per discharge or, for qualifying sole community hospitals, the FY 1996 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 2001. We are increasing the hospital-specific rates by 3.4 percent (the hospital market basket rate of increase) for sole community hospitals and by 2.3 percent (the hospital market basket percentage increase minus 1.1 percentage points) for Medicare-dependent, small rural hospitals for FY 2001. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for sole community hospitals in FY 2001, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2001, is the

market basket rate of increase minus 1.1 percentage points.

b. Calculation of Hospital-Specific Rate. For sole community hospitals, the applicable FY 2001 hospital-specific rate is the greater of the following: the hospital-specific rate for the preceding fiscal year, increased by the applicable update factor (3.4 percent); or, if the hospital qualifies to rebase its hospital-specific rate based on cost per case in FY 1996 and elects rebasing, 75 percent of the hospital-specific rate for the preceding fiscal year, increased by the applicable update factor, plus 25 percent of its rebased FY 1996 hospital-specific rate updated through FY 2001. For Medicare-dependent, small rural hospitals, the applicable FY 2001 hospital-specific rate is calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (2.3 percent), which is the same as the update for all prospective payment hospitals, except sole community hospitals. In addition, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, 0.997225) as discussed in section II.A.4.a. of this Addendum. The resulting rate is 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, 2000, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 2000 and Before October 1, 2001

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 of section VI 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 VI 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 VI 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 of section VI of the Addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI 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 VI 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 the Payment Rates for Blood Clotting Factor for Hemophilia Inpatients

For the past 2 years in the **Federal Register** (63 FR 41010 and 64 FR 41549), we have discussed section 4452 of Public Law 105–33, which 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. In these prior rules, we have described the payment policy that the payment amount for clotting factors covered by this inpatient benefit is equal to 85 percent of the AWP, subject to the Part A deductible and coinsurance requirements, and specifically listed the updated add-on payment amounts for each clotting factor, as described by HCFA's Common Procedure Coding System (HCPCS). Because we are not changing the policy established 2 years ago, we are discontinuing the practice of listing these amounts in the annual proposed and final rules. Instead, the program manuals will instruct fiscal intermediaries to follow this policy and obtain the average wholesale price (AWP) for each relevant HCPCS from either their corresponding local carrier or the Medicare durable medical equipment regional carrier (DMERC) that has jurisdiction in their area. Carriers already calculate the AWP based on the median AWP of the several products available in each category of factor.

The payment amounts will be determined using the most recent AWP data available to the carrier at the time the intermediary performs these annual update calculations.

These amounts are updated annually and are effective for discharges beginning on or after October 1 of the current year through September 30 of the following year. Payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

Comment: One commenter disagreed with our proposal to have individual Medicare contractors determine the payment allowance for the pass-through amount payable for clotting factors for inpatients with hemophilia. The commenter stated that individual Medicare contractors would not maintain a uniform payment amount and this inconsistency would result in wide disparities in reimbursement. The commenter recommended that HCFA continue to set a standard national rate that would be the same for everyone. The commenter also expressed concern that updates in payment allowances for clotting factors would vary widely among contractors.

Response: We continue to believe that our carriers are the most appropriate entities to obtain the AWP for these factors, and are therefore proceeding with our proposed change. While we do not anticipate inconsistency in the payment allowances for these products around the country, we do not want to jeopardize access to these essential biologicals for Medicare beneficiaries who are hemophiliacs. Therefore, we have determined that a more appropriate approximation for the cost of clotting factor furnished on an inpatient basis is 95 percent of the AWP, consistent with the Part B benefit for the same factors. This increase from 85 percent to 95 percent of the AWP will assure access despite possible Medicare contractor variations in the applicable AWP.

IV. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2001

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 capital Federal prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the capital

Federal rate and the hospital-specific rates and the hospital-specific rates for FY 2001. The rates will be effective for discharges occurring on or after October 1, 2000.

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 capital 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 capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital 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 capital 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 capital 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. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that 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 the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of Public Law 105–33, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard capital Federal rate is reduced by 17.78 percent. A small 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. Section 4402 of Public Law 105–33 also requires that fFor discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital-specific rate is reduced by 17.78 percent. A small part of this 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 of this final rule.

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. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are 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. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the capital Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

In the July 30, 1999 final rule (64 FR 41551), we established a capital Federal rate of $377.03 for FY 2000. In the proposed rule, we stated that, as a result of the changes we proposed to the factors used to establish the capital Federal rate, the proposed FY 2001 capital Federal rate was $383.06. In this final rule, we are establishing a FY 2001 capital Federal rate of $382.03.

In the discussion that follows, we explain the factors that were used to determine the FY 2001 capital Federal rate. In particular, we explain why the FY 2001 capital Federal rate has increased 1.33 percent compared to the FY 2000 capital Federal rate. We also estimate aggregate capital payments will increase by 5.48 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions, the increase in case-mix, and the increase in the Federal blend percentage from 90 to 100 percent for fully prospective payment hospitals.

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. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 2001 compared to FY 2000.

1. Standard Capital Federal Rate Update

a. Description of the Update Framework. Under § 412.308(c)(1), the standard capital 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 for FY 2001 under that framework of 0.9 percent, based on data available at that

time. Under the update framework, the final update factor for FY 2001 is 0.9 percent. This update factor is based on a projected 0.9 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 1999 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2001 CIPI projection in section II.D of this Addendum. In this section IV of the Addendum, 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 1999 DRG reclassification and recalibration as part of our FY 2001 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2001, we are projecting a 0.5 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.5 percent in FY 2001. Therefore, the net adjustment for case-mix change in FY 2001 is 0.0 percentage points.

Comment: One commenter stated that the magnitude of the upward adjustment of 0.5 percent for real case-mix change and the downward adjustment of 0.5 percent for projected case-mix change (a net case-mix adjustment of 0.0 percent) for FY 2001 appears inconsistent with past numbers published by HCFA. They recommend that we review our adjustment for case-mix and provide a basis for these adjustment amounts.

Response: HCFA's Office of the Actuary estimates the projection of total case-mix changes used in the capital and operating update frameworks. The estimate of case-mix change for FY 2001 is the same as the estimate of case-mix change for FY 2000 published in the July 30, 1999 final rule (64 FR 41551). This estimate of case-mix change for FY 2001 is also very close to what has been used for the past 5 years. Past estimates of case-mix change have always assumed that most of the case-mix change will be real, and therefore the net adjustments for case-mix change have always been small or zero. Again this year, our estimate assumes the same kind of relationship. Therefore, we believe that our projection of a 0.5 percent increase in the case-mix index and our estimate that real case-mix increase will equal 0.5 percent (for a net case-mix adjustment of 0.0 percent) in FY 2001 is consistent with past case-mix change update recommendations. As more experience develops we may be able to develop a better estimate of the real part of the case-mix increase.

We estimate that FY 1999 DRG reclassification and recalibration will result 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. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update recommendation for FY 2001.

The capital 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 and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index 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. A forecast error of 0.0 percentage points was calculated for the FY 1999 update. That is, current historical data indicate that the FY 1999 CIPI used in calculating the forecasted FY 1999 update factor did not overstate or understate realized price increases. We therefore are making a 0.0 percent adjustment for forecast error in the update for FY 2001.

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 for hospital and related services), 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. Therefore, we have 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 2001, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1995 through 1999 data. In determining case-mix constant intensity, we found that observed case-mix increase was 1.7 percent in FY 1995, 1.6 percent in FY 1996, 0.3 percent in FY 1997, −0.4 percent in FY 1998, and −0.3 percent in FY 1999. For 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 usually 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 1995 through FY 1999. Based on this analysis, we believe that all of the observed case-mix increase for FY 1997, FY 1998, and FY 1999 is real. The increases for FY 1995 and FY 1996 were in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. Given estimates of real case-mix of 1.0 percent for FY 1995, 1.0 percent for FY 1996, 0.3 percent for FY 1997, −0.4 percent for FY 1998, and −0.3 percent for FY 1999, we estimate that case-mix constant intensity declined by an average 0.7 percent during FYs 1995 through 1999, for a cumulative decrease of 3.6 percent. If we assume that real case-mix increase was 1.4 percent for FY 1995, 1.4 percent for FY 1996, 0.3 percent for FY 1997, −0.4 percent for FY 1998, and −0.3 percent for FY 1999, we estimate that case-mix constant intensity declined by an average 0.9 percent during FYs 1995 through 1999, for a cumulative decrease of 4.5 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 2001.

We note that the operating recommendation addressed in Appendix C of this final rule reflects the possible range that a negative adjustment could span (−0.6 percent to 0.0 percent adjustment) based on our analyses that intensity has declined during that 5-year period. While the calculation of the adjustment for intensity is identical in both the capital and the operating update frameworks, consistent with past capital update recommendations and the FY 2001 operating recommendation, we did not make a negative adjustment for intensity in the FY 2001 capital update.

b. Comparison of HCFA and MedPAC Update Recommendations. MedPAC's FY 2001 update recommendation for capital prospective payments was not included in its March 2000 Report to Congress. In the May 5, 2000 proposed rule, we stated that we would address the comparison of HCFA's update recommendation and MedPAC's update recommendation in this final rule, once we have had the opportunity to review the data analyses that substantiate MedPAC's recommendation.

In its June 2000 Report to Congress, MedPAC presented a combined operating and capital update for hospital inpatient prospective payment system payments for FY 2001, and recommended that Congress implement a single combined (operating and capital) prospective payment system rate. With the end of the transition to fully prospective capital payments ending with FY 2001, both operating and capital prospective system payments will be made using standard Federal rates adjusted by hospital specific payment variables. Currently, section 1886(b)(3)(B)(i)(XVI) of the Act sets forth the FY 2001 percentage increase in the prospective payment system operating cost standardized amounts. The prospective payment system capital update is set under the framework established by the Secretary outlined in § 412.308(c)(1).

For FY 2001, MedPAC's update framework supports a combined operating and capital update for hospital inpatient prospective payment system payments of 3.5 percent to 4.0 percent (or between the increase in the combined operating and capital market basket plus 0.6 percentage points and the increase in the combined operating and capital market basket plus 1.1 percentage points). MedPAC also notes that while the number of hospitals with negative inpatient hospital margins have increased in FY 1998 (mostly likely as the result of the implementation of Pub. L. 105–33), overall high inpatient Medicare margins generally offset hospital losses on other lines of Medicare services. MedPAC continues to project positive (greater than 11 percentage points) Medicare inpatient hospital margins through FY 2002.

MedPAC's FY 2001 combined operating and capital update framework uses a weighted average of HCFA's forecasts of the operating (PPS Input Price Index) and capital (CIPI) market baskets. This combined market basket is used to develop an estimate of the change in overall operating and capital prices. MedPAC calculated a combined market basket forecast by weighting the operating market basket forecast by 0.92 and the capital market basket forecast by 0.08, since operating costs are estimated to represent 92 percent of total hospital costs (capital costs are estimated to represent the remaining 8 percent of total hospital costs). MedPAC's combined market basket for FY 2001 is estimated to increase by 2.9 percent, based on HCFA's March 2000 forecasted operating market basket increase of 3.1 percent and HCFA's March 2000 forecasted capital market basket increase of 0.9 percent.

HCFA's Response to MedPAC's Recommendation: As we stated in the May 5, 2000 proposed rule (65 FR 26317), we responded to a similar comment in the July 30, 1999 final rule (64 FR 41552), the July 31, 1998 final rule (63 FR 41013), and the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. However, we have not yet developed such a single framework as the actual operating system update has been determined by Congress through FY 2002. In the meantime, we intend to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We maintain our goal of combining the update frameworks at the end of the 10-year capital transition period (the end of FY 2001) and may examine combining the payment systems post-transition. Because of the similarity of the update frameworks, we believe that they could be combined with little difficulty.

Our recommendation for updating the prospective payment system capital Federal rate is supported by the following analyses that measure changes in scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification and recalibration, and forecast error correction. MedPAC recommends a 3.5 to 4.0 percent combined operating and capital update for hospital inpatient prospective payments. Under our existing capital update framework, we are recommending a 0.9 percent update to the capital Federal rate. For purposes of comparing HCFA's capital update recommendation and MedPAC's update recommendation for FY 2001, we have isolated the capital component of MedPAC's combined market basket forecast, which was based on HCFA's March 2000 CIPI forecast of 0.9 percent. As a result, MedPAC's update recommendation for FY 2001 for capital

payments is between 1.4 percent and 1.9 percent (see Table 1).

There are some differences between HCFA's and MedPAC's update frameworks, which account for the difference in the respective update recommendations. In it's combined FY 2001 update recommendation, MedPAC uses HCFA's capital input price index (the CIPI) as the starting point for estimating the change in prices since the previous year. HCFA's CIPI includes price measures for interest expense, which are an indicator of the interest rates facing hospitals during their capital purchasing decisions. Previously, MedPAC's capital market basket did not include interest expense; instead it included a financing policy adjustment when necessary to account for the prolonged changes in interest rates. HCFA's CIPI is vintage-weighted, meaning that it takes into account price changes from past purchases of capital when determining the current period update. In the past, MedPAC's capital market basket was not vintage-weighted, and only accounted for the current year price changes. This year, both HCFA's and MedPAC's FY 2001 update frameworks use HCFA's CIPI, which is currently forecast at 0.9 percent.

MedPAC and HCFA also differ in the adjustments they make in their respective frameworks. (See Table 1 for a comparison of HCFA and MedPAC's update recommendations.) MedPAC makes an adjustment for scientific and technological advances, which is offset by a fixed standard for productivity growth. HCFA has not adopted a separate adjustment for capital science and technology or productivity and efficiency. Instead, we have identified a total intensity factor, which reflects scientific and technological advances, but we have not identified an adequate total productivity measure. The Commission also includes a site-of-care substitution adjustment (unbundling of the payment unit) to account for the decline in the average length of Medicare acute inpatient stays. This adjustment is designed to shift funding along with associated costs when Medicare patients are discharged to postacute settings that replace acute impatient days. Other factors, such as technological advances that allow for a decreased need in follow-up care and BBA mandated policy on payment for transfer cases that limits payments within certain DRGs, are reflected in the site-of-care substitution adjustment as well. A negative intensity adjustment would capture the site-of-care substitution accounted for in MedPAC's update framework. However, we did not make a negative adjustment for intensity this year. We may examine the appropriateness of adopting a negative intensity adjustment at a later date.

For FY 2001, MedPAC recommends a 0.0 percent combined adjustment for site-of-care substitutions. MedPAC recommends a 0.0 to a 0.5 percent combined adjustment for scientific and technological advances, which was offset by a fixed productivity standard of 0.5 percent for FY 2001. We recommend a 0.0 percent intensity adjustment.

Additionally, MedPAC has included an adjustment for one-time factors to account for significant costs incurred by hospitals for unusual, non-recurring events or for the costs of major new regulatory requirements. The Commission is not recommending any additional allowance for FY 2001 and recommends a 0.0 percent combined adjustment for one-time factors for FY 2001.

MedPAC makes a two-part adjustment for case-mix changes, which takes into account changes in case-mix in the past year. They recommend a 0.5 percent combined adjustment for DRG coding change and a 0.0 percent combined adjustment for within-DRG complexity change. This results in a combined total case mix adjustment of 0.5 percent. We recommend a 0.0 percent total case-mix adjustment, since we are projecting a 0.5 percent increase in the case-mix index and we estimate that real case-mix increase will equal 0.5 percent in FY 2001.

We recommend a 0.0 percent adjustment for forecast error correction. MedPAC's combined FY 2001 update recommendation includes a 0.1 percent adjustment for forecast error correction. However, they noted that this forecast error adjustment is a result of the difference between the forecasted FY 1999 operating market basket of 2.4 percent and the actual FY 1999 operating market basket increase of 2.5 percent. The FY 1999 capital market basket forecast was equal to the actual observed increase of 0.7 percent for capital costs. Therefore, we have included 0.0 percent adjustment for FY 1999 forecast error correction in the comparison of MedPAC's and HCFA's update recommendations for FY 2001 shown below in Table 1.

We applied MedPAC's ratio of hospital capital costs to total hospital costs (8 percent) to the adjustment factors in their update framework for comparison with HCFA's capital update framework. The net result of these adjustments is that MedPAC has recommended a 0.9 to 1.0 percent update to the capital Federal rate for FY 2001. MedPAC believes that the annual updates to the capital and operating payments under the prospective payment system should not differ substantially, even though they are determined separately, since they correspond to costs generated by providing the same inpatient hospital services to the same Medicare patients. We describe the basis for our 0.9 percent total capital update for FY 2001 in the preceding section. While our recommendation is below the range recommended by MedPAC, in past years our update recommendation has been above the lower limit of MedPAC's update recommendation. For instance, for FY 2000 MedPAC's update recommendation was −1.1 percent to 1.8 percent. HCFA's FY 2000 update factor was 0.3 percent, which is 1.4 percentage points higher than the lower limit of MedPAC's update recommendation. For FY 2001, our update 0.9 percent is only 0.5 percentage points below MedPAC's lower limit of their recommendation.

TABLE 1.—HCFA'S FY 2001 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION

	HCFA's update factor	MedPAC's recommendation
Capital Input Price Index	0.9	0.9[1]
Policy Adjustment Factors		
Intensity	0.0	
Science and Technology		0.0 to 0.5
Intensity		([2])

TABLE 1.—HCFA'S FY 2001 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION—Continued

	HCFA's update factor	MedPAC's recommendation
Real within DRG Change	.....	([3])
Site-of-Care Substitution	.....	0.0
Subtotal	0.0	0.0 to 0.5
Case-Mix Adjustment Factors		
Projected Case-Mix Change	−0.5	
Real Across DRG Change	0.5	
Coding Change	.....	0.5
Real within DRG Change	[4]	0.0
Subtotal	0.0	0.5
One-Time Factors	.....	0.0
Effect of FY 1998 Reclassification and Recalibration	0.0	
Forecast Error Correction	0.0	0.0
Total Update	0.9	1.4 to 1.9

[1] Used HCFA's March 2000 capital market basket forecast in its combined update recommendations.
[2] Included in MedPAC's productivity offset in its science and technology adjustment.
[3] Included in MedPAC's case-mix adjustment.
[4] Included in HCFA's intensity factor.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the capital Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 100 percent for cost reporting periods beginning in FY 2001 for hospitals paid under the fully prospective payment 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 capital Federal rate to total inpatient capital-related payments under the capital 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 100 percent of the capital Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model payments as if all hospitals were paid 100 percent of the capital Federal rate because, as explained above, outlier payments are made only on the portion of the capital Federal rate that is included in the hospital's inpatient capital-related payments.

In the July 30, 1999 final rule, we estimated that outlier payments for capital in FY 2000 would equal 5.98 percent of inpatient capital-related payments based on the capital Federal rate (64 FR 41553). Accordingly, we applied an outlier adjustment factor of 0.9402 to the capital 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 5.91 percent of inpatient capital-related payments based on the capital Federal rate in FY 2001. Therefore, we are establishing an outlier adjustment factor of 0.9409 to the capital Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2001 is lower than the percentage for FY 2000.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2001 is 1.0007 (0.9409/0.9402). The outlier adjustment increases the FY 2001 capital Federal rate by 0.07 percent compared with the FY 2000 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 capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. We use the actuarial model, described in Appendix B of this final rule, to estimate the aggregate payments that would have been made on the basis of the capital 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 capital 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 2000, we calculated a GAF/DRG budget neutrality factor of 0.9985. In the proposed rule for FY 2001, we proposed a GAF/DRG budget neutrality factor of 0.9986. In this final rule, based on calculations using updated data, we are applying a factor of 0.9979. The GAF/DRG budget neutrality factors are built permanently into the rates; that is,

they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more 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 2000 to FY 2001 is 0.9979. The cumulative change in the rate due to this adjustment is 0.9993 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, and FY 2001: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 = 0.9993$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2001 geographic reclassification decisions made by the MGCRB compared to FY 2000 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard capital 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 capital Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to determine the exceptions payment adjustment factor. We describe that model in Appendix B to this final rule.

For FY 2000, we estimated that exceptions payments would equal 2.70 percent of aggregate payments based on the capital Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9730 (1 − 0.0270) in determining the capital Federal rate. In the May 5, 2000 proposed rule, we estimated that exceptions payments for FY 2001 would equal 2.04 percent of aggregate payments based on the capital Federal rate and the hospital-specific rate. Therefore, we proposed an exceptions payment reduction factor of 0.9796 to the capital Federal rate for FY 2001. The proposed exceptions reduction factor for FY 2001 was 0.68 percent higher than the factor for FY 2000. For this final rule, based on updated data, we estimate that exceptions payments for FY 2001 will equal 2.15 percent of aggregate payments based on the capital Federal rate and the hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9785 (1 − 0.0215) to the capital Federal rate for FY 2001. The final exceptions reduction factor for FY 2001 is 0.57 percent higher than the factor for FY 2000 and 0.11 percent lower than the factor in the FY 2001 proposed rule.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net adjustment to the FY 2001 capital Federal rate is 0.9785/0.9730, or 1.0057.

5. Standard Capital Federal Rate for FY 2001

For FY 2000, the capital Federal rate was $377.03. As a result of changes that we proposed to the factors used to establish the capital Federal rate, we proposed that the FY 2001 capital Federal rate would be $383.06. In this final rule, we are establishing the capital Federal rate of $382.03. The capital Federal rate for FY 2001 was calculated as follows:

- The FY 2001 update factor is 1.0090; that is, the update is 0.90 percent.
- The FY 2001 budget neutrality adjustment factor that is applied to the standard capital Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9979.
- The FY 2001 outlier adjustment factor is 0.9409.
- The FY 2001 exceptions payments adjustment factor is 0.9785.

Since the capital 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 capital 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 2001 affected the computation of the FY 2001 capital Federal rate in comparison to the FY 2000 capital Federal rate. The FY 2001 update factor has the effect of increasing the capital Federal rate by 0.90 percent compared to the rate in FY 2000, while the geographic and DRG budget neutrality factor has the effect of decreasing the capital Federal rate by 0.21 percent. The FY 2001 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.07 percent compared to FY 2000. The FY 2001 exceptions reduction factor has the effect of increasing the capital Federal rate by 0.57 percent compared to the exceptions reduction for FY 2000. The combined effect of all the changes is to increase the capital Federal rate by 1.33 percent for FY 2001 compared to the capital Federal rate for FY 2000.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2000 CAPITAL FEDERAL RATE AND FY 2001 CAPITAL FEDERAL RATE

	FY 2000	FY 2001	Change	Percent change
Update factor [1]	1.0030	1.0090	1.0090	0.90
GAF/DRG Adjustment Factor [1]	0.9985	0.9979	0.9979	−0.21
Outlier Adjustment Factor [2]	0.9402	0.9409	1.0007	0.07
Exceptions Adjustment Factor [2]	0.9730	0.9785	1.0057	0.57
Federal Rate	$377.03	$382.03	1.0133	1.33

[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 2000 to FY 2001 resulting from the application of the 0.9979 GAF/DRG budget neutrality factor for FY 2001 is 0.9979.

[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 2001 outlier reduction factor is 0.9409/0.9402, or 1.0007.

As stated previously in this section, the FY 2001 capital Federal rate has increased 1.33 percent compared to the FY 2000 capital Federal rate as a result of the combination of the FY 2001 factors and adjustments applied to the

capital Federal rate. Specifically, the capital update factor increased the FY 2001 capital Federal rate 0.90 percent over FY 2000. The exceptions reduction factor increased 0.57 percent from 0.9730 for FY 2000 to 0.9785 for FY 2001, which results in an increase to the capital Federal rate for FY 2001 compared to FY 2000. Also, the outlier adjustment factor increased 0.07 percent from 0.9402 for FY 2000 to 0.9409 for FY 2001, which results in an increase to the capital Federal rate for FY 2001 compared to FY 2000. The GAF/DRG adjustment factor decreased 0.21 percent from 0.9986 for FY 2000 to 0.9979 for FY 2001, which results in a decrease the capital Federal rate for FY 2001 compared to FY 2000. The effect of all of these changes is a 1.33 percent increase in the FY 2001 capital Federal rate compared to FY 2000.

We are also providing a chart that shows how the final FY 2001 capital Federal rate differs from the proposed FY 2001 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2001 PROPOSED CAPITAL FEDERAL RATE AND FY 2001 FINAL CAPITAL FEDERAL RATE

	Proposed FY 2001	Final FY 2001	Change	Percent change
Update Factor[1]	1.0090	1.0090	1.0000	0.00
GAF/DRG Adjustment Factor	0.9986	0.9979	0.9992	−0.08
Outlier Adjustment Factor	0.9416	0.9409	0.9992	−0.08
Exceptions Adjustment Factor	0.9796	0.9785	0.9989	−0.11
Federal Rate	$383.06	$382.03	0.9973	−0.27

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section IV of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the capital Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the capital 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 geographic adjustment factor (GAF) to both portions of the blended rate. The GAF is calculated using the operating prospective payment system wage index and varies depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Since we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget neutrality factor is 1.0037, while the DRG adjustment is 1.0001, for a combined cumulative adjustment of 1.0037.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is 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). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of Public Law 105–33.

For FY 2000, before application of the GAF, the special rate for Puerto Rico hospitals was $174.81. With the changes we proposed to the factors used to determine the rate, the proposed FY 2001 special rate for Puerto Rico was $185.38. In this final rule, the FY 2001 capital rate for Puerto Rico is $185.06.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 2001 be determined by adjusting the FY 2000 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard capital Federal rate determined under § 412.308(c)(1). For FY 2001, we are updating the hospital-specific rate by a factor of 1.0090.

2. Exceptions Payment Adjustment Factor

For FYs 1992 through FY 2001, the updated hospital-specific rate is multiplied by an adjustment factor to account for estimated exceptions payments for capital-related costs under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the capital Federal rate. For FY 2001, we estimated in the proposed rule that exceptions payments would be 2.04 percent of aggregate payments based on the capital Federal rate and the hospital-specific rate. Therefore, the proposed exceptions adjustment factor was 0.9796. In this final rule, we estimate that exceptions payments will be 2.15 percent of aggregate payments based on the capital Federal rate and hospital-specific rate. Accordingly, for FY 2001, we are applying an exceptions reduction factor of 0.9785 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. The net adjustment to the FY 2001 hospital-specific rate is 0.9785/0.9730, or 1.0057.

3. 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 2000 and FY 2001 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 2000 to FY 2001 is 1.0147, which represents an increase of 1.47 percent to the hospital-specific rate. For each hospital, the FY 2001 hospital-specific rate is determined by multiplying the FY 2000 hospital-specific rate by the cumulative net adjustment of 1.0147.

FY 2001 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 2000	FY 2001	Net adjustment	Percent change
Update Factor	1.0030	1.0090	1.0090	0.90
Exceptions Payment Adjustment Factor	0.9730	0.9785	1.0057	0.57
Cumulative Adjustments	0.9759	0.9903	1.0147	1.47

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 2000 to FY 2001 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 2000 to FY 2001 is 0.9785/0.9730, or 1.0057.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 2001

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two 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 capital Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard capital Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

If the hospital-specific rate is above the applicable capital Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable capital 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 capital 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 the adjusted capital Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of the following:

- 100 percent of the adjusted capital 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 capital Federal rate for each discharge. The percentage of the adjusted capital 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 capital 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 based on the applicable transition blend percentage of the hospital-specific rate and the adjusted capital Federal rate. Thus, for FY 2001 payments under the fully prospective methodology will be based on 100 percent of the adjusted capital Federal rate and zero percent of the hospital-specific rate.

Hospitals also may 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 capital Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that portion is 100 percent of the capital Federal rate for discharges occurring in cost reporting periods beginning during FY 2001. Thus, a fully prospective hospital will receive 100 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 2001. For hold-harmless hospitals that are paid 85 percent of their reasonable costs for old inpatient capital, the portion of the capital 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 capital Federal rate, 100 percent of the capital Federal rate is included in the hospital's outlier payments.

The outlier thresholds for FY 2001 are in section II.A.4.c. of this Addendum. For FY 2001, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $17,550.

During the capital prospective payment system transition period, a hospital also may 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 2001 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 or that receive more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 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 operating input price index, the Capital Input Price Index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects 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, American Hospital Association (AHA) data, and Securities Data Company 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 final rule with comment period for FY 1998 published on August 29, 1997 (62 FR 46050).

2. Forecast of the CIPI for Federal Fiscal Year 2001

We are forecasting the CIPI to increase 0.9 percent for FY 2001. This reflects a projected 1.5 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.6 percent increase in other capital expense prices in FY 2001, partially offset by a 1.2 percent decline in vintage-weighted interest rates in FY 2001. The weighted average of these three factors produces the 0.9 percent increase for the CIPI as a whole.

V. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

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 regulations at § 413.40. Under these limits, a hospital-specific 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). In the case of a psychiatric hospital or hospital unit, a rehabilitation hospital or hospital unit, or a long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts adjusted to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. 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-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the update factor for a hospital or unit depends on the hospital's or hospital unit's costs in relation to the ceiling for the most recent cost reporting period for which information is available. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 2001 for hospitals and hospital units excluded from the prospective payment system is 3.4 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2001 would be between 0.9 and 3.4 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its rate-of-increase limit.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class.

Section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to direct the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. We are publishing an interim final rule with comment period elsewhere in this issue of the **Federal Register** that implements this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. This final rule addresses the wage adjustment to the caps for cost reporting periods beginning on or after October 1, 2000.

As discussed in section VI. of the preamble of this final rule, under section 121 of Public Law 106–113, the cap on the target amount per discharge is determined by adding the hospital's

nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap (the labor-related portion of costs equals 0.71553 and the nonlabor-related portion of costs equals 0.28447). A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the wage index under the hospital inpatient prospective payment system (see § 412.63), without taking into account reclassifications under sections 1886(d)(10) and (d)(8)(B) of the Act.

For cost reporting periods beginning in FY 2001, in the May 5, 2000 proposed rule, we included the following proposed caps:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$8,106	$3,223
Rehabilitation	15,108	6,007
Long-Term Care	29,312	11,654

We have reconsidered the methodology that was originally used to calculate the labor-related and nonlabor-related portions of the proposed FY 2001 wage neutralized national 75th percentile caps on the target amounts for each class of provider. Using the revised methodology discussed previously in this final rule, we have calculated revised labor-related and nonlabor-related portions of the wage-neutralized 75th percentile caps for FY 2001 for each class of hospital, updated by the market basket percentage increase of 3.4 percent. These revised caps are as follows:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$8,131	$3,233
Rehabilitation	15,164	6,029
Long-Term Care	29,284	11,642

Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 1E (a new table, as described in section II of this Addendum), 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 7A, 7B, 8A, and 8B 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 Sole Community Hospitals (SCH), Labor/Nonlabor
Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1999 and Hospital Average Hourly Wage for Federal Fiscal Year 2001 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—Revised Procedure Codes
Table 6F—Additions to the CC Exclusions List
Table 6G—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 99 MedPAR Update March 2000 GROUPER V18.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 99 MedPAR Update March 2000 GROUPER V18.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 2000
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 2000

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,864.19	$1,164.21	$2,818.85	$1,145.78

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$2,839.54	$1,154.19	$2,839.54	$1,154.19
Puerto Rico	$1,374.71	$553.36	$1,352.95	$544.60

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$382.03
Puerto Rico	$185.06

TABLE 1E.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR SOLE COMMUNITY HOSPITALS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,894.99	$1,176.73	$2,849.16	$1,158.10

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TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
010001	1.4294	16.41	010054	1.1479	18.51	010115	0.8633	14.63	020013	1.0626	23.88	030043	1.2567	20.93	040001	1.1095	15.16
010004	1.0044	17.97	010055	1.4580	18.95	010118	1.2295	18.85	020014	1.1928	27.38	030044	0.9256	16.86	040002	1.0910	13.06
010005	1.2569	17.60	010056	1.3402	19.22	010119	0.7792	18.80	020017	1.6747	26.83	030047	0.8534	22.64	040003	1.0688	14.21
010006	1.4036	16.75	010058	0.9956	16.17	010120	0.9619	17.23	020018	0.9095	.	030049	0.8945	19.09	040004	1.6075	17.85
010007	1.1138	15.48	010059	1.0872	19.13	010121	1.2258	14.64	020019	0.8528	.	030054	0.8303	15.33	040005	0.9870	13.26
010008	1.0833	14.74	010061	0.9939	14.95	010123	1.2688	16.73	020021	0.8366	.	030055	1.2371	16.36	040007	1.6827	21.96
010009	1.0663	18.77	010062	1.1102	14.77	010124	.	16.28	020024	1.0571	24.09	030059	1.3346	24.05	040008	1.0105	15.30
010010	1.0868	16.45	010064	1.8188	20.41	010125	1.0258	15.53	020025	0.8739	21.76	030060	1.1241	19.25	040010	1.2829	18.60
010011	1.6155	20.80	010065	1.2899	16.40	010126	1.0990	19.57	020026	1.4443	.	030061	1.6750	18.91	040011	0.9480	14.53
010012	1.3038	17.72	010066	0.8564	15.43	010127	.	19.52	020027	0.9692	.	030062	1.1595	17.67	040014	1.4158	17.63
010015	0.9899	15.45	010068	1.2573	12.05	010128	0.9027	14.51	030001	1.3864	20.37	030064	1.7338	19.57	040015	1.1465	16.59
010016	1.2613	17.25	010069	1.1544	13.86	010129	1.0725	14.73	030002	1.8284	21.60	030065	1.7680	20.51	040016	1.6681	19.03
010018	1.0518	17.64	010072	1.1121	14.95	010130	0.9882	16.68	030003	2.2227	23.48	030067	1.1041	14.44	040017	1.1712	13.51
010019	1.1661	16.35	010073	0.9005	13.86	010131	1.2711	17.83	030004	0.8926	14.07	030068	1.0055	17.36	040018	1.1358	17.60
010021	1.1942	16.29	010078	1.2718	17.92	010134	0.8006	18.88	030006	1.5668	18.27	030069	1.3563	19.10	040019	1.0803	22.68
010022	1.0136	18.59	010079	1.2274	16.44	010137	1.3664	12.12	030007	1.2597	19.67	030071	0.8901	.	040020	1.5880	16.48
010023	1.7322	16.10	010081	1.3837	18.95	010138	0.9612	12.87	030008	2.0837	22.28	030072	0.9288	.	040021	1.2285	17.64
010024	1.3776	16.29	010083	1.1292	16.89	010139	1.5811	19.00	030009	1.1423	18.18	030073	1.0190	.	040022	1.4527	17.04
010025	1.2879	15.14	010084	1.4692	18.50	010143	1.1566	16.79	030010	1.3808	19.09	030074	0.9265	.	040024	1.0608	14.45
010027	0.8259	11.79	010085	1.3063	18.47	010144	1.4241	17.13	030011	1.3889	19.30	030075	0.8143	.	040025	0.8685	11.51
010029	1.5761	17.65	010086	1.0461	16.67	010145	1.2522	20.84	030012	1.2250	18.99	030076	0.8824	.	040026	1.6029	19.56
010031	1.3658	18.78	010087	1.7486	19.00	010146	1.2928	18.52	030013	1.2636	20.75	030077	0.8316	.	040027	1.3958	16.10
010032	0.8643	12.60	010089	1.2784	16.80	010148	0.9675	12.22	030014	1.5278	19.93	030078	1.1550	.	040028	0.9947	14.66
010033	2.0381	20.39	010090	1.6552	18.39	010149	1.2051	18.63	030016	1.3250	19.40	030079	0.8532	.	040029	1.2717	17.88
010034	1.0742	15.10	010091	0.9348	13.94	010150	1.0446	17.90	030017	1.4749	22.88	030080	1.3831	20.51	040030	0.9476	13.54
010035	1.2514	20.19	010092	1.3958	16.99	010152	1.3255	17.83	030018	1.8370	20.20	030083	1.2596	23.33	040032	0.9430	13.70
010036	1.0591	17.81	010095	0.9431	12.45	010155	1.0695	9.03	030019	1.2062	21.70	030084	1.1368	.	040035	0.9187	12.83
010037	0.8778	.	010097	0.8641	13.04	010157	1.2005	.	030022	1.4830	19.30	030085	1.4857	21.10	040036	1.3651	18.98
010038	1.2054	18.27	010098	0.9271	15.92	010158	1.0838	17.32	030023	1.4981	23.67	030086	3.7429	19.54	040037	1.0856	14.66
010039	1.6113	20.10	010099	1.1321	15.99	010159	1.1094	.	030024	1.7469	22.25	030087	1.5530	21.41	040039	1.2261	14.36
010040	1.4462	18.94	010100	1.2972	17.20	020001	1.4968	28.17	030025	0.9397	12.73	030088	1.3540	19.87	040040	0.9444	18.09
010043	1.0031	30.75	010101	1.1227	15.39	020002	0.9967	24.58	030027	0.9273	15.76	030089	1.5975	20.40	040041	1.2162	15.99
010044	0.9814	22.01	010102	0.9069	13.79	020004	1.0678	30.57	030030	1.6808	20.83	030092	1.5944	20.70	040042	1.2969	15.21
010045	1.1919	15.22	010103	1.8406	17.94	020005	0.8735	30.29	030033	1.2115	20.00	030093	1.3235	19.73	040044	1.0466	12.63
010046	1.5067	17.40	010104	1.7091	17.71	020006	1.1421	31.24	030034	0.9490	16.82	030094	1.2428	21.62	040045	0.9487	14.94
010047	0.9424	13.35	010108	1.1575	17.90	020007	0.9291	27.83	030035	1.2644	19.28	030095	0.9887	13.73	040047	1.0251	16.87
010049	1.1840	14.76	010109	1.0211	15.31	020008	1.0779	29.41	030036	1.2445	20.76	030099	0.9037	16.15	040050	1.1711	13.38
010050	1.0828	18.52	010110	0.8856	15.63	020009	0.8178	20.19	030037	2.0155	22.83	030100	1.9339	.	040051	1.0437	15.86
010051	0.9004	11.93	010112	1.0448	15.14	020010	0.9185	23.67	030038	1.5744	22.68	030101	1.5314	.	040053	1.0540	16.36
010052	1.0027	16.55	010113	1.6456	16.97	020011	0.9448	30.47	030040	1.0672	18.55	030102	2.5448	.	040054	1.0177	15.32
010053	1.0167	14.63	010114	1.3073	15.25	020012	1.2715	24.85	030041	0.8921	15.89	030103	1.7199	.	040055	1.4755	17.13

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
040058	1.0416	17.68	050007	1.4710	30.71	050069	1.5649	25.94	050125	1.3280	29.61	050192	1.0679	18.67	050262	1.8330	28.88
040060	0.9520	12.81	050008	1.4627	26.25	050070	1.3239	32.52	050126	1.4539	23.92	050193	1.1441	22.63	050264	1.3064	32.13
040062	1.5964	18.20	050009	1.6316	26.82	050071	1.2726	33.19	050127	1.2399	22.19	050194	1.2706	29.74	050267	1.7125	26.23
040064	1.0308	10.73	050013	1.9820	23.22	050072	1.2757	33.29	050128	1.5292	25.72	050195	1.5364	35.56	050270	1.3453	24.04
040066	1.0679	18.34	050014	1.1284	22.85	050073	1.2725	33.39	050129	1.6756	26.50	050196	1.3104	18.52	050272	1.3864	22.42
040067	1.0648	14.60	050015	1.4834	26.25	050075	1.2822	33.91	050131	1.2602	31.07	050197	2.0333	35.74	050274	.	20.04
040069	1.0572	17.51	050016	1.2093	20.56	050076	2.3222	27.78	050132	1.3422	24.08	050204	1.4461	23.61	050276	1.2302	29.86
040070	0.9169	16.90	050017	2.1020	23.96	050077	1.5539	24.10	050133	1.2298	24.97	050205	1.2941	23.68	050277	1.3538	20.05
040071	1.6024	16.96	050018	1.2247	15.47	050078	1.3425	23.07	050135	1.3503	23.24	050207	1.2345	21.62	050278	1.5511	24.78
040072	1.0367	16.09	050021	.	25.90	050079	1.5395	33.24	050136	1.2605	24.79	050211	1.2337	31.61	050279	1.2429	20.84
040074	1.3020	18.32	050022	1.6505	24.03	050082	1.6310	22.10	050137	1.3378	32.65	050213	1.5293	21.48	050280	1.6891	25.21
040075	0.9833	13.36	050024	1.3078	21.40	050084	1.5990	23.59	050138	2.1668	37.33	050214	1.5271	21.73	050281	1.4289	19.69
040076	1.1169	19.07	050025	1.7307	23.39*	050088	0.9053	20.84	050139	1.1835	32.94	050215	1.5862	29.86	050282	1.3170	28.83
040077	1.0446	12.92	050026	1.5309	27.87	050089	1.2850	20.91	050140	1.3745	34.15	050217	1.2595	19.60	050283	1.5413	29.77
040078	1.5823	18.76	050028	1.3413	16.47	050090	1.2711	23.41	050144	1.4511	27.88	050219	1.0424	21.74	050286	.	16.57
040080	1.0135	19.25	050029	1.2961	25.13	050091	1.1411	25.28	050145	1.3366	32.39	050222	1.6060	27.48	050289	1.7654	34.14
040081	0.8788	11.32	050030	1.2995	20.98	050092	0.8504	16.80	050146	1.6421	.	050224	1.6218	23.53	050290	1.6656	28.62
040082	1.0675	16.22	050032	1.2823	25.20	050093	1.5472	25.21	050148	1.0679	21.92	050225	1.5005	23.35	050291	1.2486	30.27
040084	1.1045	17.26	050033	1.4763	24.93	050095	.	33.67	050149	1.3798	24.61	050226	1.4309	27.73	050292	1.0280	21.62
040085	1.1047	16.90	050036	1.7433	21.24	050096	1.0790	20.05	050150	1.2159	24.91	050228	1.3482	34.07	050293	1.3962	22.30
040088	1.3780	17.96	050038	1.3741	28.65	050097	1.4174	16.71	050152	1.3229	34.08	050230	1.5488	27.74	050295	1.4587	21.29
040090	0.8680	17.83	050039	1.5559	22.71	050099	1.4580	24.81	050153	1.6072	30.57	050231	1.5727	26.15	050296	1.1953	27.29
040091	1.2247	19.87	050040	1.2725	32.13	050100	1.7215	29.88	050155	1.0589	21.03	050232	1.7696	24.31	050298	1.2702	24.45
040093	0.9349	12.35	050042	1.2393	24.81	050101	1.4138	31.03	050158	1.2993	27.56	050234	1.1399	25.70	050299	1.4001	26.45
040100	1.1440	14.76	050043	1.5332	33.00	050102	1.2900	22.29	050159	1.3159	23.29	050235	1.5894	25.25	050300	1.5152	23.51
040105	0.9915	15.33	050045	1.2182	19.88	050103	1.5901	24.79	050167	1.4416	21.91	050236	1.4039	26.98	050301	1.2121	22.52
040106	1.0840	15.65	050046	1.1380	25.32	050104	1.4053	25.58	050168	1.5905	23.35	050238	1.5410	24.29	050305	1.5659	34.52
040107	1.0427	18.81	050047	1.6291	29.92	050107	1.4083	21.27	050169	1.4390	22.39	050239	1.6572	22.66	050307	.	17.21
040109	1.1328	14.63	050051	0.9874	17.89	050108	1.8765	23.56	050170	1.4341	23.96	050240	1.5249	26.37	050308	1.4632	29.38
040114	1.8668	18.87	050054	1.1957	20.72	050110	1.1553	20.19	050172	1.2223	20.18	050241	.	26.37	050309	1.3005	23.79
040116	.	20.27	050055	1.1926	29.40	050111	1.2610	21.55	050173	1.1940	24.55	050242	1.3993	31.16	050312	1.9962	26.76
040118	1.4713	19.37	050056	1.3747	27.43	050112	1.4200	25.30	050174	1.7378	30.21	050243	1.5566	28.96	050313	1.2093	21.76
040119	1.1829	15.53	050057	1.6416	21.16	050113	1.2098	28.84	050175	1.3762	27.28	050245	1.5683	23.81	050315	1.2761	24.71
040124	0.9573	19.13	050058	1.4744	23.16	050114	1.3384	24.73	050177	1.2092	21.79	050248	1.2062	26.20	050317	.	21.69
040126	0.9159	12.54	050060	1.5602	20.77	050115	1.5065	21.33	050179	1.2160	21.72	050251	1.0505	21.66	050320	1.2285	30.41
040132	.	17.52	050061	1.3804	23.55	050116	1.5551	25.21	050180	1.5829	31.89	050253	1.4108	16.07	050324	2.0245	26.60
040134	2.6321	18.08	050063	1.3286	24.89*	050117	1.3993	23.36	050183	.	20.36	050254	1.1383	19.31	050325	1.2379	24.49
040135	1.4614	22.68	050065	1.7152	24.04	050118	1.1760	23.77	050186	1.3588	22.42	050256	1.7282	23.69	050327	1.6171	23.95
040136	2.2285	.	050066	1.3859	16.57	050121	1.3130	19.53	050188	1.4760	28.09	050257	1.0952	15.23	050329	1.2753	19.75
050002	1.5130	37.83	050067	1.2781	23.20	050122	1.6016	26.32	050189	0.9931	22.87	050260	0.9729	23.24	050331	1.4029	22.25
050006	1.4898	19.56	050068	1.0725	20.69	050124	1.2563	22.77	050191	1.3728	20.83	050261	1.2488	20.06	050333	1.0599	19.46

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
050334	1.7198	34.23	050411	1.3458	34.89	050488	1.3456	34.69	050567	1.5230	24.65	050641	1.1922	21.83	050721	1.3599	.
050335	1.3886	23.03	050414	1.2179	24.21	050491	1.1165	26.87	050568	1.2191	19.58	050643	0.8109	.	050722	1.1328	.
050336	1.3169	20.80	050417	1.2667	21.57	050492	1.4208	19.55	050569	1.2232	26.55	050644	1.0478	22.35	050723	1.1458	.
050337	1.3409	.	050419	1.4165	23.76	050494	1.2598	29.26	050570	1.5734	25.23	050660	1.3997	.	060001	1.6560	21.37
050342	1.2313	20.18	050420	1.2831	22.32	050496	1.6617	32.52	050571	1.3916	26.20	050661	.	19.68	060003	1.2450	19.80
050343	.	17.21	050423	1.1073	17.38	050497	0.8090	13.81	050573	1.5666	24.96	050662	0.7859	26.96	060004	1.2401	22.88
050345	0.8081	.	050424	1.8980	22.83	050498	1.2005	24.97	050575	1.0859	19.56	050663	1.0941	30.66	060006	1.1951	19.37
050348	1.7914	23.88	050425	1.2440	32.84	050502	1.7572	22.38	050577	1.3879	25.15	050667	0.9522	25.00	060007	1.1130	17.47
050349	0.8947	14.98	050426	1.4508	25.25	050503	1.3610	24.41	050578	1.3279	28.54	050668	1.0325	42.10	060008	1.0579	18.03
050350	1.4096	24.83	050427	0.9257	20.17	050506	1.3777	25.08	050579	1.3278	30.50	050670	0.7818	20.01	060009	1.5799	21.43
050351	1.4609	25.48	050430	0.9725	23.88	050510	1.1920	33.38	050580	1.2430	25.90	050674	1.2420	34.74	060010	1.6140	24.09
050352	1.3561	26.14	050432	1.5786	24.41	050512	1.3583	35.36	050581	1.4104	23.86	050675	.	15.68	060011	1.3550	23.44
050353	1.5602	23.06	050433	0.9702	17.46	050515	1.3774	35.34	050583	1.5678	24.40	050676	0.9591	18.67	060012	1.4000	20.14
050355	0.8485	17.28	050434	1.0486	19.76	050516	1.4947	24.80	050584	1.1273	21.24	050677	1.3476	35.65	060013	1.3094	22.73
050357	1.3846	22.65	050435	1.2440	25.67	050517	1.1886	20.96	050585	1.2592	25.94	050678	1.3309	26.87	060014	1.8352	24.25
050359	1.2332	17.79	050436	.	14.81	050522	1.1534	35.38	050586	1.2201	23.41	050680	1.2222	28.06	060015	1.6041	20.98
050360	1.3892	31.35	050438	1.7078	25.01	050523	1.2559	27.05	050588	1.3013	25.31	050682	0.9010	26.29	060016	1.1378	16.47
050366	1.2340	23.75	050440	1.2220	23.52	050526	1.2343	23.81	050589	1.1422	24.87	050684	1.2852	22.34	060018	1.2594	20.32
050367	1.2258	28.28	050441	1.9615	28.98	050528	1.1739	19.06	050590	1.3405	22.45	050685	1.2151	31.17	060020	1.6894	18.31
050369	1.3189	27.05	050443	0.7668	19.90	050531	1.1214	22.73	050591	1.2390	23.94	050686	1.2407	35.26	060022	1.5342	21.06
050373	1.3743	26.98	050444	1.3195	21.45	050534	1.2615	24.07	050592	1.2571	21.17	050688	1.1255	30.66	060023	1.6370	19.24
050376	1.5548	26.58	050446	0.8710	20.49	050535	1.2205	25.42	050594	1.7225	27.16	050689	1.5021	30.73	060024	1.6918	22.00
050377	0.9251	17.18	050447	1.0025	17.98	050537	1.2810	22.23	050597	1.2900	22.85	050690	1.3154	32.82	060027	1.6340	20.98
050378	1.1111	25.98	050448	1.0661	19.70	050539	1.2979	20.71	050598	1.2550	24.36	050693	1.2207	26.83	060028	1.5273	23.21
050379	0.9751	15.20	050449	1.4294	23.80	050541	1.5699	34.46	050599	1.5667	29.12	050694	1.3346	23.23	060029	0.8712	20.86
050380	1.6344	31.43	050454	1.7542	28.74	050542	1.0181	16.09	050601	1.4829	31.87	050695	1.1816	21.14	060030	1.3093	20.50
050382	1.3423	26.14	050455	1.9538	20.16	050543	0.8627	22.40	050603	1.3656	23.34	050696	2.0732	28.00	060031	1.4973	21.16
050385	1.4093	24.61	050456	1.1464	20.13	050545	0.7893	26.33	050604	1.4342	34.05	050697	1.1678	21.16	060032	1.4822	23.42
050388	0.8344	19.15	050457	1.6183	34.49	050546	0.6812	26.19	050608	1.2769	18.09	050699	0.5929	25.78	060033	1.0878	15.91
050390	1.1918	25.04	050464	1.7414	25.33	050547	0.8107	26.83	050609	1.5764	34.99	050701	1.2955	22.69	060034	1.5449	22.48
050391	1.2245	18.93	050468	1.5228	23.31	050548	.	28.81	050613	1.0324	23.38	050704	1.0434	22.87	060036	1.1014	15.07
050392	0.9498	21.67	050469	1.0325	23.88	050549	1.6573	27.28	050615	1.4553	23.88	050707	1.0699	26.27	060037	0.9899	15.56
050393	1.4701	25.70	050470	1.0920	16.03	050550	1.3328	24.80	050616	1.3937	22.74	050708	1.4627	22.78	060038	0.8834	14.08
050394	1.5619	23.06	050471	1.6664	25.62	050551	1.3151	25.47	050618	0.9967	21.65	050709	1.2556	21.96	060041	0.8407	14.89
050396	1.6587	24.06	050476	1.3078	22.48	050552	1.1745	21.52	050623	1.3428	29.18	050710	1.3017	26.91	060042	0.9939	19.19
050397	0.8335	20.26	050477	1.4897	27.96	050557	1.4951	21.12	050624	1.3036	22.71	050713	0.8043	17.73	060043	0.8817	13.67
050401	0.9837	20.75	050478	0.9807	24.54	050559	1.3270	23.58	050625	1.6121	26.48	050714	1.2848	28.93	060044	1.3096	19.70
050404	1.0584	17.34	050481	1.4495	28.97	050561	1.1801	34.58	050630	1.1951	23.92	050717	1.3723	25.95	060046	1.0232	19.46
050406	1.0485	17.30	050482	0.9444	18.12	050564	1.5745	23.59	050633	1.3377	23.19	050718	0.8128	17.61	060047	1.0220	15.88
050407	1.2790	29.96	050483	.	22.72	050565	.	23.78	050636	1.3786	21.26	050719	2.5629	25.55	060049	1.3733	21.78
050410	0.9752	17.68	050485	1.5735	24.20	050566	0.9370	17.44	050638	1.2157	18.28	050720	0.8820	.	060050	1.2397	18.22

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
060052	1.0096	13.42	070019	1.2559	25.73	100010	1.4768	21.91	100062	1.7067	19.44	100122	1.1578	19.88	100179	1.7878	22.30
060053	0.9789	15.98	070020	1.3583	24.00	100012	1.6509	19.62	100063	1.2326	19.26	100124	1.2709	17.07	100180	1.4269	20.21
060054	1.3802	22.90	070021	1.1970	25.30	100014	1.4070	19.80	100067	1.3627	18.09	100125	1.2050	18.95	100181	1.2057	23.08
060056	0.9313	18.28	070022	1.8535	26.57	100015	1.4230	18.48	100068	1.3243	19.93	100126	1.4297	19.54	100183	1.2032	24.61
060057	1.0403	26.40	070024	1.3313	25.30	100017	1.6812	19.06	100069	1.3150	16.83	100127	1.5701	19.99	100187	1.3998	20.25
060058	0.9492	15.49	070025	1.8562	25.13	100018	1.5501	21.03	100070	1.4646	18.74	100128	2.2138	20.15	100189	1.3210	21.31
060060	0.8852	15.65	070027	1.3014	23.64	100019	1.6476	22.62	100071	1.2401	17.55	100129	1.2952	19.19	100191	1.3014	19.99
060062	0.8800	17.30	070028	1.5475	24.68	100020	1.2538	21.38	100072	1.2465	21.02	100130	1.2638	18.67	100199	.	21.72
060064	1.4327	21.22	070029	1.3317	22.01	100022	1.7977	26.41	100073	1.7099	21.19	100131	1.3130	23.44	100200	1.3127	22.46
060065	1.3063	21.63*	070030	1.0954	28.91	100023	1.3043	19.97	100075	1.5177	18.37	100132	1.2704	18.12	100204	1.5509	20.90
060066	0.9653	16.35	070031	1.2784	23.44	100024	1.2308	21.88	100076	1.3327	17.87	100134	1.0026	15.18	100206	1.3713	19.57
060070	1.1118	17.32	070033	1.3780	30.42	100025	1.7122	18.78	100077	1.3677	22.34	100135	1.5438	18.83	100208	1.3718	21.21
060071	1.2290	17.60	070034	1.4298	28.92	100026	1.6555	20.56	100078	1.0113	18.45	100137	1.2029	18.69	100209	1.4892	22.46
060073	0.8801	15.79	070035	1.4142	23.09	100027	0.9677	19.15	100079	1.4697	.	100138	0.9934	17.14	100210	1.5745	21.36
060075	1.2310	24.16	070036	1.7768	28.84	100028	1.2175	19.38	100080	1.6026	22.20	100139	1.0511	15.65	100211	1.3116	20.64
060076	1.4510	24.87	070038	0.9007	.	100029	1.2995	20.87	100081	1.0771	14.83	100140	1.1455	17.14	100212	1.6043	21.12
060085	0.9227	13.63	070039	0.9155	22.90	100030	1.2253	22.82	100082	.	18.90	100142	1.2535	19.68	100213	1.5130	20.66
060088	1.0677	25.28	080001	1.6605	25.48	100032	1.8433	19.81	100084	1.5861	22.37	100144	.	12.29	100217	1.2276	20.59
060090	0.8332	22.30	080002	.	19.60	100034	1.7323	17.87	100085	.	22.12	100146	0.9840	18.13	100220	1.6360	21.28
060096	1.2869	21.96	080003	1.3359	22.19	100035	1.6444	20.15	100086	1.2203	21.70	100147	1.0454	14.66	100221	1.9717	17.40
060100	1.5438	23.60	080004	1.2756	21.94	100038	1.8862	23.36	100087	1.8911	23.61	100150	1.3644	21.28	100223	1.4612	20.63
060103	1.3692	24.82	080006	1.3228	20.08	100039	1.5160	21.53	100088	1.6738	20.37	100151	1.7568	21.61	100224	1.3092	20.03
060104	1.2596	22.23	080007	1.3634	19.62	100040	1.7918	19.04	100090	1.3666	19.15	100154	1.5562	20.00	100225	1.2947	20.68
060107	1.2686	14.27	080008	1.2135	.	100043	1.2933	18.80	100092	1.5578	17.92	100156	1.1110	19.50	100226	1.3759	20.69
060109	1.2053	.	090001	1.5880	21.75	100044	1.3450	21.48	100093	1.6751	16.51	100157	1.5741	22.67	100228	1.2632	21.32
070001	1.8305	26.09	090002	1.2381	19.42	100045	1.3467	20.92	100098	1.0495	19.24	100159	0.8737	10.28	100229	1.3076	19.69
070002	1.8301	26.28	090003	1.3584	22.11	100046	1.3499	21.62	100099	1.1718	15.78	100160	1.1962	20.56	100230	1.3669	20.51
070003	1.1623	25.69	090004	1.8640	24.34	100047	1.8042	20.01	100102	1.0366	18.97	100161	1.6933	22.30	100231	1.6423	17.92
070004	1.2793	22.49	090005	1.3353	23.86	100048	0.9466	15.06	100103	0.9617	17.24	100162	1.4192	20.14	100232	1.2490	19.35
070005	1.4204	26.65	090006	1.3430	20.87	100049	1.1979	18.85	100105	1.4120	21.66	100165	.	19.04	100234	1.3541	20.91
070006	1.3549	27.57	090007	1.5335	22.20	100050	1.2972	17.24	100106	1.0366	17.25	100166	1.4576	20.03	100235	.	17.16
070007	1.3095	26.95	090008	1.4797	20.22	100051	1.3291	23.13	100107	1.2761	20.13	100167	1.4353	23.41	100236	1.3952	20.38
070008	1.2543	23.02	090010	1.1378	24.13	100052	1.3220	17.95	100108	0.9743	19.96	100168	1.3353	20.20	100237	2.1465	22.09
070009	1.1583	24.62	090011	2.1415	27.48	100053	1.1953	20.17	100109	1.3754	20.84	100169	1.8069	20.95	100238	1.6295	19.64
070010	1.6702	26.24	100001	1.5588	19.58	100054	1.2568	23.55	100110	1.3863	20.90	100170	1.3547	18.51	100239	1.4056	21.32
070011	1.3717	23.36	100002	1.4001	20.71	100055	1.3618	18.05	100112	1.0431	25.26	100172	1.4357	14.34	100240	0.8726	20.43
070012	1.2277	23.03	100004	0.9641	14.63	100056	1.5304	25.79	100113	1.7346	23.20	100173	1.6963	18.57	100241	0.8328	14.72
070015	1.4027	23.82	100006	1.6064	20.11	100057	1.3415	19.97	100114	1.3580	21.63	100174	1.3537	26.18	100242	1.4072	17.93
070016	1.4796	24.91	100007	1.8840	21.72	100059	1.9893	.	100117	1.2235	20.76	100175	1.1227	18.17	100243	1.3654	21.26
070017	1.4083	26.29	100008	1.6961	20.50	100060	1.7353	23.26	100118	1.1406	22.87	100176	2.1365	22.86	100244	1.3260	18.62
070018	1.3599	28.07	100009	1.5195	22.64	100061	1.4169	22.11	100121	1.1625	.	100177	1.2949	24.43	100246	1.4821	19.64

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
100248	1.5201	20.70	110015	1.1561	21.21	110069	1.2529	19.31	110124	1.1240	17.57	110186	1.3162	17.43	120021	0.9929	23.45
100249	1.2562	19.28	110016	1.1897	22.53	110070	1.1370	21.02	110125	1.2691	19.13	110187	1.2613	20.12	120022	1.6644	21.79
100252	1.2083	17.78	110017	0.9461	13.20	110071	1.0977	14.60	110127	0.9462	14.61	110188	1.3277	24.84	120024	0.6619	29.48
100253	1.3554	21.32	110018	1.1354	19.61	110072	0.9639	12.79	110128	1.2140	18.18	110189	1.1089	22.27	120025	.	20.11
100254	1.5503	19.66	110020	1.2508	18.31	110073	1.1546	15.43	110129	1.6422	18.94	110190	1.0680	18.57	120026	1.2778	26.08
100255	1.2607	25.21	110023	1.3528	21.20	110074	1.5148	21.39	110130	0.9636	16.06	110191	1.3181	20.20	120027	1.4770	24.73
100256	2.0962	20.94	110024	1.3599	20.73	110075	1.3349	18.52	110132	1.1729	16.04	110192	1.3977	21.50	120028	1.4041	27.50
100258	1.6125	21.35	110025	1.3344	19.57	110076	1.4371	21.29	110134	0.9264	12.57	110193	1.2441	20.64	130001	1.0353	18.85
100259	1.3111	20.38	110026	1.1409	17.30	110078	1.7644	22.37	110135	1.3459	17.44	110194	0.9213	15.15	130002	1.3202	16.66
100260	1.4178	21.05	110027	1.1311	16.06	110079	1.3862	21.06	110136	1.1652	18.06	110195	1.0290	13.91	130003	1.3064	21.73
100262	1.3800	20.04	110028	1.7816	20.15	110080	1.2783	18.48	110140	0.9166	17.89	110198	1.3144	24.20	130005	1.3959	20.72
100264	1.3552	19.16	110029	1.3634	20.29	110082	2.0714	23.88	110141	1.0114	13.25	110200	1.8368	18.19	130006	1.8254	19.34
100265	1.3056	18.83	110030	1.3100	18.81	110083	1.7799	23.12*	110142	0.9247	14.61	110201	1.4260	20.47	130007	1.6733	20.83
100266	1.3903	18.30	110031	1.2251	19.95	110086	1.3509	18.28	110143	1.3909	20.16	110203	0.9334	26.81	130008	0.9495	12.55
100267	1.3402	20.11	110032	1.2304	15.73	110087	1.3990	21.78	110144	1.0711	16.87	110204	0.8006	19.73	130009	0.9556	19.18
100268	1.2061	23.92	110033	1.4377	22.19	110089	1.2185	18.56	110146	1.1375	16.13	110205	1.0118	21.14	130010	0.9805	17.68
100269	1.4262	21.67	110034	1.6830	19.60	110091	1.2467	19.51	110149	1.1382	17.75	110207	0.9426	12.97	130011	1.2351	20.50
100270	1.0016	15.15	110035	1.3980	19.38	110092	1.0874	17.35	110150	1.3942	20.26	110208	0.9243	15.17	130012	0.9391	22.98
100271	1.8641	20.48	110036	1.8392	22.25	110093	0.9405	.	110152	1.0318	15.40	110209	0.6585	17.92	130013	1.3163	17.40
100275	1.3912	20.92	110038	1.5174	17.71	110094	0.9977	14.56	110153	1.1311	19.27	110211	0.9705	20.94	130014	1.2630	18.98
100276	1.2153	22.36	110039	1.3613	20.60	110095	1.3360	16.47	110154	1.0059	14.96	110212	1.0169	11.85	130015	0.8878	15.72
100277	0.9847	16.63	110040	1.0234	17.07	110096	1.1202	16.85	110155	1.0140	15.53	110213	.	14.37	130016	0.9572	17.39
100279	1.2503	22.91	110041	1.1574	18.80	110097	1.0153	15.58	110156	1.0322	14.75	110215	1.1702	20.19	130017	1.0061	17.17
100280	1.3253	17.37	110042	1.1758	24.01	110098	0.9533	16.35	110161	1.3020	21.72	110216	1.6690	.	130018	1.4857	19.74
100281	1.2855	22.44	110043	1.8284	20.10	110100	0.9897	18.70	110162	0.7571	.	110217	1.0577	.	130019	1.1124	18.66
100282	1.0730	19.20	110044	1.1332	16.36	110101	1.0025	10.82	110163	1.5142	20.42	120001	1.7578	27.92	130021	1.1750	12.86
100284	1.1182	.	110045	1.1485	20.25	110103	0.9619	13.68	110164	1.4067	20.21	120002	1.2857	25.07	130022	1.2516	16.53
100366	0.5957	.	110046	1.3106	19.74	110104	1.1332	15.78	110165	1.5017	21.26	120003	1.0675	25.91	130024	1.1071	19.36
110001	1.2989	19.20	110048	1.1232	16.31	110105	1.3071	16.89	110166	1.4846	20.59	120004	1.2001	23.92	130025	1.1281	17.52
110002	1.2782	17.14	110049	1.1595	16.18	110107	1.9809	19.36	110168	1.7199	20.66	120005	1.2626	23.40	130026	1.1760	21.59
110003	1.3401	18.12	110050	1.1042	20.76	110108	0.9666	19.79	110169	1.2966	20.64	120006	1.2582	25.09	130027	0.9261	21.43
110004	1.3362	19.56	110051	1.0218	17.01	110109	1.1051	15.94	110171	1.6317	23.79	120007	1.7597	22.72	130028	1.2822	19.11
110005	1.1310	17.73	110054	1.4061	.	110111	1.2209	18.51	110172	1.4315	23.37	120009	1.0067	17.47	130029	1.0949	18.43
110006	1.4048	20.78	110056	1.0305	15.62	110112	1.0140	19.06	110174	0.8958	13.73	120010	1.7837	25.15	130030	0.9563	17.84
110007	1.6001	21.95	110059	1.1787	16.67	110113	1.0488	16.82	110177	1.6235	20.72	120011	1.4540	35.06	130031	0.9377	16.24
110008	1.1612	22.01	110061	1.0891	15.04	110114	1.1384	14.69	110178	.	18.83	120012	0.8988	23.11	130034	1.0449	16.99
110009	1.1614	16.31	110062	0.9078	18.80	110115	1.7105	43.94	110179	1.1381	22.78	120014	1.2467	22.89	130035	0.9055	19.35
110010	2.1822	23.32	110063	1.0045	16.96	110118	1.0966	20.54	110181	0.9770	14.09	120015	0.8200	32.99	130036	1.3855	13.79
110011	1.1587	18.61	110064	1.4492	18.95	110120	1.0474	15.26	110183	1.3561	23.38	120016	1.0310	27.91	130037	1.4307	18.81
110013	1.0518	16.28	110065	1.0354	15.68	110121	1.1613	16.27	110184	1.3194	22.20	120018	0.9098	24.50	130043	0.9498	16.51
110014	0.9591	16.07	110066	1.4902	21.02	110122	1.3656	21.14	110185	1.2359	16.72	120019	1.2774	22.93	130044	0.9313	17.82

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
130045	0.9558	16.10	140042	0.9892	15.41	140095	1.3673	24.05	140148	1.8761	18.66	140207	1.2684	21.98	150001	1.0961	22.81
130048	1.0584	16.09	140043	1.1605	19.47	140097	0.9299	17.51	140150	1.5468	27.34	140208	1.7009	25.99	150002	1.4810	19.34
130049	1.2597	20.31	140045	1.0042	15.58	140100	1.3439	21.36	140151	0.9279	21.39	140209	1.5933	18.12	150003	1.8126	19.77
130054	1.0083	17.27	140046	1.2980	18.98	140101	1.1732	21.55	140152	1.1995	24.63	140210	1.1292	15.69	150004	1.5384	20.37
130056	0.8268	14.69	140047	1.1728	17.15	140102	1.0753	17.15	140155	1.3323	19.97	140211	1.2324	21.89	150005	1.1302	20.63
130060	1.3119	21.87	140048	1.3586	24.09	140103	1.3665	19.28	140158	1.3329	22.76	140213	1.2798	27.06	150006	1.2667	20.82
130061	.	15.40	140049	1.6823	28.50	140105	1.2652	22.66	140160	1.1491	17.77	140215	0.9827	15.99	150007	1.1797	20.18
130062	0.7754	16.57	140051	1.4544	23.83	140107	0.9570	13.75	140161	1.1381	20.09	140217	1.3142	24.82	150008	1.3764	21.45
130063	1.6666	15.94	140052	1.2827	19.64	140108	1.3348	25.47	140162	1.8143	19.65	140218	0.9762	14.95	150009	1.3792	18.71
140001	1.2176	16.34	140053	2.0553	19.19	140109	1.1477	15.75	140164	1.4391	18.78	140220	1.1358	17.64	150010	1.3460	21.71
140002	1.2407	19.02	140054	1.3693	22.19	140110	1.1879	19.18	140165	1.1132	14.92	140223	1.5180	24.92	150011	1.1586	18.37
140003	1.0106	21.29	140055	0.9934	16.34	140112	1.0909	17.69	140166	1.1649	17.55	140224	1.4016	25.87	150012	1.5933	22.48
140004	1.1044	15.70	140058	1.3067	17.49	140113	1.5040	19.06	140167	1.1024	17.15	140228	1.6645	19.70	150013	1.0477	17.03
140005	0.9925	11.61	140059	1.1068	15.02	140114	1.3187	21.16	140168	1.2012	16.68	140230	0.9202	18.09	150014	1.5409	22.01
140007	1.4589	22.98	140061	1.1025	17.30	140115	1.3042	21.19*	140170	1.1349	16.16	140231	1.5297	23.92	150015	1.2952	22.54
140008	1.4727	21.65	140062	1.2475	28.09	140116	1.2352	23.12	140171	0.9900	14.16	140233	1.7458	19.45	150017	1.8570	18.77
140010	1.3751	31.82	140063	1.4962	25.36	140117	1.5556	21.57	140172	1.7225	23.84	140234	1.2127	18.99	150018	1.4858	20.49
140011	1.1654	17.87	140064	1.2598	19.10	140118	1.7413	23.60	140173	0.9333	15.15	140239	1.6490	18.81	150019	1.1102	16.63
140012	1.2798	23.07	140065	1.4177	24.11*	140119	1.7501	29.14	140174	1.5586	20.53	140240	1.3562	23.69	150020	1.0755	15.11
140013	1.5935	18.31	140066	1.1873	17.39	140120	1.3462	18.07	140176	1.2136	23.29	140242	1.6241	24.54	150021	1.6509	19.51
140014	1.1508	22.47	140067	1.7590	19.33	140121	1.3415	16.04	140177	1.3038	18.26	140245	1.1878	13.48	150022	1.1219	19.16
140015	1.2388	16.67	140068	1.4582	19.97	140122	1.5465	24.65	140179	1.3325	21.19	140246	1.0433	13.46	150023	1.5928	18.36
140016	1.0061	13.13	140069	0.9782	16.75	140124	1.1188	27.19	140180	1.4284	22.45	140250	1.2950	25.09	150024	1.3982	18.41
140018	1.3458	22.31	140070	1.1803	22.97	140125	1.3218	17.67	140181	1.4221	20.87	140251	1.3473	21.44	150025	1.4278	17.70
140019	1.0159	16.65	140074	0.9349	19.35	140127	1.4174	19.90	140182	1.3514	22.02	140252	1.4884	25.22	150026	1.2234	18.84
140024	0.9843	16.83	140075	1.2766	21.63	140128	1.0088	19.50	140184	1.1880	17.82	140253	1.1842	18.55	150027	1.0123	17.33
140025	1.0506	16.95	140077	1.0565	17.53	140129	1.1841	18.26	140185	1.4704	17.65	140258	1.5250	23.30	150029	1.3648	23.05
140026	1.1496	16.66	140079	1.1955	23.30	140130	1.1970	22.23	140186	1.3232	22.79	140271	0.9410	15.51	150030	1.2737	18.00
140027	1.2099	18.76	140080	1.4832	21.07	140132	1.4751	23.55	140187	1.6400	17.92	140275	1.2790	20.17	150031	1.0525	17.24
140029	1.3319	22.83	140081	1.0317	16.22	140133	1.3795	21.41	140188	0.9867	15.25	140276	2.0067	26.68	150033	1.5657	21.88
140030	1.8591	21.95	140082	1.3053	23.90	140135	1.2675	17.81	140189	1.2371	21.06	140280	1.4485	20.24	150034	1.4343	22.13
140031	1.1639	19.57	140083	1.3361	19.31	140137	1.0600	16.90	140190	1.0808	16.34	140281	1.6244	24.02	150035	1.4773	20.45
140032	1.2551	18.10	140084	1.2566	20.97	140138	0.9876	16.74	140191	1.3873	25.88	140285	1.2593	18.12	150036	1.0051	20.87
140033	1.2941	24.17	140086	1.0731	18.38	140139	1.0648	14.06	140193	0.9673	15.80	140286	1.1206	20.37	150037	1.2338	21.71
140034	1.2080	19.53	140087	1.3565	16.10	140140	1.1269	17.82	140197	1.2470	18.64	140288	1.6195	25.23	150038	1.1488	21.22
140035	1.0676	15.26	140088	1.7648	25.24	140141	1.2248	17.52	140199	1.0736	18.35	140289	1.3216	17.14	150039	0.9673	18.47
140036	1.2542	18.58	140089	1.2772	17.64	140143	1.0801	19.19	140200	1.5266	21.52	140290	1.3080	21.18	150042	1.2980	18.16
140037	1.0619	13.08	140090	1.4463	26.43	140144	0.9808	21.32	140202	1.3146	22.19	140291	1.3217	25.09	150043	1.1311	19.01
140038	1.0620	18.30	140091	1.8707	20.90	140145	1.1293	17.55	140203	1.1787	19.92	140292	1.2018	20.86	150044	1.2395	18.44
140040	1.1966	19.93	140093	1.1361	18.29	140146	1.0397	21.96	140205	1.5345	17.48	140294	1.1339	17.72	150045	1.1091	16.81
140041	1.1937	17.66	140094	1.2552	21.47	140147	1.2073	16.13	140206	1.2274	21.33	140300	1.5055	25.37	150046	1.4223	17.63

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
150047	1.5548	19.74	150097	1.0606	19.38	160016	1.1890	19.63	160065	1.0386	16.94	160113	1.0604	14.71	170023	1.4037	19.14
150048	1.1828	19.33	150098	1.1351	15.09	160018	0.9389	14.59	160066	1.0699	17.19	160114	0.9688	16.14	170024	1.0560	13.68
150049	1.1915	17.01	150099	.	22.42	160020	1.1347	15.47	160067	1.4189	17.85	160115	0.9815	15.90	170025	1.1828	17.87
150050	1.0891	16.83	150100	1.5717	18.41	160021	0.9996	16.50	160068	1.0723	17.99	160116	1.0506	16.95	170026	1.0303	15.05
150051	1.4769	19.01	150101	1.0455	16.46	160023	1.0324	15.07	160069	1.5072	19.73	160117	1.3356	17.94	170027	1.2437	17.36
150052	1.0296	15.86	150102	1.0869	19.74	160024	1.5676	19.71	160070	0.9286	16.70	160118	1.0368	17.25	170030	0.9983	14.65
150053	0.9666	19.14	150103	1.0079	18.48	160026	0.9794	18.84	160072	1.0484	14.95	160120	0.9606	10.60	170031	0.8963	13.96
150054	1.2297	17.38	150104	1.0488	17.70	160027	1.0597	16.35	160073	0.9892	11.83	160122	1.0888	18.92	170032	1.0181	15.61
150056	1.8704	22.41	150105	1.2888	20.04	160028	1.2276	19.96	160074	0.9931	19.51	160124	1.2749	18.09	170033	1.3716	16.41
150057	2.1498	16.59	150106	0.9758	16.15	160029	1.5419	20.47	160075	1.1054	19.49	160126	1.0585	17.81	170034	1.0464	15.82
150058	1.7018	20.82	150109	1.4431	18.81	160030	1.3367	19.95	160076	1.0723	17.94	160129	0.9310	16.71	170035	0.9164	18.59
150059	1.4196	21.25	150110	0.9738	18.66	160031	1.0458	15.24	160077	1.1064	12.88	160130	1.0192	16.05	170038	0.8630	14.78
150060	1.1497	17.07	150111	1.1113	18.46	160032	1.1095	17.32	160079	1.4272	17.62	160131	1.0654	15.49	170039	1.0411	15.86
150061	1.2136	17.39	150112	1.2498	20.41	160033	1.8678	18.87	160080	1.1627	18.67	160134	0.9949	13.47	170040	1.6231	21.64
150062	1.0069	20.54	150113	1.2243	20.38	160034	1.1092	15.00	160081	1.1175	17.01	160135	0.9409	18.27	170041	1.1058	11.76
150063	1.0264	22.09	150114	0.9415	19.52	160035	0.8430	15.22	160082	1.8732	19.65	160138	1.0465	16.87	170044	0.9420	15.30
150064	1.1320	18.14	150115	1.2734	17.43	160036	0.9888	17.88	160083	1.6823	20.62	160140	1.1049	18.40	170045	1.0821	14.09
150065	1.1819	19.89	150122	1.1132	18.71	160037	1.0334	19.05	160085	1.0408	18.01	160142	0.9676	16.29	170049	1.4389	19.94
150066	0.9694	15.34	150123	1.0230	14.11	160039	1.0217	17.48	160086	0.9072	17.33	160143	1.1451	16.62	170051	0.9580	15.09
150067	1.1307	18.29	150124	1.1623	14.62	160040	1.3529	18.19	160088	1.1114	20.23	160145	1.0588	13.92	170052	1.0777	15.01
150069	1.1721	21.53	150125	1.4695	20.67	160041	1.0096	16.78	160089	1.2300	16.95	160146	1.4364	16.60	170053	0.9645	16.51
150070	0.9399	17.93	150126	1.4199	21.37	160043	1.0505	15.69	160090	1.0131	17.11	160147	1.2868	17.49	170054	1.0501	14.44
150071	1.1041	13.48	150127	1.0338	17.20	160044	1.2178	16.74	160091	0.9832	12.85	160151	0.9959	16.83	170055	0.9156	16.98
150072	1.1923	16.21	150128	1.2621	18.51	160045	1.7238	20.12	160092	1.0498	15.50	160152	1.0281	15.62	170056	0.9157	17.04
150073	1.0447	22.30	150129	1.1517	24.77	160046	0.9295	14.57	160093	1.0756	17.75	160153	1.7619	20.23	170057	.	13.00
150074	1.6432	20.42	150130	1.3279	18.20	160047	1.4784	18.36	160094	1.1674	18.76	170001	1.1900	17.93	170058	1.1528	18.70
150075	1.1646	15.56	150132	1.4207	20.17	160048	1.1572	14.61	160095	1.0535	15.19	170004	1.0598	15.06	170060	0.9524	17.35
150076	1.1130	22.94	150133	1.2310	17.40	160049	0.9902	14.55	160097	1.1304	15.93	170006	1.2265	17.22	170061	1.1127	15.65
150078	1.0269	19.27	150134	1.0717	19.25	160050	1.0344	17.49	160098	0.9348	16.31	170008	0.9945	14.91	170063	0.8876	12.81
150079	1.2034	17.24	150136	0.8719	20.12	160051	1.0516	14.64	160099	0.9639	13.91	170009	1.1611	20.78	170066	0.9084	15.53
150082	1.5227	17.53	150145	.	16.69	160052	0.9904	18.09	160101	1.1048	18.37	170010	1.2832	18.74	170067	0.9801	14.75
150084	1.9364	23.25	160001	1.2868	18.60	160054	1.0994	16.17	160102	1.3544	18.88	170012	1.4492	17.87	170068	1.3058	15.18
150086	1.2075	18.97	160002	1.0984	15.95	160055	0.9237	14.76	160103	0.9399	17.10	170013	1.4696	18.65	170070	0.9598	14.24
150088	1.3248	18.99	160003	1.0300	16.09	160056	1.1034	16.16	160104	1.1675	18.83	170014	1.0168	17.93	170072	0.8337	12.63
150089	1.5038	23.88	160005	1.1423	17.62	160057	1.2725	18.18	160106	1.1340	16.96	170015	0.9421	16.58	170073	1.0589	17.54
150090	1.4078	20.77	160007	1.0002	13.21	160058	1.8148	21.12	160107	1.1110	18.06	170016	1.6697	19.21	170074	1.1477	17.55
150091	1.0239	20.41	160008	1.1119	15.97	160060	1.0746	16.04	160108	1.0645	16.05	170017	1.1933	17.80	170075	0.9137	12.42
150092	1.0634	16.74	160009	1.1960	16.84	160061	1.0821	17.32	160109	1.1920	16.56	170018	1.0340	15.30	170076	0.9228	14.59
150094	1.0040	16.58	160012	0.9906	16.48	160062	0.9842	17.81	160110	1.5320	19.14	170019	1.2564	15.21	170077	0.9011	13.52
150095	1.0586	17.13	160013	1.2031	18.40	160063	1.0218	16.88	160111	1.0094	14.16	170020	1.4588	17.34	170079	1.0051	13.53
150096	0.9851	23.28	160014	1.0396	15.91	160064	1.5638	20.55	160112	1.3682	16.83	170022	1.1249	18.53	170080	1.0157	12.60

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
170081	0.9179	13.81	170143	1.0808	15.65	180026	1.1066	14.68	180080	1.0590	16.50	190002	1.7040	19.19	190077	0.9399	15.78
170082	0.9560	12.86	170144	1.4747	19.09	180027	1.2062	16.41	180087	1.2432	14.92	190003	1.4197	19.77	190078	1.1615	14.88
170084	0.8997	12.54	170145	1.0637	17.18	180028	1.0852	19.53	180088	1.6618	22.04	190004	1.4585	17.77	190079	1.2231	17.71
170085	0.8789	15.45	170146	1.4371	20.91	180029	1.2353	17.77	180092	1.2189	18.24	190005	1.4428	17.24*	190081	0.8911	15.32
170086	1.6269	20.41	170147	1.1919	22.30	180030	1.1131	17.34	180093	1.5273	17.01	190006	1.2536	17.80	190083	0.9794	18.89
170088	0.9383	13.45	170148	1.2974	16.92	180031	1.0049	13.98	180094	0.9848	13.55	190007	1.0847	13.82	190086	1.3591	15.87
170089	0.8581	18.81	170150	1.1401	15.57	180032	1.0497	16.83	180095	1.0815	13.80	190008	1.5972	18.67	190088	1.1887	20.55
170090	1.0305	11.91	170151	1.0251	13.89	180033	1.0826	17.73	180099	1.0812	13.36	190009	1.2292	15.36	190089	1.1187	13.05
170093	0.9152	13.55	170152	0.9663	14.91	180034	1.0225	15.34	180101	1.0980	18.49	190010	1.0652	16.28	190090	1.1149	16.67
170094	0.9430	20.20	170160	0.9394	13.71	180035	1.5443	20.13	180102	1.5077	17.96	190011	1.1242	15.95	190095	1.0279	16.23
170095	1.0081	15.55	170164	0.9528	16.65	180036	1.1682	19.84	180103	2.2745	19.90	190013	1.2743	16.82	190098	1.7314	20.49
170097	0.9135	16.46	170166	1.0411	27.56	180037	1.2564	19.97	180104	1.5793	18.93	190014	1.1194	17.10	190099	1.2034	19.90
170098	1.1140	15.53	170171	1.0039	12.52	180038	1.4857	17.76	180105	0.8848	15.24	190015	1.2875	18.63	190102	1.6385	20.03
170099	1.2219	13.60	170175	1.3130	19.02	180040	1.9528	19.53	180106	0.8749	14.35	190017	1.3202	16.24	190103	0.9168	12.14
170101	0.8928	14.56	170176	1.5629	21.34	180041	1.1640	15.08	180108	0.8427	14.82	190018	1.1770	15.07	190106	1.1523	18.58
170102	1.0037	13.63	170180	.	16.69	180042	1.1421	16.77	180115	1.0497	16.70	190019	1.7402	18.53	190109	1.1535	15.58
170103	1.3029	17.28	170182	1.4962	22.22	180043	1.1411	16.80	180116	1.2349	18.04	190020	1.1662	17.53	190110	0.9774	15.81
170104	1.4777	20.62	170183	1.9768	20.35	180044	1.2021	18.56	180117	1.0923	17.78	190025	1.2825	18.64	190111	1.5897	19.75
170105	1.1432	16.54	170185	1.0622	.	180045	1.2788	17.71	180118	0.9296	15.86	190026	1.5256	18.16	190112	1.5528	21.02
170106	0.9683	18.55	170186	2.9004	.	180046	1.0399	19.25	180120	0.9686	16.16	190027	1.4896	17.08	190113	1.3703	12.58
170109	1.0114	17.26	180001	1.3208	17.99	180047	1.0459	16.23	180121	1.1356	15.10	190029	1.1610	16.52	190114	1.0231	12.64
170110	0.9676	16.98	180002	1.0414	17.97	180048	1.2349	18.34	180122	1.1054	18.51	190034	1.1765	16.85	190115	1.2486	20.25
170112	1.1397	14.39	180004	1.0481	17.26	180049	1.3091	16.43	180123	1.3656	21.06	190036	1.6931	20.18	190116	1.2116	15.55
170113	1.1135	13.90	180005	1.2239	21.14	180050	1.2654	17.85	180124	1.2800	17.50	190037	0.9934	17.69	190118	0.9765	14.79
170114	0.9553	14.45	180006	0.9725	11.44	180051	1.4163	16.40	180125	1.0652	19.64	190039	1.3993	19.47	190120	1.0772	13.96
170115	0.9614	12.70	180007	1.4014	17.68	180053	1.0510	15.93	180126	1.0659	12.92	190040	1.3542	21.46	190122	1.2334	15.48*
170116	1.0957	16.87	180009	1.3469	21.47	180054	1.1113	19.49	180127	1.2669	19.26	190041	1.5887	17.66	190124	1.6143	20.62
170117	0.8910	15.79	180010	1.9348	19.11	180055	1.2882	15.27	180128	1.0381	17.64	190043	1.0177	15.56	190125	1.4908	20.45
170119	0.9504	15.20	180011	1.3322	17.10	180056	1.1845	17.01	180129	0.9553	16.84	190044	1.1755	17.29	190128	1.1552	20.47
170120	1.2820	17.67	180012	1.3882	18.72	180058	0.9969	15.97	180130	1.4281	19.82	190045	1.5147	21.61	190130	0.9796	15.15
170122	1.7033	20.06	180013	1.4630	18.24	180059	0.8712	13.40	180132	1.2192	17.77	190046	1.4143	19.80	190131	1.2652	20.76
170123	1.7172	23.17	180014	1.6410	21.49	180063	1.1133	13.10	180133	1.3321	21.68	190048	1.1254	16.67	190133	0.9962	13.54
170124	1.0038	11.12	180016	1.2498	19.89	180064	1.2154	15.24	180134	1.0956	13.19	190049	0.9682	17.23	190134	.	12.17
170126	0.9277	12.81	180017	1.2719	15.41	180065	1.0311	12.06	180136	.	17.35	190050	1.0587	16.20	190135	1.4466	21.69
170128	0.9646	14.89	180018	1.2845	17.17	180066	1.0038	19.30	180138	1.1655	19.37	190053	1.1151	13.22	190136	0.9819	12.41
170131	.	10.10	180019	1.1635	17.40	180067	1.9537	20.63	180139	1.0331	18.72	190054	1.3637	19.17	190140	0.9581	14.23
170133	1.0846	18.02	180020	1.0889	17.73	180069	1.1159	17.79	180140	0.9801	16.82	190059	0.9281	15.69	190142	0.9509	15.49
170134	0.8935	14.11	180021	1.0602	15.46	180070	1.1350	13.19	180141	1.7587	20.98	190060	1.4180	14.72	190144	1.1790	16.21
170137	1.1867	17.83	180023	0.8648	15.88	180072	1.0971	16.90	180142	1.7748	.	190064	1.5435	20.45	190145	0.9717	15.23
170139	0.9665	14.20	180024	1.2656	16.17	180078	1.1261	21.12	180143	1.6771	.	190065	1.4662	20.99*	190146	1.5466	21.28
170142	1.3188	.	180025	1.1446	14.18	180079	1.1868	15.16	190001	0.8922	17.68	190071	0.9278	14.48	190147	0.9621	14.43

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
190148	0.8906	16.63	190238	2.2526	.	210001	1.3750	20.48	210051	1.3718	22.43	220055	.	21.37	220126	1.1979	22.52
190149	0.9665	17.60	190239	1.2930	.	210002	1.9731	19.92	210054	1.3449	22.35	220057	1.2991	25.39	220133	0.6689	25.46
190151	0.9874	14.73	190240	0.9593	.	210003	1.5516	20.34	210055	1.2826	29.25	220058	1.0709	19.94	220135	1.2670	25.65
190152	1.4654	22.21	200001	1.2974	18.05	210004	1.3195	24.29	210056	1.3522	19.27	220060	1.1973	28.08	220153	0.9335	22.96
190156	0.9348	15.75	200002	1.1115	19.36	210005	1.2893	21.49	210057	1.3527	23.83	220062	0.5889	20.47	220154	0.9417	22.48
190158	1.2527	20.46	200003	1.1105	16.96	210006	1.0867	18.94	210058	1.4772	22.08	220063	1.2556	20.40	220162	1.5749	.
190160	1.2291	17.10	200006	1.0504	17.66	210007	1.8486	23.10	210059	1.2070	22.68	220064	1.2030	22.33	220163	1.9697	29.11
190161	0.9863	15.57	200007	1.0325	18.80	210008	1.2749	21.18	210060	1.2192	.	220065	1.2547	20.14	220171	1.7342	24.56
190162	1.1566	20.61	200008	1.2729	21.75	210009	1.9447	20.54	210061	1.1158	17.22	220066	1.3452	20.78	230001	1.1432	19.80
190164	1.1628	15.18	200009	1.8745	22.23	210010	1.0726	18.72	220001	1.3264	21.94	220067	1.2798	26.44	230002	1.2574	22.80
190167	1.0912	16.67	200012	1.1257	18.35	210011	1.3814	21.49	220002	1.4324	24.13	220070	1.1693	19.75	230003	1.1861	19.84
190170	0.9034	14.18	200013	1.1578	18.06	210012	1.7070	20.72	220003	1.0393	16.92	220071	1.9058	25.62	230004	1.6751	23.10
190173	1.3080	23.64	200016	1.0186	18.09	210013	1.3658	19.73	220006	1.3492	22.31	220073	1.3530	25.60	230005	1.2670	18.56
190175	1.4252	19.36	200017	.	17.29	210015	1.3135	16.19	220008	1.3285	24.47	220074	1.3032	25.64	230006	1.0052	19.10
190176	1.5535	24.06	200018	1.1181	18.54	210016	1.7812	23.87	220010	1.3462	21.86	220075	1.8156	22.81	230007	.	15.55
190177	1.6845	18.67	200019	1.2339	19.23	210017	1.2263	18.89	220011	1.1325	26.18	220076	1.1831	22.67	230012	0.7495	15.08
190178	0.9682	11.07	200020	1.1906	22.45	210018	1.2192	22.21	220012	1.3273	32.08	220077	1.8447	25.26	230013	1.3269	20.80
190182	1.1484	20.28	200021	1.1093	19.91	210019	1.6597	19.30	220015	1.1643	22.58	220079	0.7680	22.63	230015	1.0862	20.11
190183	1.1619	16.77	200023	0.8613	16.17	210022	1.4497	22.64	220016	1.3209	23.38	220080	1.3219	21.52	230017	1.6036	22.28
190184	0.9918	17.20	200024	1.4154	19.43	210023	1.3948	23.19	220017	1.3141	22.46	220081	0.9893	29.17	230019	1.5446	22.26
190185	1.3294	20.14	200025	1.1508	20.23	210024	1.7226	20.60	220019	1.1190	19.56	220082	1.3034	21.67	230020	1.7448	22.13
190186	0.9135	18.76	200026	1.0686	18.12	210025	1.2925	19.59	220020	1.1919	21.42	220083	1.1981	23.92	230021	1.5037	18.96
190190	0.9308	17.46	200027	1.2380	18.57	210026	1.3244	12.13	220023	.	16.19	220084	1.3040	23.66	230022	1.2020	18.80
190191	1.1525	20.50	200028	0.9559	19.57	210027	1.2645	17.69	220024	1.1824	21.54	220086	1.7752	23.87	230024	1.3908	23.73
190196	0.8609	17.92	200031	1.2491	16.22	210028	1.1840	19.64	220025	1.1445	20.79	220088	1.6326	22.91	230027	1.0593	14.70
190197	1.2134	19.56	200032	1.2931	18.93	210029	1.2401	21.22	220028	1.4832	22.80	220089	1.2427	23.10	230029	1.6432	19.49
190199	1.2359	16.06	200033	1.8163	21.86	210030	1.2537	21.74	220029	1.1952	23.15	220090	1.2971	22.00	230030	1.3297	18.39
190200	1.5590	22.04	200034	1.2552	20.15	210031	1.1427	16.23	220030	1.1366	18.54	220092	1.1430	18.52	230031	1.4167	19.32
190201	1.2161	18.71	200037	1.2116	18.67	210032	1.1936	17.72	220031	1.6739	30.24	220095	1.2186	21.48	230032	1.7052	21.88
190202	1.2084	.	200038	1.1309	23.39	210033	1.2617	20.81	220033	1.2513	20.07	220098	1.2582	21.59	230034	1.2402	19.05
190203	1.4659	21.74	200039	1.2521	19.86	210034	1.2805	15.73	220035	1.2845	21.64	220100	1.3692	25.71	230035	1.1347	17.51
190204	1.4734	21.46	200040	1.1933	19.55	210035	1.2804	20.27	220036	1.6131	24.65	220101	1.4126	25.92	230036	1.2516	23.21
190205	1.8421	19.66	200041	1.1206	19.36	210037	1.2093	18.31	220038	1.3092	22.65	220104	.	28.00	230037	1.2570	20.47
190206	1.6321	21.70	200043	0.8145	16.72	210038	1.4381	23.50	220041	1.2373	23.47	220105	1.2465	21.41	230038	1.7393	23.53
190207	1.1356	20.51	200050	1.2191	20.12	210039	1.1973	19.99	220042	1.2302	25.08	220106	1.1883	25.66	230040	1.1232	21.44
190208	0.8355	20.01	200051	0.9579	22.15	210040	1.2818	21.50	220046	1.3510	22.71	220108	1.1610	21.91	230041	1.3387	20.31
190218	0.9927	19.75	200052	0.9937	17.21	210043	1.2915	19.65	220049	1.2912	26.00	220110	2.0558	28.71	230042	1.1919	22.10
190227	0.9050	.	200055	1.0153	18.84	210044	1.3683	22.58	220050	1.1623	22.01	220111	1.2403	23.81	230046	1.9225	25.57
190231	1.4047	15.83	200062	0.9335	17.23	210045	1.1044	11.61	220051	1.1874	21.10	220116	1.8733	26.17	230047	1.3063	21.54
190236	1.5060	19.34	200063	1.1789	19.93	210048	1.3341	23.05	220052	1.2388	23.76	220119	1.2692	23.32	230053	1.5945	25.50
190237	2.1390	.	200066	1.1319	17.03	210049	1.1474	19.08	220053	1.1723	19.13	220123	1.0842	25.90	230054	1.8701	20.70

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
230055	1.1203	20.79	230116	0.9083	16.54	230186	1.1092	19.53*	230279	0.6318	17.70	240047	1.5659	22.62	240102	0.8440	14.61
230056	0.9351	16.08	230117	1.8494	25.93	230188	1.0835	15.71	230280	1.6338	15.67	240050	1.2141	25.30	240103	1.2314	19.15
230058	1.0864	20.42	230118	1.0877	21.30	230189	0.9337	16.68	230283	1.6069	27.95	240051	0.9178	19.92	240104	1.1401	23.22
230059	1.4296	19.92	230119	1.3276	21.19	230190	0.9231	26.82	230284	1.5182	.	240052	1.2787	20.77	240105	.	14.40
230060	1.4092	19.80	230120	1.1257	18.53	230191	0.9599	19.00	230285	1.0969	.	240053	1.4381	22.96	240106	1.3868	23.51
230062	0.9324	17.15	230121	1.1820	20.32	230193	1.2756	19.71	230286	1.0244	.	240056	1.2534	23.42	240107	0.9531	20.40
230063	.	20.42	230122	.	20.91	230195	1.3302	21.78	230287	1.3972	.	240057	1.8006	24.22	240108	0.9321	15.35
230065	1.3761	22.35	230124	1.1525	20.36	230197	1.3916	24.02	240001	1.5028	24.62	240058	0.9248	14.97	240109	0.9410	13.55
230066	1.3365	22.18	230128	1.3947	24.91	230199	1.0917	19.44	240002	1.7890	22.80	240059	1.0536	23.62	240110	0.9112	19.48
230069	1.2071	23.21	230130	1.6943	23.52	230201	1.2368	17.21	240004	1.5975	25.19	240061	1.7531	27.26	240111	1.0183	17.21
230070	1.5125	20.25	230132	1.4029	26.64	230204	1.4473	25.42	240005	0.8805	17.96	240063	1.4499	23.79	240112	1.0171	15.84
230071	1.1490	22.91	230133	1.2282	17.69	230205	0.9746	14.38	240006	1.1281	25.16	240064	1.3532	23.29	240114	0.9035	16.25
230072	1.2378	20.69	230135	1.1610	22.53	230207	1.2460	20.64	240007	1.0860	17.76	240065	1.0543	12.79	240115	1.6062	23.78
230075	1.4560	20.05	230137	.	19.18	230208	1.2196	16.07	240008	1.1229	20.22	240066	1.2749	23.07	240116	0.8674	16.67
230076	1.4487	24.45	230141	1.6450	22.13	230211	0.9286	18.67	240009	0.9543	16.90	240069	1.1527	19.83	240117	1.1117	18.06
230077	1.9883	21.02	230142	1.2627	22.29	230212	0.9617	23.30	240010	1.9613	23.65	240071	1.1319	20.21	240119	0.8284	20.61
230078	1.1578	17.56	230143	1.2379	16.30	230213	0.9755	15.19	240011	1.1593	20.52	240072	0.9542	21.18	240121	0.9326	23.40
230080	1.2269	19.77	230144	1.0627	22.11	230216	1.6154	20.33	240013	1.2586	20.33	240073	0.8902	16.08	240122	0.9920	19.18
230081	1.2121	19.03	230145	1.1073	20.25	230217	1.2416	21.27	240014	1.0914	23.00	240075	1.1861	21.26	240123	1.0161	16.51
230082	1.0448	18.30	230146	1.3346	20.50	230219	0.8434	19.15	240016	1.3568	20.40	240076	1.0846	21.88	240124	0.9325	19.44
230085	1.2776	20.21	230147	1.3696	21.85	230222	1.3659	22.18	240017	1.1403	18.36	240077	0.9452	15.38	240125	0.8970	12.36
230086	1.0491	18.94	230149	1.2010	20.77	230223	1.2712	21.15	240018	1.2471	20.85	240078	1.5334	23.92	240127	1.0015	15.90
230087	1.0389	18.90	230151	1.4616	22.17	230227	1.4817	23.73	240019	1.3331	22.15	240079	0.9508	18.43	240128	1.0654	17.25
230089	1.3223	23.91	230153	0.9925	19.56	230230	1.5443	22.24	240020	1.1766	21.19	240080	1.6172	24.34	240129	0.9684	14.42
230092	1.3548	20.01	230154	0.8789	15.45	230235	1.0234	16.87	240021	0.9236	18.75	240082	1.0499	18.35	240130	0.9414	14.94
230093	1.1862	20.47	230155	0.9754	17.21	230236	1.3511	24.38	240022	1.1157	21.79	240083	1.1947	19.76	240132	1.2582	23.07
230095	1.1832	17.33	230156	1.6633	24.76	230239	1.1387	18.09	240023	0.9404	21.51	240084	1.3076	19.47	240133	1.1757	19.21
230096	1.0647	22.84	230157	0.9068	20.37	230241	1.1312	19.10	240025	1.1766	18.83	240085	1.0269	22.57	240135	0.8354	14.31
230097	1.6631	21.28	230159	.	20.07	230244	1.3667	21.74	240027	1.0164	19.10	240086	1.0130	16.94	240137	1.1304	20.38
230099	1.1334	21.19	230162	0.9980	21.46	230253	0.9338	20.59	240028	.	19.79	240087	1.1033	18.83	240138	0.9440	15.21
230100	1.1975	17.13	230165	1.8188	23.01	230254	1.2808	21.94	240029	1.1447	21.13	240088	1.3565	21.69	240139	1.0046	20.81
230101	1.0859	20.09	230167	1.7813	21.50	230257	0.9954	19.70	240030	1.2686	18.85	240089	0.9910	20.72	240141	1.1415	23.81
230103	0.9854	22.77	230169	1.3470	23.07	230259	1.1211	22.24	240031	0.9686	18.16	240090	1.0609	19.30	240142	1.0571	25.28
230104	1.6193	23.15	230171	0.9830	13.39	230264	1.4357	17.13	240036	1.5891	22.25	240093	1.2532	18.71	240143	0.8930	16.62
230105	1.7578	21.52	230172	1.2261	20.64	230269	1.3187	23.31	240037	1.0051	19.23	240094	0.9189	20.94	240144	1.0413	18.26
230106	1.1915	20.80	230174	1.3655	23.03	230270	1.2247	22.62	240038	1.4968	25.31	240096	1.0387	20.16	240145	0.9289	17.28
230107	0.9343	16.60	230175	2.7449	16.89	230273	1.5773	22.92	240040	1.3177	20.48	240097	1.0242	24.27	240146	0.9351	16.07
230108	1.2424	18.86	230176	1.2172	22.78	230275	0.5155	17.75	240041	1.1214	19.29	240098	0.9402	21.35	240148	0.9095	18.88
230110	1.3532	18.98	230178	0.9947	16.92	230276	0.5135	21.37	240043	1.2418	17.73	240099	1.0571	14.46	240150	0.7099	13.88
230113	.	14.94	230180	1.1004	15.88	230277	1.3005	23.15	240044	1.1411	18.84	240100	1.2704	20.83	240152	0.9989	21.17
230115	0.9632	18.41	230184	1.2876	19.06	230278	.	18.21	240045	1.1379	21.14	240101	1.1726	19.21	240153	1.0139	16.54

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
240154	0.9861	17.58	250023	0.9100	13.91	250079	0.8718	16.27	250149	0.9670	12.96	260054	1.3049	20.02	260120	1.1535	16.38
240155	0.9382	19.88	250024	0.9331	12.71	250081	1.2885	17.33	250150	1.7338	.	260055	0.9769	12.01	260122	1.0944	14.97
240157	0.9796	17.42	250025	1.0576	19.04	250082	1.5686	16.10	260001	1.7310	18.10	260057	1.0375	17.46	260123	0.9832	14.64
240160	0.9985	15.95	250027	0.9856	14.95	250083	0.9078	14.26	260002	1.3519	22.12	260059	1.2131	16.10	260127	1.1142	18.36
240161	0.9772	15.80	250029	0.8439	16.48	250084	1.1572	17.02	260003	1.1104	14.66	260061	1.0893	14.72	260128	1.0236	13.05
240162	1.0664	16.63	250030	0.9057	17.36	250085	0.9496	14.38	260004	0.9092	13.01	260062	1.1842	20.15	260131	1.1615	17.77
240163	0.9685	18.83	250031	1.1993	17.97	250088	0.9698	17.87	260005	1.5319	19.56	260063	1.0409	18.23	260134	1.1753	16.28
240166	1.0868	17.32	250032	1.2706	17.13	250089	1.0825	13.42	260006	1.5269	19.75	260064	1.3153	16.59	260137	1.7529	17.95
240169	.	16.67	250033	0.9662	17.83	250093	1.1749	15.20	260008	0.9459	13.85	260065	1.7721	19.44	260138	1.8777	22.65
240170	1.0880	18.88	250034	1.5059	16.70	250094	1.3028	18.08	260009	1.3027	18.51	260066	1.0201	14.96	260141	1.9575	19.16
240171	0.9467	17.29	250035	0.8318	15.24	250095	0.9866	17.00	260011	1.5625	19.10	260067	0.8996	14.22	260142	1.1147	17.12
240172	0.9243	18.28	250036	0.9373	15.84	250096	1.2288	19.07	260012	1.0105	14.36	260068	1.6754	20.24	260143	1.0674	12.79
240173	0.9561	17.26	250037	0.9013	15.43	250097	1.2227	16.99	260013	1.1272	15.99	260070	0.9982	.	260147	0.9506	14.08
240179	0.9728	17.51	250038	0.9448	16.85	250098	0.8736	13.13	260014	0.7243	.	260073	1.0537	14.26	260148	0.8693	11.87
240184	0.9966	15.38	250039	1.0126	14.16	250099	1.2369	14.85	260015	1.1808	16.58	260074	1.2874	19.03	260158	1.0756	12.30
240187	1.2630	19.92	250040	1.3202	17.34	250100	1.3065	17.17	260017	1.1993	16.79	260077	1.7862	18.65	260159	0.9736	20.32
240193	0.9661	17.82	250042	1.2329	16.39	250101	0.9552	18.47	260018	0.8930	12.01	260078	1.1331	15.64	260160	1.1133	15.84
240196	0.7807	24.35	250043	0.8712	16.07	250102	1.5108	23.93	260019	1.1483	18.61	260079	1.0014	14.30	260162	1.6546	19.57
240200	0.9272	14.34	250044	0.9680	16.12	250104	1.4599	18.25	260020	1.7749	20.51	260080	0.9773	13.54	260163	1.3117	16.42
240205	0.9243	.	250045	1.2067	22.08	250105	0.9041	14.54	260021	1.3795	22.10	260081	1.5736	21.01	260164	0.8809	14.94
240206	0.8234	.	250047	0.9759	13.37	250107	0.9187	15.15	260022	1.1850	17.25	260082	1.1306	15.94	260166	1.2189	20.10
240207	1.1594	24.11	250048	1.5786	16.89	250109	0.8783	22.16	260023	1.3634	16.47	260085	1.5483	20.47	260172	0.9460	15.42
240210	1.2491	24.22	250049	0.8829	11.67	250112	0.9694	15.56	260024	0.9407	15.24	260086	0.9234	14.32	260173	1.0151	12.85
240211	0.9874	19.74	250050	1.2004	14.39	250117	1.0304	16.12	260025	1.3070	15.49	260091	1.6738	20.00	260175	1.1562	16.90
250001	1.6112	18.42	250051	0.8618	9.35	250119	1.0912	15.22	260027	1.6845	20.64	260094	1.2029	18.01	260176	1.5718	26.87*
250002	0.8541	17.25	250057	1.1764	15.92	250120	1.1700	15.34	260029	1.1663	19.75	260095	1.3973	19.69	260177	1.2878	21.26
250003	1.0047	17.65	250058	1.1864	15.53	250122	1.1738	18.94	260030	1.0946	12.51	260096	1.5339	23.03	260178	1.5350	19.66
250004	1.5584	17.89	250059	1.0693	16.28	250123	1.1743	18.87	260031	1.5437	19.49	260097	1.1362	16.56	260179	1.6138	21.49
250005	0.9383	12.60	250060	0.7500	13.03	250124	0.9027	13.18	260032	1.7894	20.20	260100	0.9513	15.70	260180	1.6069	19.58
250006	0.9859	16.90	250061	0.8374	11.03	250125	1.3343	20.89	260034	0.9603	17.42	260102	0.9927	20.13	260183	1.6375	20.07
250007	1.2467	19.29	250063	0.8472	13.25	250126	0.9689	18.24	260035	0.9701	13.11	260103	1.3726	18.60	260186	1.6400	19.32
250008	1.0048	14.18	250065	0.8716	12.89	250127	0.8221	.	260036	0.9895	16.74	260104	1.6047	21.01	260188	1.2131	20.64
250009	1.3292	18.56	250066	0.8898	15.68	250128	1.0216	14.00	260039	1.0788	14.19	260105	1.8093	24.72	260189	0.8520	11.30
250010	0.9977	13.39	250067	1.1539	16.41	250131	1.0306	12.61	260040	1.6310	17.31	260107	1.4582	19.84	260190	1.1988	18.52
250012	0.9786	14.16	250068	0.8249	13.68	250134	0.9418	17.07	260042	1.0374	18.76	260108	1.8731	19.46	260191	1.3262	17.98
250015	0.9911	13.53	250069	1.2716	17.90	250136	0.8988	18.97	260044	0.9634	15.99	260109	1.0518	13.91	260193	1.2305	21.16
250017	1.0353	17.94	250071	0.8828	14.38	250138	1.2422	18.40	260047	1.5740	19.01	260110	1.6778	17.84	260195	1.1982	17.72
250018	0.8896	11.93	250072	1.4487	18.22	250141	1.2465	19.01	260048	1.3286	20.09	260113	1.2672	14.68	260197	1.2405	19.28
250019	1.5527	16.74	250076	.	10.51	250145	0.8594	10.25	260050	1.0042	15.69	260115	1.1526	19.23	260198	1.2928	11.98
250020	0.9604	13.45	250077	0.9834	12.26	250146	0.9408	14.49	260052	1.3534	18.06	260116	1.0764	16.28	260200	1.1747	20.53
250021	0.9933	9.43	250078	1.5177	15.63	250148	1.0949	18.10	260053	1.1619	15.22	260119	1.1354	16.88	260205	1.4868	17.62

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
260206	3.5316	.	270079	0.9307	15.69	280048	1.0610	15.87	280105	1.3280	18.66	300003	1.8880	22.91	310019	1.6477	24.05
270002	1.3163	29.00	270080	1.0688	16.32	280049	1.1344	18.36	280106	0.9652	16.12	300005	1.2652	20.75	310020	1.4285	24.18
270003	1.1745	22.10	270081	0.9728	15.63	280050	0.9190	16.64	280107	1.0640	13.33	300006	1.1972	23.78	310021	1.6599	23.94
270004	1.7340	19.63	270082	1.0769	17.34	280051	0.9767	15.63	280108	1.1057	17.56	300007	1.1496	20.24	310022	1.3049	21.27
270006	0.8753	16.02	270083	1.0248	18.44	280052	1.0544	14.08	280109	0.9708	12.68	300008	1.1617	20.77	310024	1.3490	24.24
270007	1.0201	11.31	270084	0.9263	16.62	280054	1.2303	18.80	280110	0.9881	12.75	300009	1.0513	18.06	310025	1.2385	24.35
270009	1.0858	17.23	280001	1.0557	17.35	280055	0.9476	13.57	280111	1.3031	21.88	300010	1.3185	19.39	310026	1.3332	23.55
270011	1.0194	20.27	280003	2.1265	22.32	280056	0.8578	12.65	280114	0.9370	15.72	300011	1.3296	22.43	310027	1.3242	21.88
270012	1.5776	19.73	280005	1.3927	19.24	280057	0.9221	18.05	280115	0.9539	16.70	300012	1.3252	24.57	310028	1.2710	23.46
270014	1.9206	19.09	280009	1.7899	19.81	280058	1.1285	19.67	280117	1.0304	17.73	300013	1.1199	19.12	310029	1.8589	22.66
270016	0.8704	19.67	280010	0.8079	17.49	280060	1.5675	19.75	280118	0.9359	16.87	300014	1.2241	20.33	310031	2.8282	26.16
270017	1.2553	21.08	280011	0.8768	15.86	280061	1.3985	17.16	280119	0.8813	.	300015	1.1925	20.49	310032	1.2800	24.35
270019	1.1179	18.11	280013	1.7399	22.81	280062	1.1417	14.49	280123	0.8947	14.06	300016	1.2015	21.87	310034	1.2957	23.27
270021	1.0774	17.18	280014	0.9194	15.96	280064	0.9605	16.30	280125	1.2270	16.13	300017	1.4332	21.66	310036	1.1769	20.19
270023	1.2742	22.26	280015	1.0055	17.03	280065	1.2540	19.29	290001	1.7238	22.82	300018	1.3174	21.24	310037	1.3727	27.78
270026	0.9444	17.51	280017	1.0439	14.21	280066	1.0137	11.66	290002	0.9215	17.26	300019	1.2062	20.98	310038	1.9845	26.72
270027	1.0309	13.14	280018	0.9921	15.13	280068	0.8544	9.49	290003	1.6788	22.88	300020	1.3569	21.92	310039	1.2730	22.17
270028	1.1116	21.15	280020	1.7874	19.97	280070	0.9526	17.74	290005	1.3091	19.49	300021	1.1376	18.62	310040	1.2261	26.15
270029	0.9261	16.57	280021	1.1393	17.10	280073	0.9819	17.42	290006	1.2330	21.81	300022	1.1045	18.35	310041	1.3095	24.90
270032	1.1138	17.74	280022	0.9370	16.72	280074	1.0434	16.43	290007	1.6320	29.77	300023	1.4287	22.12	310042	1.2518	23.25
270033	0.8100	16.96	280023	1.3767	25.85	280075	1.1198	15.53	290008	1.1991	20.62	300024	1.2956	19.91	310043	1.1489	21.90
270035	0.9560	16.83	280024	0.9506	14.22	280076	1.1016	14.85	290009	1.6409	23.36	300028	1.2847	17.41	310044	1.3209	21.67
270036	0.9083	14.25	280025	0.9383	15.59	280077	1.2257	19.21	290010	1.1177	15.64	300029	1.5945	22.57	310045	1.4617	28.49
270039	1.0428	15.94	280026	1.0401	16.69	280079	0.9470	10.45	290011	0.9665	20.16	300033	1.0874	17.19	310047	1.3298	25.11
270040	1.1301	18.81	280028	1.0583	17.32	280080	1.0743	15.33	290012	1.3568	21.83	300034	2.1189	25.52	310048	1.2895	23.61
270041	1.1196	19.03	280029	1.1040	23.13	280081	1.6635	21.08	290013	1.0146	18.27	310001	1.7580	28.13	310049	1.2085	24.83
270044	1.0627	16.77	280030	1.7572	24.54	280082	0.9945	14.34	290014	1.0345	18.97	310002	1.8321	28.34	310050	1.3112	25.17
270048	0.9847	17.01	280031	1.0339	13.57	280083	1.0392	18.30	290015	0.9468	22.35	310003	1.3223	29.11	310051	1.4177	27.13
270049	1.7311	22.24	280032	1.3348	18.90	280084	0.9599	12.58	290016	1.0872	14.35	310005	1.3372	22.11	310052	1.2477	22.93
270050	1.0823	16.71	280033	0.9923	15.76	280085	.	20.43	290019	1.3051	21.25	310006	1.2911	21.60	310054	1.3222	26.17
270051	1.3362	20.27	280035	1.0577	15.92	280088	.	20.30	290020	0.9228	20.87	310008	1.3617	23.51	310057	1.2566	21.17
270052	0.9741	14.48	280037	1.0092	16.80	280089	0.9474	18.17	290021	1.6563	21.58	310009	1.3139	23.64	310058	1.2174	26.53
270057	1.2854	21.13	280038	1.0720	17.09	280090	.	14.14	290022	1.6276	24.55	310010	1.2710	22.57	310060	1.2836	19.20
270058	0.9740	14.75	280039	1.0240	16.04	280091	1.0634	15.84	290027	0.8971	16.78	310011	1.2150	23.20	310061	1.2297	23.26
270059	0.7770	14.75	280040	1.7213	19.53	280092	1.0073	14.19	290029	0.9152	.	310012	1.6329	26.52	310062	.	22.91
270060	0.9697	15.27	280041	0.9411	16.41	280094	0.9541	17.69	290032	1.4460	22.84	310013	1.3374	21.23	310063	1.3701	21.90
270063	1.0414	12.61	280042	1.0223	16.12	280097	1.0200	14.17	290038	0.8689	20.67	310014	1.6575	27.46	310064	1.3388	24.86
270073	1.2129	14.46	280043	1.0169	16.66	280098	0.9236	13.00	290039	1.3617	25.39	310015	2.0201	27.43	310067	1.3359	25.09
270074	0.8911	.	280045	1.0114	16.90	280101	1.0304	13.53	290041	1.2968	.	310016	1.2890	24.38	310069	1.2380	23.75
270075	0.9208	.	280046	1.0452	17.92	280102	.	14.01	290043	1.4085	.	310017	1.3423	25.79	310070	1.3766	26.09
270076	0.8683	.	280047	1.0712	18.34	280104	0.9154	13.28	300001	1.5543	22.09	310018	1.1254	22.84	310072	1.3529	21.76

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
310073	1.6662	28.51	320011	1.1635	20.06	330007	.	18.90	330066	1.3239	19.56	330133	1.4015	37.25	330201	1.6150	32.11
310074	1.4017	23.83	320012	1.0161	16.44	330008	1.1462	19.00	330067	1.3648	20.94	330135	1.1921	18.71	330202	1.2954	31.44
310075	1.3322	23.33	320013	1.2033	22.96	330009	1.2478	30.69	330072	1.3899	30.80	330136	1.3320	18.24	330203	1.4145	20.76*
310076	1.4861	30.08	320014	1.0710	16.36	330010	1.3039	17.45	330073	1.2028	16.29	330140	1.7844	19.14	330204	1.4205	29.44
310077	1.5989	25.25	320016	1.1670	20.54	330011	1.2557	18.30	330074	1.2902	18.00	330141	1.3349	26.50	330205	1.2419	20.58
310078	1.3604	23.88	320017	1.0924	18.64	330012	1.2482	32.76	330075	1.0712	17.23	330144	0.9514	14.06	330208	1.2196	26.18
310081	1.3165	22.08	320018	1.4866	18.85	330013	2.0884	19.08	330078	1.4088	16.79	330148	1.0294	16.82	330209	1.1879	23.99
310083	1.2091	23.89	320019	1.4324	24.47	330014	1.3548	32.34	330079	1.1676	17.46	330151	1.1133	16.07	330211	1.2026	19.51
310084	1.2832	26.67	320021	1.7040	17.87	330016	1.0280	16.97	330080	1.2833	29.27	330152	1.4507	30.54	330212	1.0308	21.77
310086	1.2428	22.17	320022	1.1678	16.18	330019	1.3322	35.98	330084	1.0903	18.04	330153	1.6757	18.97	330213	1.0956	18.77
310087	1.3332	20.72	320023	0.9239	18.05	330020	1.0410	15.55	330085	1.2357	20.29	330154	1.7681	.	330214	1.8054	36.44
310088	1.2256	22.32	320030	1.1665	16.55	330023	1.3047	24.40	330086	1.3374	31.30	330157	1.3655	22.08	330215	1.1628	19.69
310090	1.3837	23.83	320031	0.9716	19.68	330024	1.7869	34.17	330088	1.0435	25.66	330158	1.4573	25.76	330218	1.1070	21.48
310091	1.2506	22.80	320032	0.9893	18.81	330025	1.1203	16.20	330090	1.5198	19.40	330159	1.2553	19.15	330219	1.5277	23.99
310092	1.3627	20.52	320033	1.0647	25.08	330027	1.3967	33.47	330091	1.3988	19.10	330160	1.4835	32.78	330221	1.4119	27.85
310093	1.2382	22.43	320035	0.9774	21.52	330028	1.4167	28.21	330092	1.0016	14.07	330162	1.3018	27.12	330222	1.2932	18.37
310096	2.0551	25.16	320037	1.2047	17.03	330029	1.0048	18.16*	330094	1.2723	17.56	330163	1.2807	18.78	330223	1.0727	17.62
310105	1.2277	25.59	320038	1.1866	16.81	330030	1.5264	17.50	330095	1.2586	20.11	330164	1.3877	19.86	330224	1.2910	19.64
310108	1.4164	22.48	320046	1.4604	18.32	330033	1.2438	18.53	330096	1.1052	17.96	330166	1.0961	15.10	330225	1.1884	25.58
310110	1.2388	21.83	320048	1.2998	19.96	330034	.	31.40	330097	1.1926	16.22	330167	1.7307	29.36	330226	1.3214	16.67
310111	1.2815	21.11	320056	0.9230	.	330036	1.2491	23.99	330100	1.0517	27.07	330169	1.4082	37.27	330229	1.2677	16.80
310112	1.3102	23.67	320057	0.9771	.	330037	1.1393	16.11	330101	1.7645	32.41	330171	1.2626	25.53	330230	1.2694	29.76
310113	1.2462	23.68	320058	0.9443	.	330038	1.0977	16.25	330102	1.3654	17.58	330175	1.1803	17.33	330231	1.0236	30.09
310115	1.2716	21.73	320059	1.0804	.	330041	1.2947	24.52	330103	1.2136	15.72	330177	0.9549	17.29	330232	1.2275	17.91
310116	1.3459	22.98	320060	0.9844	.	330043	1.3001	28.75*	330104	1.3505	31.65	330179	0.8666	13.50	330233	1.4892	30.92
310118	1.3484	26.46	320061	1.2609	.	330044	1.2702	20.02	330106	1.6789	40.27	330180	1.2308	16.88	330234	2.3628	35.18
310119	1.7942	33.67	320062	0.8443	.	330045	1.3692	28.08	330107	1.2277	28.56	330181	1.3089	32.52	330235	1.1567	21.08
310120	1.1620	23.97	320063	1.2658	18.32	330046	1.4433	32.42	330108	1.2557	17.36	330182	2.5752	32.94	330236	1.4014	29.59
310528	1.4071	.	320065	1.1439	16.79	330047	1.2317	18.18	330111	1.0706	19.53	330183	1.4721	19.92	330238	1.2153	15.62
310529	1.4071	.	320067	0.9611	33.87	330048	1.2598	17.88	330114	0.9086	17.35	330184	1.3680	30.04	330239	1.2077	17.45
310534	0.5907	.	320068	0.8789	17.48	330049	1.1966	19.50	330115	1.1376	17.44	330185	1.2876	25.61	330240	1.3427	29.71
310832	0.8079	.	320069	0.9685	13.01	330053	1.2453	17.44	330116	0.8466	24.46	330188	1.2389	20.96	330241	2.0322	24.61
310850	0.7641	.	320070	0.9979	.	330055	1.6309	36.11	330118	.	20.69	330189	0.9157	15.13	330242	1.3667	28.26
310858	0.8079	.	320074	1.1344	19.34	330056	1.3738	30.45	330119	1.6632	34.84	330191	1.2923	18.62	330245	1.6763	17.68
320001	1.5222	19.12	320079	1.1973	18.28	330057	1.7171	18.75	330121	1.0206	16.10	330193	1.4076	36.55	330246	1.3462	28.11
320002	1.3286	22.62	330001	1.1783	26.55	330058	1.2879	17.00	330122	1.0280	20.82	330194	1.8635	34.68	330247	0.9357	28.53
320003	1.1472	15.95	330002	1.3658	26.54	330059	1.5454	34.17	330125	1.8727	19.85	330195	1.6392	33.33	330249	1.1696	16.27
320004	1.2303	18.58	330003	1.3551	19.41	330061	1.2623	25.73	330126	1.2024	23.79	330196	1.2994	30.82	330250	1.3145	19.58
320005	1.3699	21.61	330004	1.2751	22.53	330062	1.1007	17.61	330127	1.3854	31.90	330197	1.0855	17.66	330254	1.3200	18.41
320006	1.4044	18.90	330005	1.6335	24.83	330064	1.3544	33.13	330128	1.3017	29.02	330198	1.4001	24.60	330258	1.2262	29.74
320009	1.6940	18.29	330006	1.3530	25.06	330065	1.2485	19.89	330132	1.1944	15.76	330199	1.3274	28.76	330259	1.4464	26.27

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
330261	1.2037	25.72	330393	1.8382	26.50	340037	1.1033	16.66	340098	1.5952	21.41	340158	1.0371	18.14	350042	1.0451	16.74
330263	0.9766	20.41	330394	1.5304	19.24	340038	1.0927	17.38	340099	1.0903	16.83	340159	1.1720	17.39	350043	1.5466	16.89
330264	1.1703	22.87	330395	1.3654	32.87	340039	1.2714	20.59	340101	1.0078	14.00	340160	1.0931	16.18	350044	0.8810	10.22
330265	1.3006	18.02	330396	1.2228	34.86	340040	1.7834	20.43	340104	0.8760	13.05	340162	.	14.35	350047	0.9607	14.46
330267	1.4341	24.52	330397	1.3012	33.91	340041	1.2050	15.14	340105	1.4836	20.30	340164	1.3481	21.25	350049	1.1631	14.80
330268	0.9369	13.06	330398	.	28.77	340042	1.2299	16.93	340106	1.1165	17.72	340166	1.3044	20.04	350050	0.8465	11.49
330270	1.9561	34.43	330399	1.2690	32.91	340044	1.0557	18.87	340107	1.2071	18.02	340168	0.5101	15.29	350051	0.9311	17.73
330273	1.3015	23.15	330400	0.8784	.	340045	0.9666	13.05	340109	1.3153	18.77	340171	1.1444	21.60	350053	1.0115	14.64
330275	1.9700	19.05	340001	1.4103	18.18	340047	1.8747	20.06	340111	1.0635	16.33	340173	1.2105	19.33	350055	1.0247	14.57
330276	1.2323	18.29	340002	1.6732	20.89	340049	0.7283	19.21	340112	0.9904	14.76	350001	0.9882	14.91	350056	0.9278	14.83
330277	1.1145	18.32	340003	1.0954	20.25	340050	1.1213	20.01	340113	1.8636	21.29	350002	1.8088	17.53	350058	0.9796	15.94
330279	1.3749	19.60	340004	1.4557	19.07	340051	1.2485	16.56	340114	1.5492	21.22	350003	1.2254	18.25	350060	0.8490	10.37
330285	1.8612	23.53	340005	1.0289	15.82	340052	1.0005	22.82	340115	1.5723	19.76	350004	1.9072	20.65	350061	1.0017	15.73
330286	1.2781	26.76	340006	0.9746	16.98	340053	1.5846	20.95	340116	1.8238	20.42	350005	1.0417	18.38	350063	0.9667	.
330290	1.7529	33.51	340007	1.1555	17.24	340054	1.1409	15.60	340119	1.2150	18.85	350006	1.5536	18.41	350064	0.7558	.
330293	1.1720	16.22	340008	1.1423	21.29	340055	1.2622	19.60	340120	1.0492	15.04	350007	0.8587	13.33	350069	1.2802	.
330297	1.0131	.	340009	.	20.50	340060	1.0867	18.71	340121	1.0746	16.33	350008	1.1682	20.48	360001	1.2943	17.08
330304	1.2300	26.77	340010	1.3354	18.34	340061	1.7364	21.54	340123	1.1160	16.91	350009	1.1136	19.16	360002	1.1397	18.01
330306	1.3163	27.38	340011	1.1279	13.66	340063	1.0093	17.02	340124	1.0777	15.58	350010	1.0119	16.28	360003	1.7057	22.75
330307	1.2304	21.07	340012	1.2312	18.87	340064	1.1283	20.71	340125	1.4295	19.72	350011	1.8859	18.20	360006	1.9148	21.80
330314	1.3586	24.54	340013	1.2499	20.17	340065	1.2215	17.54	340126	1.3008	18.81	350012	1.1412	15.70	360007	1.0242	18.09
330316	1.3137	27.61	340014	1.5206	20.57	340067	1.0003	19.38	340127	1.1952	19.39	350013	1.0371	16.46	360008	1.3481	18.54
330327	0.8647	16.46	340015	1.2769	20.16	340068	1.1733	16.63	340129	1.2483	20.46	350014	0.9712	16.84	360009	1.5341	18.93
330331	1.3091	31.62	340016	1.1190	17.54	340069	1.7753	21.08	340130	1.2830	19.74	350015	1.7379	16.34	360010	1.2338	19.23
330332	1.2556	27.69	340017	1.2086	19.42	340070	1.2877	19.78	340131	1.4399	19.79	350016	.	11.65	360011	1.3384	19.38
330333	1.2826	29.19	340018	1.0798	14.09	340071	1.0822	17.14	340132	1.3407	17.34	350017	1.2975	17.63	360012	1.3386	19.99
330336	1.2323	29.77	340019	0.9708	14.90	340072	1.2078	16.74	340133	1.0257	16.48	350018	1.0471	14.49	360013	1.1574	20.60
330338	1.1713	22.46	340020	1.1758	18.63	340073	1.2972	21.98	340137	1.0849	21.02	350019	1.6648	19.31	360014	1.1009	20.24
330339	0.8910	20.01	340021	1.2527	19.80	340075	1.1567	18.71	340138	1.1262	20.76	350021	1.0506	16.29	360016	1.5829	17.81
330340	1.1929	28.84	340022	1.0713	17.82	340080	.	22.25	340141	1.6889	21.38	350023	0.9937	17.90	360017	1.9321	21.75
330350	1.6644	30.89	340023	1.3871	18.54	340084	1.0707	17.15	340142	1.1665	17.15	350024	0.9642	14.75	360018	1.6759	23.52
330353	1.3479	32.20	340024	1.1993	17.38	340085	1.1699	17.35	340143	1.4587	21.36	350025	0.9326	17.12	360019	1.2030	18.71
330354	1.6425	.	340025	1.1962	17.26	340087	1.0973	17.39	340144	1.2427	20.91	350027	0.9559	15.08	360020	1.5244	21.78
330357	1.3539	36.59	340027	1.1833	18.08	340088	1.3505	21.02	340145	1.3092	20.11	350029	0.8521	13.52	360024	1.2677	19.85
330372	1.2479	28.85*	340028	1.5802	18.48	340089	0.9797	13.85	340146	1.1830	15.92	350030	1.0705	17.72	360025	1.3829	20.36
330381	1.2237	31.01	340030	2.0520	21.14	340090	1.1476	17.06	340147	1.2067	19.68	350033	0.9207	14.90	360026	1.3590	18.22
330385	1.2605	35.67	340031	0.9218	14.70	340091	1.6272	20.59	340148	1.2925	18.59	350034	0.9218	18.72	360027	1.4750	21.04
330386	1.1316	17.64	340032	1.4555	20.00	340093	1.0292	16.33	340151	1.1889	16.73	350035	0.9169	10.46	360028	1.4691	17.02
330387	0.9061	.	340034	1.2593	.	340094	1.3752	19.04	340153	1.8514	20.64	350038	1.0670	17.67	360029	1.1467	18.76
330389	1.8502	30.25	340035	1.0683	20.23	340096	1.1811	17.82	340155	1.4057	20.58	350039	0.9504	17.04	360030	1.2387	17.57
330390	1.3637	31.16	340036	1.0915	18.22	340097	1.1358	18.84	340156	0.8353	.	350041	1.1019	14.67	360031	1.2614	19.39

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
360032	1.1939	18.66	360079	1.9049	22.11	360132	1.3751	19.92	360189	1.0459	17.90	370019	1.3148	14.23	370080	0.9633	13.92
360034	1.2090	14.95	360080	1.1499	17.39	360133	1.5669	19.43	360192	1.3209	21.64	370020	1.2259	14.38	370082	0.8272	13.96
360035	1.6387	20.56	360081	1.3624	21.73	360134	1.6859	20.69*	360194	1.1996	17.19	370021	0.8554	12.05	370083	0.9352	13.15
360036	1.2495	20.21	360082	1.2764	22.95	360136	1.0035	17.78	360195	1.1079	19.93	370022	1.2696	17.23	370084	1.0547	22.05
360037	1.7878	23.51	360084	1.5179	20.49	360137	1.7667	20.17	360197	1.1036	20.06	370023	1.2673	17.76	370085	0.9432	11.28
360038	1.6177	21.25	360085	1.9538	21.91	360140	0.9452	20.28	360200	0.9540	16.23	370025	1.3064	17.50	370086	1.1237	15.44
360039	1.3100	18.78	360086	1.5008	19.54	360141	1.6731	23.00	360203	1.0978	16.32	370026	1.5030	18.34	370089	1.2280	16.10
360040	1.2325	18.16	360087	1.5438	20.17	360142	1.0195	17.01	360204	1.0541	22.25	370028	1.9043	18.44	370091	1.6042	19.17
360041	1.3558	19.57	360088	1.3338	24.01	360143	1.3575	20.20	360210	1.1394	21.00	370029	1.1685	16.49	370092	1.0128	14.98
360042	1.1140	17.43	360089	1.2080	18.39	360144	1.3413	23.22	360211	1.2947	19.99	370030	1.1316	16.33	370093	1.8140	18.46
360044	1.2326	17.06	360090	1.2526	21.04	360145	1.7451	19.64	360212	1.3355	21.11	370032	1.5632	18.28	370094	1.4121	18.00
360045	1.4050	22.15	360091	1.2923	21.31	360147	1.2678	16.66	360213	1.2090	19.48	370033	1.0528	13.52	370095	0.9814	12.64
360046	1.1640	20.48	360092	1.1336	20.45	360148	1.1105	19.28	360218	1.2990	18.95	370034	1.2294	15.64	370097	1.2813	22.97
360047	1.0989	17.19	360093	1.0956	19.33	360149	.	19.98	360230	1.4935	21.98	370035	.	25.58	370099	1.0939	15.45
360048	1.8272	22.58	360094	1.3367	18.88	360150	1.3667	21.13	360231	1.1068	12.96	370036	0.9960	12.40	370100	0.9114	14.02
360049	1.2098	20.46	360095	1.3127	20.41	360151	1.4056	16.60	360234	1.3214	23.26	370037	1.7616	16.70	370103	0.9544	19.24
360050	1.1453	12.99	360096	1.0794	18.22	360152	1.5126	20.83	360236	1.2707	17.84	370038	0.9615	13.31	370105	1.9098	21.33
360051	1.6254	20.83	360098	1.5056	19.53	360153	1.1645	15.41	360239	1.3379	20.19	370039	1.1423	15.52	370106	1.5203	18.55
360052	1.6229	19.62	360099	1.0207	18.58	360154	1.0085	14.33	360241	0.4315	23.53	370040	1.0080	14.47	370108	0.9726	12.33
360054	1.2059	17.26	360100	1.2112	17.90	360155	1.4648	22.53	360242	1.8124	.	370041	0.9018	16.74	370112	1.0949	14.85
360055	1.3527	21.56	360101	1.3238	21.39	360156	1.2197	17.88	360243	.	14.87	370042	0.8535	14.92	370113	1.1539	16.10
360056	1.4038	19.05	360102	1.2557	19.43	360159	1.1594	20.28	360245	0.6904	16.46	370043	0.9540	15.95	370114	1.5822	16.53
360057	1.0536	15.01	360106	1.1941	18.98	360161	1.3926	19.20	360247	0.4151	16.31	370045	0.9785	10.20	370121	1.0684	22.56
360058	1.1192	18.70	360107	1.1829	19.76	360162	0.7891	.	360250	3.9348	.	370046	0.9928	18.83	370122	0.9493	15.06
360059	1.6015	20.56	360108	1.0318	17.58	360163	1.8350	20.73	360252	1.2846	.	370047	1.3912	16.76	370123	1.3873	18.92
360062	1.4229	20.76	360109	1.1103	20.10	360165	1.1664	18.26	360253	2.8198	.	370048	1.2019	18.22	370125	0.9161	15.63
360063	1.1771	18.45	360112	1.8530	22.56	360166	.	18.73	370001	1.7256	22.52	370049	1.2855	20.72	370126	1.0242	23.97
360064	1.6013	20.48	360113	1.2890	24.26	360170	1.3600	16.47	370002	1.3093	14.73	370051	0.9584	11.67	370131	0.8147	17.57
360065	1.2483	20.05	360114	1.0978	17.88	360172	1.3341	18.67	370004	1.2169	19.32	370054	1.2816	16.90	370133	1.0890	10.96
360066	1.6104	21.60	360115	1.3848	18.81	360174	1.2913	19.97	370005	0.8524	15.17	370056	1.6450	18.46	370138	0.9847	16.40
360067	1.0771	15.32	360116	1.2651	18.89	360175	1.2196	21.17	370006	1.1504	16.65	370057	1.0951	16.73	370139	0.9891	14.86
360068	1.8258	21.28	360118	1.4279	19.37	360176	1.1316	15.94	370007	1.0947	15.29	370059	1.0657	18.14	370140	1.0495	16.07
360069	1.1757	16.70	360121	1.1624	22.11	360177	1.1805	18.79	370008	1.4123	16.66	370060	1.0383	16.54	370141	1.2713	18.41
360070	1.7376	17.38	360123	1.3123	20.32	360178	1.2352	18.87	370011	1.0147	14.97	370063	1.2088	14.41	370146	1.0233	12.64
360071	1.3032	17.98	360125	1.2278	19.08	360179	1.4844	21.13	370012	0.9609	11.73	370064	0.8972	10.97	370148	1.4777	20.65
360072	1.2207	18.15	360126	1.2281	19.00	360180	2.1817	21.38	370013	1.8324	19.34	370065	0.9824	16.69	370149	1.3538	16.19
360074	1.2812	20.83	360127	1.1662	17.59	360184	.	19.12	370014	1.1749	20.65	370071	1.0039	16.14	370153	1.1105	17.83
360075	1.3409	22.45	360128	1.2292	16.12	360185	1.2320	18.73	370015	1.0990	17.03	370072	0.8627	14.47	370154	0.9998	15.51
360076	1.3672	20.07	360129	0.9269	15.50	360186	1.0140	18.32	370016	1.3358	19.12	370076	1.2090	13.57	370156	1.0548	13.93
360077	1.5738	21.10	360130	1.0412	17.20	360187	1.4775	18.51	370017	.	12.64	370078	1.5885	18.41	370158	0.9803	15.69
360078	1.2572	21.44	360131	1.2846	19.22	360188	0.9362	17.10	370018	1.3286	18.51	370079	0.9792	16.69	370159	1.2132	28.05

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
370163	0.9450	17.64	380020	1.4424	20.15	380087	1.2587	16.53	390043	1.1751	17.26	390095	1.2478	16.33	390147	1.2027	20.97
370165	1.1226	13.09	380021	1.2501	21.16	380088	0.9243	21.52	390044	1.6352	20.28	390096	1.4937	19.12	390150	1.1454	20.73
370166	1.0946	17.28	380022	1.1707	22.64	380089	1.2392	19.53	390045	1.6020	18.56	390097	1.2579	23.60	390151	1.2245	21.60
370169	1.0537	12.52	380023	1.1767	20.55	380090	1.3232	29.27	390046	1.5717	20.73	390100	1.6324	20.78	390152	1.0777	20.33
370170	1.0516	.	380025	1.3340	26.37	380091	1.2525	27.56	390047	1.5521	27.67	390101	1.2154	17.95	390153	1.2248	23.70
370171	0.9963	.	380026	1.0941	20.47	390001	1.5409	19.30	390048	1.1542	19.09	390102	1.3788	19.05	390154	1.2094	17.40
370172	0.8438	.	380027	1.2669	20.86	390002	1.3556	21.83	390049	1.5583	21.12	390103	1.1332	18.43	390156	1.4322	21.85
370173	1.1305	.	380029	1.1923	19.42	390003	1.2304	17.14	390050	2.1184	22.88	390104	1.0109	15.90	390157	1.3607	19.66
370174	0.9456	.	380031	0.9295	23.32	390004	1.3919	19.23	390051	2.1193	25.79	390106	1.0782	16.67	390160	1.2339	21.48
370176	1.2063	15.95	380033	1.7558	25.25	390005	1.1055	17.35	390052	1.1752	20.93	390107	1.4337	19.52	390161	1.0720	16.48
370177	0.9538	11.25	380035	1.2490	22.41	390006	1.8380	20.30	390054	1.2292	17.89	390108	1.3818	21.09	390162	1.4937	21.41
370178	1.0145	10.57	380036	.	27.16	390007	1.1621	21.75	390055	1.8812	24.22	390109	1.1714	16.46	390163	1.2989	16.80
370179	0.8841	17.28	380037	1.2564	21.92	390008	1.1629	17.83	390056	1.1545	17.78	390110	1.6077	21.53	390164	2.1680	24.68
370180	0.9414	.	380038	1.3121	26.09	390009	1.7853	20.65	390057	1.2900	20.21	390111	1.9598	27.52	390166	1.1239	19.04
370183	1.0832	10.29	380039	1.2788	23.17	390010	1.2237	17.51	390058	1.3441	19.74	390112	1.2207	14.94	390167	.	19.90
370186	0.9477	13.62	380040	1.2224	26.27	390011	1.3618	18.17	390061	1.4577	21.24	390113	1.2392	19.19	390168	1.4322	18.74
370190	1.4549	14.14	380042	0.9451	21.12	390012	1.1598	20.65	390062	1.1868	16.67	390114	1.1875	19.63	390169	1.4256	20.24
370192	1.3555	18.46	380047	1.6747	23.07	390013	1.2038	19.27	390063	1.8771	20.01	390115	1.3878	23.35	390170	1.6553	26.59
370196	0.8606	.	380048	0.9866	17.59	390015	1.1147	13.13	390065	1.2183	19.94	390116	1.3074	21.49	390173	1.1623	18.54
370198	.	21.31	380050	1.4245	20.39	390016	1.2108	16.99	390066	1.2690	19.85	390117	1.1923	17.94	390174	1.6421	25.42
370199	0.8460	.	380051	1.6005	22.36	390017	1.1680	16.75	390067	1.7231	20.97	390118	1.2260	18.34	390176	1.2018	17.87
370200	1.1167	.	380052	1.2346	19.46	390018	1.2446	21.36	390068	1.3352	18.32	390119	1.3516	18.30	390178	1.3214	16.70
370201	1.5233	.	380056	1.1446	19.52	390019	1.0960	16.78	390069	1.2268	19.65	390121	1.3953	20.88	390179	1.2722	21.69
370202	1.6376	.	380060	1.4007	24.27	390022	1.2621	21.51	390070	1.3969	16.20	390122	1.0574	17.19	390180	1.4437	25.71
370203	0.9723	.	380061	1.5383	22.37	390023	1.2729	21.83	390071	1.0708	15.72	390123	1.2557	20.83	390181	1.0951	19.47
380001	1.2457	20.31	380062	1.0568	20.77	390024	1.1958	24.94	390072	1.0682	16.31	390125	1.2811	16.80	390183	1.1931	17.83
380002	1.2141	24.02	380063	.	20.41	390025	0.4921	15.62	390073	1.6461	20.56	390126	.	20.65	390184	1.1495	20.81
380003	1.1384	21.78	380064	1.2431	19.98	390026	1.2531	22.39	390074	1.2043	18.48	390127	1.2363	21.77	390185	1.1726	18.88
380004	1.7735	23.15	380065	1.3768	26.14	390027	1.6967	26.89	390075	0.8141	17.98	390128	1.2387	19.68	390189	1.1611	20.09
380005	1.1597	24.08	380066	1.2332	22.03	390028	1.8226	22.77	390076	1.2350	20.25	390130	1.1429	17.70	390191	1.1895	16.32
380006	1.2204	21.27	380068	.	22.32	390029	2.0542	21.57	390078	1.1633	19.21	390131	1.3543	16.10	390192	1.1508	17.45
380007	1.8190	25.30	380069	0.9632	19.83	390030	1.3048	17.96	390079	1.8013	18.33	390132	1.3477	21.19	390193	1.2787	16.79
380008	1.1181	20.71	380070	1.2447	27.25	390031	1.1835	19.28	390080	1.3020	18.80	390133	1.7892	23.35	390194	1.2397	20.80
380009	1.9219	23.81	380071	1.2946	22.64	390032	1.2290	17.80	390081	1.2458	24.83	390135	1.2535	21.58	390195	1.8205	24.69
380010	1.0877	23.75	380072	0.9634	19.16	390035	1.2915	20.20	390083	1.1651	.	390136	1.1030	16.97	390196	1.5092	.
380011	1.1279	21.12	380075	1.3998	22.36	390036	1.4817	19.99	390084	1.1982	16.40	390137	1.4914	17.57	390197	1.4691	19.27
380013	1.1967	18.68	380078	0.9866	20.25	390037	1.4177	21.06	390086	1.1481	18.53	390138	1.3171	19.62	390198	1.2532	15.97*
380014	1.6863	24.66	380081	0.9938	20.99	390039	1.1906	17.10	390088	1.3822	23.62	390139	1.4959	24.45	390199	1.1978	17.05
380017	1.8293	26.06	380082	1.2819	22.23	390040	1.0206	15.96	390090	1.8116	21.64	390142	1.5731	26.81	390200	0.9382	15.14
380018	1.8422	22.35	380083	1.1537	21.39	390041	1.2734	19.81	390091	1.1338	18.16	390145	1.4000	20.37	390201	1.2380	20.63
380019	1.2490	22.12	380084	1.2465	24.28	390042	1.5058	22.77	390093	1.1624	17.72	390146	1.2747	18.79	390203	1.3449	20.94

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
390204	1.2778	20.18	390285	1.6773	.	400098	1.3040	9.33	420015	1.3625	18.84	420080	1.4061	22.34	430048	1.1084	18.35
390206	.	18.40	390286	1.1146	.	400102	1.1154	9.85	420016	0.9104	15.62	420082	1.5063	20.47	430049	0.8828	15.54
390209	1.0418	17.48	390287	1.5519	.	400103	1.4138	11.21	420018	1.6907	19.74	420083	1.3496	20.15	430051	0.9216	17.06
390211	1.2274	17.86	390288	1.3223	.	400104	1.2732	11.07	420019	1.1322	17.00	420085	1.4404	19.96	430054	0.9526	14.73
390213	1.1661	18.85	390289	1.2775	.	400105	1.1795	9.30	420020	1.1856	20.94	420086	1.4443	25.72	430056	0.8957	11.76
390215	1.1898	20.71	390290	1.9170	.	400106	1.2231	9.31	420023	1.4592	19.49	420087	1.7284	19.14	430057	0.9837	15.44
390217	1.2172	19.14	390291	1.0064	.	400109	1.4639	10.98	420026	1.8478	20.35	420088	1.0674	17.19	430060	0.8973	9.04
390219	1.2817	18.83	390292	1.6512	.	400110	1.2211	10.33	420027	1.3024	18.85	420089	1.1728	20.25	430064	1.0133	14.44
390220	1.1341	18.72	390293	1.1807	.	400111	1.2002	9.56	420030	1.2525	19.15	420091	1.2948	18.87	430066	0.9008	14.36
390222	1.2828	21.57	400001	1.2704	9.95	400112	1.0782	10.18	420031	0.9074	14.19	420093	0.9809	17.47	430073	1.0143	16.11
390223	1.7600	23.65	400002	1.7014	10.14	400113	1.2094	9.22	420033	1.1229	21.73	420095	2.5155	.	430076	0.9191	12.76
390224	0.8469	15.30	400003	1.3336	10.88	400114	1.0938	9.05	420036	1.2331	17.61	420096	1.7514	.	430077	1.6721	19.30
390225	1.2363	18.61	400004	1.2013	8.99	400115	1.0871	9.82	420037	1.2653	21.79	430004	0.9633	18.54	430079	0.9080	13.68
390226	1.7155	21.83	400005	1.1669	9.56	400117	1.1337	10.23	420038	1.2437	17.67	430005	1.2825	16.31	430081	0.9463	.
390228	1.3762	19.41	400006	1.1930	10.34	400118	1.2347	9.44	420039	1.1392	15.84	430007	1.0403	14.11	430082	0.8214	.
390231	1.5428	22.75	400007	1.1671	6.45	400120	1.3234	9.53	420043	1.1810	19.45	430008	1.1204	17.66	430083	0.8717	.
390233	1.3670	19.49	400009	1.0022	8.42	400121	0.9227	7.81	420048	1.2222	18.44	430010	1.0599	17.18	430084	0.8880	.
390235	1.4497	25.08	400010	0.8818	10.65	400122	1.0333	8.19	420049	1.2076	17.58	430011	1.2701	16.98	430085	0.8145	.
390236	1.1965	16.24	400011	1.0851	7.50	400123	1.2664	7.81	420051	1.5734	19.50	430012	1.2857	17.28	430089	0.8934	17.89
390237	1.5383	19.52	400012	1.2487	8.24	400124	2.9192	12.10	420053	1.1074	16.96	430013	1.2128	18.13	430090	1.5851	21.52
390238	1.3058	17.82	400013	1.2445	8.46	400125	1.0767	.	420054	1.2681	18.27	430014	1.2999	16.89	430091	1.8060	19.21
390244	0.9301	15.46	400014	1.3944	9.52	410001	1.3868	23.28	420055	1.0334	19.20	430015	1.1567	18.00	430092	2.0606	.
390245	1.3389	26.02	400015	1.5550	10.95	410004	1.2965	22.48	420056	1.2204	14.87	430016	1.8945	19.48	430093	0.9831	.
390246	1.1336	18.97	400016	1.3421	13.28	410005	1.2954	23.14	420057	1.1456	15.98	430018	0.9370	14.89	440001	1.1951	14.87
390247	1.0155	20.95	400017	1.2238	8.64	410006	1.2614	23.40	420059	0.9931	15.82	430022	0.8643	13.49	440002	1.6605	19.15
390249	0.9450	12.79	400018	1.2832	10.46	410007	1.6132	22.15	420061	1.1300	16.56	430023	0.9049	12.23	440003	1.2542	18.37
390256	1.8872	20.95	400019	1.5224	10.43	410008	1.2095	23.07	420062	1.1742	17.82	430024	0.9611	15.47	440006	1.3364	19.60
390258	1.4926	21.92	400021	1.4434	10.70	410009	1.3252	24.49	420064	1.1834	16.72	430027	1.7835	19.15	440007	1.0210	12.12
390260	1.1989	21.95	400022	1.3544	11.59	410010	1.1306	26.98	420065	1.3501	19.69	430028	1.1333	18.23	440008	1.0193	17.28
390262	1.9235	18.24	400024	0.9636	7.90	410011	1.2456	25.29	420066	1.0336	15.18	430029	0.9464	16.65	440009	1.1335	17.84
390263	1.3571	25.47	400026	1.0182	5.65	410012	1.8184	24.58	420067	1.2057	18.86	430031	0.8722	13.13	440010	0.9359	19.98
390265	1.2957	20.36	400027	.	9.59	410013	1.2785	24.51	420068	1.3324	18.50	430033	0.9751	15.30	440011	1.3657	17.69
390266	1.1667	17.17	400028	1.1211	8.86	420002	1.4861	19.48	420069	1.0437	17.08	430034	0.9643	15.41	440012	1.6469	15.98
390267	1.2434	21.30	400031	.	8.27	420004	1.8856	19.80	420070	1.2714	18.01	430036	0.9604	13.70	440014	0.9859	15.92
390268	1.3335	21.35	400032	1.2042	10.55	420005	1.0765	17.35	420071	1.3358	19.45	430037	0.9250	16.54	440015	1.8167	18.26
390270	1.3998	19.09	400044	1.4724	11.97	420006	1.0764	18.34	420072	0.9270	13.86	430038	1.0092	13.72	440016	1.0272	15.41
390272	0.5153	.	400048	1.1607	9.17	420007	1.5934	18.21	420073	1.2990	19.16	430040	1.0441	13.67	440017	1.8057	19.62
390278	0.6686	18.29	400061	1.7879	12.45	420009	1.1757	18.55	420074	0.9703	16.93	430041	0.8894	13.19	440018	1.2741	16.41
390279	1.0621	14.32	400079	1.2002	.	420010	1.1485	17.12	420075	0.9049	14.29	430043	1.1838	13.69	440019	1.7622	20.04
390281	1.3650	.	400087	1.5059	9.51	420011	1.1604	16.57	420078	1.8714	20.73	430044	0.7894	18.50	440020	1.1151	18.12
390284	1.4412	.	400094	1.0919	8.91	420014	1.0098	16.61	420079	1.4533	20.86	430047	1.0486	17.50	440022	.	15.85

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
440023	1.0911	15.47	440083	1.0260	14.85	440174	0.9274	17.33	450028	1.4881	18.88	450096	1.4321	17.88	450157	1.0333	15.64
440024	1.3014	18.44	440084	1.1547	13.44	440175	1.1198	20.08	450029	1.6986	17.47	450097	1.3603	19.57	450160	0.9633	16.65
440025	1.1416	15.88	440091	1.6378	19.61	440176	1.3125	18.03	450031	1.3759	22.22	450098	1.0440	20.58	450162	1.2453	20.96
440026	.	23.06	440100	0.9811	13.84	440180	1.1300	19.78	450032	1.2417	17.33	450099	1.1798	19.23	450163	1.0142	17.54
440029	1.2727	19.43	440102	1.1448	14.35	440181	0.9170	16.49	450033	1.6071	19.74	450101	1.5395	17.13	450164	1.1251	16.97
440030	1.1742	16.29	440103	.	20.31	440182	0.9915	17.75	450034	1.5586	19.67	450102	1.6849	18.67	450165	0.9970	13.92
440031	1.0699	15.54	440104	1.7583	22.44	440183	1.6054	22.71	450035	1.4408	20.10	450104	1.1458	16.67	450166	0.9901	11.48
440032	0.9957	13.98	440105	0.9719	16.71	440184	1.1707	17.20	450037	1.5433	19.54	450107	1.5558	25.20	450169	.	13.20
440033	1.1006	14.53	440109	1.1213	16.04	440185	1.1880	19.39	450039	1.5440	19.81	450108	1.0353	15.63	450170	0.9212	14.30
440034	1.5819	19.55	440110	1.1734	21.17	440186	0.9940	19.39	450040	1.7174	16.85	450109	0.9101	13.81	450176	1.3093	16.97
440035	1.2490	18.90	440111	1.4099	23.24	440187	1.1525	18.97	450042	1.6931	19.89	450110	.	19.58	450177	1.1285	14.92
440039	1.8440	19.94	440114	1.0932	14.50	440189	1.5018	.	450044	1.4961	24.80	450111	1.2670	19.64	450178	0.9711	17.85
440040	1.0510	16.37	440115	1.0340	17.45	440192	1.0453	19.08	450046	1.5067	18.65	450112	1.2198	16.04	450181	1.0173	15.56
440041	1.0031	14.66	440120	1.6720	17.24	440193	1.2636	19.08	450047	1.1154	13.45	450113	1.3525	20.98	450184	1.4239	21.13
440046	1.1769	18.17	440125	1.5428	15.66	440194	1.3420	19.87	450050	0.9168	14.77	450118	.	17.91	450185	0.9984	14.07
440047	0.9208	16.66	440130	1.1552	17.82	440197	1.2815	21.96	450051	1.6149	21.02	450119	1.2890	20.28	450187	1.2340	16.69
440048	1.8119	19.45	440131	1.1310	15.50	440200	1.1776	17.96	450052	1.0272	13.89	450121	1.4614	20.46	450188	0.9606	14.39
440049	1.6763	17.93	440132	1.1086	16.66	440203	0.9624	18.34	450053	1.0522	17.05	450123	1.1672	15.76	450191	1.0735	20.12
440050	1.2312	19.13	440133	1.5576	21.53	440206	.	16.44	450054	1.6197	22.90	450124	1.7302	22.75	450192	1.1837	20.38
440051	0.9193	13.19	440135	1.1865	19.20	440210	1.0245	11.02	450055	1.1121	15.04	450126	1.3316	21.72	450193	1.9904	23.20
440052	0.9791	16.65	440137	1.1342	14.56	440211	.	14.90	450056	1.6239	21.84	450128	1.2125	18.22	450194	1.3376	20.52
440053	1.3264	18.55	440141	0.9927	13.53	440212	.	17.07	450058	1.6127	18.10	450130	1.3541	20.42	450196	1.4145	17.19
440054	1.2247	13.87	440142	1.0095	15.73	440213	.	19.58	450059	1.2342	15.22	450131	1.2707	19.26	450200	1.4511	18.74
440056	1.0523	15.98	440143	1.0189	17.78	440214	1.6187	.	450063	0.8753	14.38	450132	1.5776	18.17	450201	1.0867	16.99
440057	1.0725	12.79	440144	1.2827	17.64	440217	1.2242	.	450064	1.4407	17.41	450133	1.5532	23.64	450203	1.0979	20.67
440058	1.1468	18.81	440145	0.9764	17.06	450002	1.4964	21.37	450065	0.9949	21.49	450135	1.6714	21.03	450209	1.7113	19.08
440059	1.4739	18.54	440147	1.7064	21.43	450004	1.0878	16.67	450068	1.8951	22.90	450137	1.5658	22.46	450210	1.0423	13.98
440060	1.1254	18.06	440148	1.0650	19.24	450005	1.1999	18.36	450072	1.2200	19.01	450140	0.9325	20.23	450211	1.3949	17.99
440061	1.1140	14.97	440149	1.0299	16.69	450007	1.2312	16.97	450073	1.1328	17.10	450143	1.0367	14.53	450213	1.7786	17.76
440063	1.6376	19.32	440150	1.3182	20.14	450008	1.2218	17.08	450076	1.7674	.	450144	1.0746	18.11	450214	1.3116	19.05
440064	1.1054	17.76	440151	1.1397	17.42	450010	1.4699	16.50	450078	0.9224	11.73	450145	0.8608	15.61	450217	0.9365	12.85
440065	1.3167	18.58	440152	2.0761	21.03	450011	1.5042	17.19	450079	1.4679	21.05	450146	0.8943	17.86	450219	0.9728	15.40
440067	1.1687	16.28	440153	1.1131	16.78	450014	1.1295	17.95	450080	1.1637	17.46	450147	1.3488	18.94	450221	1.0718	16.37
440068	1.2445	19.47	440156	1.4802	29.56	450015	1.5984	18.99	450081	0.9866	16.34	450148	1.1855	18.67	450222	1.5254	20.31
440070	1.0189	13.70	440157	1.0585	16.93	450016	1.5700	18.45	450082	0.9978	16.16	450149	1.5838	19.75	450224	1.3253	24.90
440071	1.1943	17.02	440159	1.2268	17.72	450018	1.4551	21.48	450083	1.7936	21.59	450150	0.9364	16.37	450229	1.6647	16.45
440072	1.2826	17.60	440161	1.8345	21.80	450020	0.9506	17.84	450085	1.1413	18.36	450151	1.1660	15.29	450231	1.5947	19.16
440073	1.2472	19.17	440162	0.7243	14.76	450021	1.8828	23.08	450087	1.4081	22.03	450152	1.1782	18.01	450234	1.0237	16.19
440078	1.0057	15.08	440166	1.6735	19.67	450023	1.4818	16.08	450090	1.1578	15.09	450153	1.5847	19.44	450235	1.0434	15.23
440081	1.0939	18.36	440168	1.0083	18.65	450024	1.3887	17.35	450092	1.1838	16.83	450154	1.2049	13.87	450236	1.2055	16.67
440082	2.0072	22.28	440173	1.6376	18.64	450025	.	17.00	450094	1.3042	21.32	450155	1.0660	11.58	450237	1.5897	20.79

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
450239	1.0093	17.13	450351	1.1982	18.41	450469	1.4654	19.63	450605	1.1715	21.14	450675	1.5244	22.50	450757	0.8813	13.87
450241	1.0067	12.57	450352	1.1558	18.75	450473	1.0004	19.98	450609	0.8760	15.98	450677	1.3370	22.68	450758	1.5789	21.87
450243	0.9967	11.91	450353	1.1247	17.75	450475	1.1266	16.34	450610	1.5025	18.99	450678	1.4676	23.26	450760	1.1219	17.49
450246	1.1557	16.55	450355	0.9621	11.95	450484	1.5182	16.81	450614	0.9407	17.99	450683	1.2556	20.91	450761	0.9087	13.62
450249	1.0096	12.03	450358	2.0636	22.32	450488	1.3168	19.35	450615	1.1099	14.86	450684	1.2346	19.70	450763	1.0783	18.21
450250	0.9090	10.28	450362	1.0670	15.88	450489	0.9233	9.93	450617	1.3682	20.34	450686	1.6703	16.57	450766	2.0488	22.43
450253	1.1334	12.24	450369	1.0434	15.22	450497	1.0756	15.09	450620	1.0723	15.84	450688	1.2896	19.63	450769	0.9131	14.59
450258	0.9566	16.05	450370	1.1661	12.61	450498	0.9646	13.86	450623	1.1407	22.19	450690	1.3023	21.66	450770	1.0388	16.55
450264	0.9279	13.89	450371	1.1437	24.63	450508	1.4174	18.81	450626	1.0306	18.17	450694	1.1863	17.48	450771	1.8344	22.45
450269	1.0241	12.36	450372	1.2145	20.09	450514	1.0529	21.32	450628	0.9750	20.56	450696	.	24.96	450774	1.5215	18.00
450270	1.1022	12.84	450373	1.0167	17.42	450517	0.9600	27.88	450630	1.4779	21.69	450697	1.3829	18.84	450775	1.2816	19.89
450271	1.2784	16.63	450374	0.9229	13.61	450518	1.4298	19.81	450631	1.7092	20.04	450698	0.9230	14.67	450776	0.9631	15.78
450272	1.2602	19.93	450378	1.3771	23.58	450523	1.4387	20.08	450632	0.9805	11.76	450700	0.9559	14.64	450777	0.9170	21.07
450276	1.0243	13.12	450379	1.4171	22.76	450530	1.2465	22.86	450633	1.5937	19.52	450702	1.3930	20.82	450779	1.3164	21.45
450278	0.9120	14.83	450381	0.9911	16.42	450534	0.9191	19.94	450634	1.7055	23.53	450704	1.1137	20.98	450780	1.6389	19.15
450280	1.6036	22.30	450388	1.7801	19.25	450535	1.2963	19.66	450638	1.5448	23.14	450705	0.8976	30.01	450785	0.8497	18.50
450283	1.0644	14.57	450389	1.3002	18.18	450537	1.2819	20.84	450639	1.4546	23.19	450706	1.2011	21.21	450788	1.5908	19.15
450288	1.1091	16.25	450393	1.1967	20.28	450539	1.1845	16.49	450641	0.9824	16.51	450709	1.2377	20.89	450794	.	18.22
450289	1.4195	20.31	450395	0.9810	18.38	450544	1.0994	23.93	450643	1.2487	18.71	450711	1.6707	19.81	450795	0.9453	16.65
450292	1.2167	16.97	450399	0.8667	15.78	450545	1.1753	19.56	450644	1.5281	23.66	450712	0.5334	13.62	450796	.	16.54
450293	0.9098	16.01	450400	1.3200	19.54	450547	1.0055	14.82	450646	1.4060	19.83	450713	1.4839	20.81	450797	0.9957	15.92
450296	1.1790	21.60	450403	1.2172	20.20	450551	1.0711	16.94	450647	1.8165	24.80	450715	1.3785	22.04	450798	.	9.46
450299	1.4776	21.57	450411	0.9201	14.48	450558	1.8452	22.26	450648	1.0150	14.85	450716	1.2400	20.55	450801	1.4415	17.57
450303	0.8524	12.46	450417	0.9596	13.50	450563	1.2798	19.92	450649	0.9511	16.45	450717	1.2506	20.72	450802	1.4005	19.92
450306	1.0552	13.82	450418	1.4637	21.92	450565	1.2365	16.26	450651	1.6805	22.77	450718	1.1925	19.69	450803	1.1873	18.38
450307	0.6915	16.46	450419	1.1974	20.63	450570	1.1060	18.95	450652	.	13.44	450723	1.3948	19.76	450804	1.6169	19.48
450309	1.0330	13.15	450422	1.0383	26.48	450571	1.5421	17.56	450653	1.1009	18.18	450724	1.2374	20.32	450806	1.0904	.
450315	0.9189	22.81	450423	.	22.71	450573	1.0077	12.25	450654	0.9539	14.53	450727	1.0614	13.55	450807	0.7878	11.32
450320	1.2144	20.09	450424	1.2348	18.97	450574	0.9175	14.60	450656	1.3430	17.67	450728	0.8811	17.53	450808	1.9776	16.99
450321	0.8878	13.18	450429	1.0777	13.87	450575	1.0415	19.39	450658	1.0274	16.26	450730	1.2146	22.08	450809	1.5552	20.02
450322	0.6218	22.77	450431	1.5198	19.63	450578	0.9355	15.48	450659	1.5200	22.26	450733	1.4104	20.77	450810	0.8196	.
450324	1.4633	17.79	450438	1.1740	19.50	450580	1.1966	15.83	450661	1.1560	19.72	450735	.	13.88	450811	2.3384	19.10
450327	0.9713	11.75	450446	0.7066	13.10	450583	1.0269	15.66	450662	1.4612	18.23	450742	1.2948	22.76	450813	0.9751	15.92
450330	1.1594	18.94	450447	1.3503	18.04	450584	1.0563	14.23	450665	0.8554	15.20	450743	1.5068	18.89	450817	0.7497	.
450334	0.9096	12.81	450451	1.1706	18.89	450586	1.0112	14.38	450666	1.2980	20.32	450746	0.9213	12.79	450818	1.1935	.
450337	1.0009	17.11	450457	1.8445	24.79	450587	1.1747	17.02	450668	1.6420	20.70	450747	1.2546	19.26	450819	1.5223	.
450340	1.3999	17.69	450460	1.0043	15.18	450591	1.1238	17.90	450669	1.2887	21.76	450749	0.9833	16.21	450820	1.0157	.
450341	1.0090	18.94	450462	1.7613	22.62	450596	1.2387	22.54	450670	1.3668	16.89	450750	1.0004	14.69	450822	1.3260	.
450346	1.3176	17.54	450464	0.8963	13.29	450597	0.9205	17.08	450672	1.6518	21.85	450751	1.2125	21.22	450823	0.8952	.
450347	1.2264	17.11	450465	1.2023	15.57	450603	0.6767	11.64	450673	0.9904	13.96	450754	0.9948	16.09	450824	2.1437	.
450348	1.0839	13.95	450467	1.0072	10.62	450604	1.3055	16.45	450674	1.0414	22.28	450755	1.0462	17.99	450825	1.7453	.

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
450827	1.3665	.	460051	1.1513	19.48	490032	1.6993	22.43	490100	.	22.50	500024	1.7078	23.75	500080	0.8127	15.66
450828	1.1367	.	460052	1.2190	.	490033	1.1609	21.17	490101	1.2097	24.76	500025	1.8526	26.48	500084	1.1794	23.40
460001	1.7774	21.80	470001	1.3216	20.23	490037	1.2489	16.38	490104	0.7590	25.69	500026	1.4310	23.80	500085	0.9772	21.44
460003	1.5123	20.05	470003	1.8887	23.69	490038	1.1722	21.02	490105	0.6195	18.58	500027	1.6207	22.22	500086	1.2476	23.33
460004	1.7367	21.37	470004	1.0878	16.88	490040	1.4247	22.71	490106	0.8205	17.66	500028	1.0295	19.27	500088	1.3476	23.27
460005	1.5705	19.71	470005	1.2279	21.92	490041	1.3266	18.36	490107	1.3750	23.52	500029	0.9294	17.92	500089	1.0605	18.71
460006	1.2699	20.63	470006	1.2142	17.87	490042	1.2593	16.47	490108	0.9199	20.21	500030	1.4388	24.90	500090	0.9553	16.16
460007	1.3638	20.80	470008	1.2017	19.61	490043	1.3050	22.16	490109	0.8819	23.66	500031	1.2628	29.27	500092	1.0462	16.79
460008	1.3326	18.87	470010	1.1124	20.30	490044	1.3719	18.31	490110	1.3349	16.51	500033	1.3605	22.35	500094	0.8633	18.58
460009	1.8610	21.90	470011	1.1746	21.77	490045	1.2390	20.55	490111	1.1784	17.18	500036	1.3717	22.11	500096	1.0379	21.01
460010	2.0346	21.98	470012	1.2339	18.53	490046	1.5433	18.48	490112	1.6377	21.45	500037	1.1283	20.71	500097	1.1266	19.77
460011	1.4191	18.87	470015	1.2624	19.54	490047	1.0565	25.04	490113	1.2776	23.22	500039	1.4020	23.89	500098	0.9592	16.35
460013	1.3869	20.73	470018	1.2090	21.54	490048	1.4978	18.44	490114	1.0703	17.30	500041	1.2884	23.96	500101	0.9900	19.73
460014	1.1723	18.39	470020	0.9228	20.66	490050	1.4045	23.07	490115	1.1805	16.52	500042	.	22.91	500102	0.9797	20.94
460015	1.2674	20.66	470023	1.3152	20.45	490052	1.6536	16.86	490116	1.1824	16.62	500043	0.9753	20.94	500104	1.2065	22.82
460016	1.0741	18.24	470024	1.1449	20.85	490053	1.2440	15.70	490117	1.1668	14.01	500044	1.9949	23.34	500106	0.9099	18.60
460017	1.3719	17.71	490001	1.1864	21.98	490054	1.0037	15.47	490118	1.7171	21.47	500045	1.0498	20.89	500107	1.1288	18.12
460018	0.9125	17.62	490002	1.0450	15.23	490057	1.6642	19.92	490119	1.4783	17.91	500048	0.9204	22.19	500108	1.7537	26.29
460019	1.0411	16.27	490003	0.6857	19.10	490059	1.5958	20.87	490120	1.3381	19.37	500049	1.4107	24.05	500110	1.1467	21.46
460020	0.9089	17.35	490004	1.2564	19.21	490060	1.0611	17.63	490122	1.3987	23.88	500050	1.3888	22.01	500118	1.1272	23.84
460021	1.4513	21.05	490005	1.6131	20.55	490063	1.7456	28.65	490123	1.1396	17.75	500051	1.7215	24.82	500119	1.2955	22.44
460022	0.9538	20.15	490006	1.1790	15.95	490066	1.2761	20.70	490124	1.0765	22.09	500052	1.3600	.	500122	1.2361	22.43
460023	1.2892	22.35	490007	2.1450	18.77	490067	1.2436	17.02	490126	1.3091	18.68	500053	1.3084	23.94	500123	1.0613	20.32
460025	0.7321	19.42	490009	1.8363	23.93	490069	1.4462	17.33	490127	1.0282	16.05	500054	1.9626	22.88	500124	1.3309	23.28
460026	1.1345	19.92	490010	.	21.74	490071	1.4389	21.89	490129	1.0921	22.59	500055	1.0899	23.74	500125	1.0770	15.11
460027	0.9043	21.89	490011	1.4281	18.61	490073	1.4347	20.80	490130	1.2500	16.43	500057	1.2646	18.27	500127	1.0838	.
460029	1.0288	20.51	490012	1.2111	16.00	490075	1.4051	18.70	490132	1.1018	18.66	500058	1.4537	24.79	500129	1.6027	26.16
460030	1.1870	17.61	490013	1.2821	17.33	490077	1.2581	21.37	500001	1.5628	22.19	500059	1.0952	23.35	500132	1.0096	15.67
460032	0.9642	21.10	490014	1.7731	25.83	490079	1.3013	17.08	500002	1.4656	21.63	500060	1.4506	25.02	500134	0.6384	17.75
460033	1.0207	19.54	490015	1.4508	19.64	490084	1.1478	16.78	500003	1.4101	24.28	500061	0.9435	21.70	500138	3.6841	.
460035	0.9156	16.00	490017	1.3974	18.44	490085	1.1531	17.46	500005	1.8166	22.40	500062	1.0804	18.63	500139	1.4968	22.23
460036	0.9355	23.59	490018	1.2388	18.34	490088	1.1448	16.44	500007	1.3742	26.06	500064	1.5961	25.57	500141	1.3705	23.88
460037	0.9602	18.69	490019	1.1702	19.62	490089	1.0649	17.77	500008	1.8318	25.31	500065	1.2610	21.93	500143	0.5356	18.03
460039	1.0285	24.91	490020	1.2437	18.57	490090	1.1180	17.02	500011	1.3619	24.02	500068	1.0026	19.66	500146	.	21.60
460041	1.2929	21.06	490021	1.4210	19.39	490091	1.2429	20.87	500012	1.5691	20.70	500069	1.0859	21.36	510001	1.8653	19.15
460042	1.3924	18.88	490022	1.5416	21.22	490092	1.1989	16.95	500014	1.5460	24.34	500071	1.2763	19.19	510002	1.2867	20.15
460043	1.0320	24.48	490023	1.1951	20.67	490093	1.4163	17.37	500015	1.3379	23.93	500072	1.1969	25.39	510005	1.0555	14.25
460044	1.1798	21.47	490024	1.6667	17.72	490094	1.0399	18.92	500016	1.5184	24.39	500073	0.9725	21.25	510006	1.2270	18.73
460046	.	18.22	490027	1.1280	16.28	490097	1.2102	15.58	500019	1.4036	22.42	500074	1.0870	18.97	510007	1.5827	21.27
460047	1.6283	23.04	490030	.	9.18	490098	1.1619	15.14	500021	1.4661	25.92	500077	1.2909	22.85	510008	1.2323	18.33
460049	2.0317	19.65	490031	1.0741	14.95	490099	0.9133	17.97	500023	1.1537	26.65	500079	1.2814	24.20	510012	0.9915	15.84

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
510013	1.0607	17.85	510085	1.2868	17.56	520048	1.4700	20.66	520109	1.0398	19.13	520173	1.1319	21.30			
510015	0.9345	14.90	510086	1.0521	13.48	520049	2.1090	20.35	520110	1.2264	20.45	520177	1.6413	22.72			
510018	1.0915	18.53	510088	1.0579	.	520051	1.7870	21.65	520111	0.9801	17.78	520178	1.0542	18.69			
510020	1.0381	13.18	520002	1.2428	19.74	520053	1.1608	17.39	520112	1.1339	19.18	520188	2.3936	13.91			
510022	1.8947	20.18	520003	1.1499	17.12	520054	1.0320	15.17	520113	1.3075	21.15	520189	1.0938	.			
510023	1.2009	16.01	520004	1.2152	19.65	520057	1.1289	19.09	520114	1.0869	16.66	520190	1.2809	.			
510024	1.5615	19.09	520006	1.0018	21.53	520058	1.1253	19.73	520115	1.2016	18.30	530002	1.1396	19.33			
510026	1.0622	13.69	520007	1.0591	16.20	520059	1.3209	20.99	520116	1.1292	19.85	530003	0.8619	16.21			
510027	0.9786	17.29	520008	1.6082	22.80	520060	1.4632	17.92	520117	1.0163	18.54	530004	0.9954	15.05			
510028	1.0350	20.06	520009	1.6644	18.60	520062	1.2308	19.15	520118	0.8954	14.23	530005	1.1870	13.35			
510029	1.2672	17.71	520010	1.1000	22.77	520063	1.1826	19.61	520120	.	18.74	530006	1.1200	18.59			
510030	1.0300	17.42	520011	1.1658	20.74	520064	1.5634	22.74	520121	0.9766	19.73	530007	0.9956	18.52			
510031	1.4190	28.67	520013	1.3414	20.40	520066	1.4380	22.88	520122	0.9672	16.24	530008	1.1835	18.83			
510033	1.2900	18.41	520014	1.1236	17.16	520068	0.9318	18.99	520123	1.0247	17.40	530009	0.9536	22.50			
510035	1.1863	16.50	520015	1.1640	18.61	520069	1.1932	20.29	520124	1.0367	17.26	530010	1.2254	21.61			
510036	0.9419	13.46	520016	1.1835	17.30	520070	1.5321	18.59	520130	1.0819	15.68	530011	1.1587	18.74			
510038	1.0707	15.81	520017	1.1203	19.60	520071	1.2017	18.73	520131	0.9922	18.73	530012	1.6508	18.99			
510039	1.4141	16.94	520018	1.0717	21.19	520074	1.0139	20.46	520132	1.1767	15.64	530014	1.4471	18.09			
510043	0.8997	14.07	520019	1.1934	19.54	520075	1.4673	19.85	520134	1.1351	18.10	530015	1.2324	22.46			
510046	1.2018	17.38	520021	1.4879	21.35	520076	1.1491	17.61	520135	0.8967	15.82	530016	1.2625	18.16			
510047	1.1611	19.90	520024	1.0039	14.02	520077	0.9328	17.78	520136	1.4611	19.85*	530017	0.9021	16.35			
510048	1.1368	21.04	520025	1.0617	18.24	520078	1.5814	21.34	520138	1.8050	21.23	530018	1.2119	18.38			
510050	1.7223	16.91	520026	1.1098	21.55	520082	.	17.74	520139	1.2575	21.00	530019	0.9196	18.54			
510053	1.0161	16.10	520027	1.2697	19.93	520083	1.6487	23.88	520140	1.6422	21.52	530022	1.1466	18.50			
510055	1.2896	23.72	520028	1.2932	21.28	520084	1.0971	20.84	520142	0.8522	20.58	530023	0.8642	20.19			
510058	1.2914	18.42	520029	0.9183	19.58	520087	1.6926	20.36	520144	1.0475	18.57	530025	1.4896	21.26			
510059	2.2171	16.58	520030	1.6824	20.50	520088	1.2649	20.63	520145	0.9006	18.26	530026	0.9932	17.01			
510060	.	17.56	520031	1.0527	20.48	520089	1.4630	21.55	520146	1.0508	17.96	530027	0.8873	18.17			
510061	1.0308	13.82	520032	1.2210	19.57	520090	1.3799	18.93	520148	1.1128	17.24	530029	0.9181	16.51			
510062	1.1709	19.39	520033	1.1933	19.30	520091	1.3147	20.99	520149	0.9111	14.19	530031	0.7881	18.33			
510066	.	12.29	520034	1.1886	17.13	520092	1.1112	17.65	520151	1.0428	17.33	530032	1.0391	21.04			
510067	1.1077	16.72	520035	1.2906	18.94	520094	0.7710	20.36	520152	1.0997	19.58						
510068	1.2062	18.79	520037	1.6611	20.67	520095	1.2738	20.33	520153	0.9397	15.98						
510070	1.3015	18.51	520038	1.2795	19.63	520096	1.4176	19.78	520154	1.1336	18.54						
510071	1.3221	17.21	520039	0.9857	20.76	520097	1.2967	20.24	520156	1.1393	21.34						
510072	1.0308	15.63	520040	1.5732	20.47	520098	1.8155	22.33	520157	1.0554	17.20						
510077	1.1060	18.07	520041	1.1839	17.19	520100	1.2287	18.38	520159	0.9103	18.68						
510080	1.0889	17.45	520042	1.0920	18.58	520101	1.1341	19.52	520160	1.7776	19.42						
510081	1.1326	13.64	520044	1.4397	18.40	520102	1.1669	20.19	520161	0.9866	19.49						
510082	1.1535	17.45	520045	1.6806	20.59	520103	1.3020	19.48	520170	1.2571	21.52						
510084	0.9774	17.24	520047	0.9645	18.30	520107	1.2263	20.37	520171	0.9407	17.46						

ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

BILLING CODE 4120–01–P

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

Urban area (constituent counties)	Wage index	GAF
0040 Abilene, TX	0.8240	0.8758
Taylor, TX		
0060 Aguadilla, PR	0.4391	0.5692
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9736	0.9818
Portage, OH		
Summit, OH		
0120 Albany, GA	0.9933	0.9954
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8549	0.8982
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9136	0.9400
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8170	0.8707
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0040	1.0027
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9346	0.9547
Blair, PA		
0320 Amarillo, TX	0.8715	0.9101
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.2865	1.1883
Anchorage, AK		
0440 Ann Arbor, MI	1.1254	1.0843
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8284	0.8790
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.9052	0.9341
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4525	0.5810
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9516	0.9666
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9739	0.9821
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	1.0096	1.0066
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	1.1182	1.0795
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.8106	0.8661
Lee, AL		
0600 Augusta-Aiken, GA–SC	0.9160	0.9417
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9577	0.9708
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	0.9861	0.9905
Kern, CA		
0720 [1] Baltimore, MD	0.9365	0.9561
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9561	0.9697
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3839	1.2492
Barnstable, MA		
0760 Baton Rouge, LA	0.8842	0.9192
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8744	0.9122
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1439	1.0964
Whatcom, WA		
0870 [2] Benton Harbor, MI	0.9021	0.9319
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1605	1.1073
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9591	0.9718
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8236	0.8756
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8690	0.9083
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.8477	0.8930
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7897	0.8507
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8733	0.9114
Monroe, IN		
1040 Bloomington-Normal, IL	0.9156	0.9414
McLean, IL		
1080 Boise City, ID	0.9042	0.9334
Ada, ID		
Canyon, ID		
1123 [1 2] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (MA Hospitals)	1.1204	1.0810
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH Hospitals)	1.1160	1.0781
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.9731	0.9815
Boulder, CO		
1145 Brazoria, TX	0.8658	0.9060
Brazoria, TX		
1150 Bremerton, WA	1.0975	1.0658
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8722	0.9106

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

Urban area (constituent counties)	Wage index	GAF
Cameron, TX		
1260 Bryan-College Station, TX	0.8237	0.8756
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9580	0.9710
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0735	1.0498
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4562	0.5842
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 [2] Canton-Massillon, OH	0.8670	0.9069
Carroll, OH		
Stark, OH		
1350 [2] Casper, WY	0.8817	0.9174
Natrona, WY		
1360 Cedar Rapids, IA	0.8736	0.9116
Linn, IA		
1400 Champaign-Urbana, IL	0.9198	0.9444
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9067	0.9351
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9240	0.9473
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC–SC	0.9391	0.9579
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0789	1.0534
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.9833	0.9885
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.8817	0.9174
Laramie, WY		
1600 [1] Chicago, IL	1.1146	1.0771
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	0.9918	0.9944
Butte, CA		
1640 [1] 1Cincinnati, OH–KY–IN	0.9415	0.9596
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	0.8277	0.8785
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9593	0.9719
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9697	0.9792
El Paso, CO		
1740 Columbia, MO	0.8961	0.9276
Boone, MO		
1760 Columbia, SC	0.9554	0.9692
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.8568	0.8996
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9619	0.9737
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8726	0.9109
Nueces, TX		
San Patricio, TX		
1890 Corvallis, OR	1.1326	1.0890
Benton, OR		
1900 [2] Cumberland, MD–WV (MD Hospitals)	0.8651	0.9055
Allegany, MD		
Mineral, WV		
1900 Cumberland, MD–WV (WV Hospital)	0.8369	0.8852
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9913	0.9940
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8589	0.9011
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8898	0.9232
Scott, IA		
Henry, IL		
Rock Island, IL		
.		
2000 Dayton-Springfield, OH	0.9442	0.9614
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
.		
2020 Daytona Beach, FL	0.9147	0.9408
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8534	0.8971
Lawrence, AL		
Morgan, AL		
2040 [2] Decatur, IL	0.8160	0.8700
Macon, IL		
2080 [1] Denver, CO	1.0181	1.0124
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.9118	0.9387
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0510	1.0347
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.8013	0.8592
Dale, AL		
Houston, AL		
2190 Dover, DE	1.0078	1.0053
Kent, DE		
2200 Dubuque, IA	0.8746	0.9123
Dubuque, IA		
2240 Duluth-Superior, MN–WI	1.0043	1.0029

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

Urban area (constituent counties)	Wage index	GAF
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	0.9491	0.9649
Dutchess, NY		
2290 [2] Eau Claire, WI	0.8880	0.9219
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9346	0.9547
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9145	0.9406
Elkhart, IN		
2335 Elmira, NY	0.8546	0.8980
Chemung, NY		
2340 Enid, OK	0.8610	0.9026
Garfield, OK		
2360 Erie, PA	0.8985	0.9293
Erie, PA		
2400 Eugene-Springfield, OR	1.0965	1.0651
Lane, OR		
2440 [2] Evansville-Henderson, IN–KY (IN Hospitals)	0.8602	0.9020
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN–KY (KY Hospitals)	0.8173	0.8710
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.8749	0.9125
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8655	0.9058
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7910	0.8517
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	1.0686	1.0465
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1205	1.0810
Genesee, MI		
2650 Florence, AL	0.7652	0.8325
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8777	0.9145
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0647	1.0439
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0152	1.0104
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9247	0.9478
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	0.9622	0.9740
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.8052	0.8621
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.9607	0.9729
Okaloosa, FL		
2760 Fort Wayne, IN	0.8665	0.9065
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9527	0.9674
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0104	1.0071
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8423	0.8891
Etowah, AL		
2900 Gainesville, FL	1.0074	1.0051
Alachua, FL		
2920 Galveston-Texas City, TX	0.9918	0.9944
Galveston, TX		
2960 Gary, IN	0.9454	0.9623
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8499	0.8946
Warren, NY		
Washington, NY		
2980 [2] Goldsboro, NC	0.8441	0.8904
Wayne, NC		
2985 Grand Forks, ND–MN	0.8954	0.9271
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9471	0.9635
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0248	1.0169
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9331	0.9537
Cascade, MT		
3060 Greeley, CO	0.9814	0.9872
Weld, CO		
3080 Green Bay, WI	0.9308	0.9521
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9124	0.9391
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9384	0.9574
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9003	0.9306
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9409	0.9591
Washington, MD		
3200 Hamilton-Middletown, OH	0.9061	0.9347
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9386	0.9575
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1 2] Hartford, CT	1.1715	1.1145
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7491	0.8205
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.8755	0.9130
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1866	1.1243
Honolulu, HI		
3350 Houma, LA	0.8086	0.8646
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9732	0.9816
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9876	0.9915
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8932	0.9256
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9787	0.9854
Boone, IN		
Hamilton, IN		

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

Urban area (constituent counties)	Wage index	GAF
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9657	0.9764
Johnson, IA		
3520 Jackson, MI	0.9134	0.9399
Jackson, MI		
3560 Jackson, MS	0.8812	0.9170
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8796	0.9159
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.9208	0.9451
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8441	0.8904
Onslow, NC		
3610 [2] Jamestown, NY	0.8499	0.8946
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9585	0.9714
Rock, WI		
3640 Jersey City, NJ	1.1573	1.1052
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8328	0.8822
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA	0.8578	0.9003
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7832	0.8459
Craighead, AR		
3710 Joplin, MO	0.8148	0.8691
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0453	1.0308
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9902	0.9933
Kankakee, IL		
3760 [1] Kansas City, KS–MO	0.9498	0.9653
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	0.9611	0.9732
Kenosha, WI		
3810 Killeen-Temple, TX	1.0119	1.0081
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8340	0.8831
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9525	0.9672
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.9211	0.9453
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8490	0.8940
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8834	0.9186
Clinton, IN		
Tippecanoe, IN		
3960 [2] Lake Charles, LA	0.7713	0.8371
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8928	0.9253
Polk, FL		
4000 Lancaster, PA	0.9259	0.9486
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9934	0.9955
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8168	0.8706
Webb, TX		
4100 Las Cruces, NM	0.8658	0.9060
Dona Ana, NM		
4120 [1] Las Vegas, NV–AZ	1.0796	1.0538
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8190	0.8722
Douglas, KS		
4200 Lawton, OK	0.8996	0.9301
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9036	0.9329
Androscoggin, ME		
4280 Lexington, KY	0.8866	0.9209
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9320	0.9529
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9666	0.9770
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8906	0.9237
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8922	0.9249
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.2033	1.1351
Los Angeles, CA		
4520 Louisville, KY–IN	0.9350	0.9550
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8838	0.9189
Lubbock, TX		
4640 Lynchburg, VA	0.8867	0.9210
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8974	0.9285
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0271	1.0185
Dane, WI		
4800 Mansfield, OH	0.8690	0.9083
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4589	0.5866
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8566	0.8994
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0344	1.0234
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9688	0.9785
Brevard, Fl		

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

Urban area (constituent counties)	Wage index	GAF
4920 [1] Memphis, TN–AR–MS	0.8723	0.9107
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 [2] Merced, CA	0.9861	0.9905
Merced, CA		
5000 [1] Miami, FL	1.0059	1.0040
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.0333	1.0227
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9767	0.9840
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN–WI	1.1017	1.0686
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		
5140 Missoula, MT	0.9332	0.9538
Missoula, MT		
5160 Mobile, AL	0.8163	0.8702
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0396	1.0270
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1283	1.0862
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8396	0.8872
Ouachita, LA		
5240 Montgomery, AL	0.7653	0.8326
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	1.0969	1.0654
Delaware, IN		
5330 Myrtle Beach, SC	0.8440	0.8903
Horry, SC		
5345 Naples, FL	0.9661	0.9767
Collier, FL		
5360 [1] Nashville, TN	0.9490	0.9648
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3932	1.2549
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2034	1.1352
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2063	1.1371
New London, CT		
5560 [1] New Orleans, LA	0.9295	0.9512
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	1.4651	1.2989
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.0757	1.0512
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.0847	1.0573
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA–NC	0.8422	0.8890
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	1.4983	1.3190
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL. Marion, FL	0.9243	0.9475
5800 Odessa-Midland, TX	0.9205	0.9449
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8822	0.9177
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0677	1.0459
Thurston, WA		
5920 Omaha, NE–IA	0.9572	0.9705
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1411	1.0946
Orange, CA		
5960 [1] Orlando, FL	0.9610	0.9731
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8159	0.8699
Daviess, KY		
6015 Panama City, FL	0.9010	0.9311
Bay, FL		
6020 Parkersburg-Marietta, WV–OH (WV Hospitals)	0.8274	0.8783
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV–OH (OH Hospitals)	0.8670	0.9069
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8928	0.9253
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8646	0.9052
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA–NJ	1.0937	1.0633
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9669	0.9772

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

Urban area (constituent counties)	Wage index	GAF
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7791	0.8429
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9741	0.9822
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.1204	1.0810
Berkshire, MA		
6340 Pocatello, ID	0.9076	0.9358
Bannock, ID		
6360 Ponce, PR	0.5006	0.6226
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9748	0.9827
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR–WA	1.0910	1.0615
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0864	1.0584
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	1.0041	1.0028
Utah, UT		
6560 [2] Pueblo, CO	0.8968	0.9281
Pueblo, CO		
6580 Punta Gorda, FL	0.9613	0.9733
Charlotte, FL		
6600 Racine, WI	0.9246	0.9477
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9646	0.9756
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8865	0.9208
Pennington, SD		
6680 Reading, PA	0.9152	0.9411
Berks, PA		
6690 Redding, CA	1.1664	1.1112
Shasta, CA		
6720 Reno, NV	1.0550	1.0373
Washoe, NV		

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

Urban area (constituent counties)	Wage index	GAF
6740 Richland-Kennewick-Pasco, WA	1.1460	1.0978
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9617	0.9736
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	1.1115	1.0751
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8782	0.9149
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1315	1.0883
Olmsted, MN		
6840 [1] Rochester, NY	0.9182	0.9432
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8819	0.9175
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8849	0.9197
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1957	1.1302
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9575	0.9707
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	1.0016	1.0011
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.9071	0.9354
Andrew, MO		
Buchanan, MO		
7040 [1] 1St. Louis, MO–IL	0.9049	0.9339
Clinton, IL		

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

Urban area (constituent counties)	Wage index	GAF
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 Salem, OR	1.0132	1.0090
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4502	1.2899
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9811	0.9870
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.8083	0.8644
Tom Green, TX		
7240 [1] San Antonio, TX	0.8580	0.9004
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1784	1.1190
San Diego, CA		
7360 [1] San Francisco, CA	1.4193	1.2710
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.3564	1.2321
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4690	0.5954
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		

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

Urban area (constituent counties)	Wage index	GAF
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0673	1.0456
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0597	1.0405
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.4095	1.2650
Santa Cruz, CA		
7490 Santa Fe, NM	1.0537	1.0365
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2646	1.1744
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9809	0.9869
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9697	0.9792
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 [2] Scranton—Wilkes-Barre—Hazleton, PA	0.8578	0.9003
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1016	1.0685
Island, WA		
King, WA		
Snohomish, WA		
7610 [2] Sharon, PA	0.8578	0.9003
Mercer, PA		
7620 [2] Sheboygan, WI	0.8880	0.9219
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8795	0.9158
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.8750	0.9126
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8473	0.8927
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8790	0.9155
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	1.0029	1.0020
St. Joseph, IN		
7840 Spokane, WA	1.0513	1.0349
Spokane, WA		
7880 Springfield, IL	0.8685	0.9080
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8488	0.8938
Christian, MO		
Greene, MO		
Webster, MO		
8003 [2] Springfield, MA	1.1204	1.0810
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9038	0.9331
Centre, PA		
8080 [2] Steubenville-Weirton, OH–WV (OH Hospitals)	0.8670	0.9069
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH–WV (WV Hospitals)	0.8548	0.8981
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0629	1.0427
San Joaquin, CA		
8140 [2] Sumter, SC	0.8370	0.8853
Sumter, SC		
8160 Syracuse, NY	0.9594	0.9720
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1564	1.1046
Pierce, WA		
8240 [2] Tallahassee, FL	0.8928	0.9253
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9099	0.9374
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 [2] Terre Haute, IN	0.8602	0.9020
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8427	0.8894
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9664	0.9769
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9117	0.9387
Shawnee, KS		
8480 Trenton, NJ	1.0137	1.0094
Mercer, NJ		
8520 Tucson, AZ	0.8821	0.9177
Pima, AZ		
8560 Tulsa, OK	0.8454	0.8914
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8064	0.8630
Tuscaloosa, AL		
8640 Tyler, TX	0.9404	0.9588
Smith, TX		
8680 Utica-Rome, NY	0.8560	0.8990
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.2266	1.1501
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0479	1.0326
Ventura, CA		
8750 Victoria, TX	0.8154	0.8696
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0501	1.0340
Cumberland, NJ		
8780 [2] Visalia-Tulare-Porterville, CA	0.9861	0.9905
Tulare, CA		
8800 Waco, TX	0.8314	0.8812
McLennan, TX		
8840 [1] Washington, DC–MD–VA–WV	1.0755	1.0511
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	0.8802	0.9163
Black Hawk, IA		
8940 Wausau, WI	0.9426	0.9603
Marathon, WI		
8960 [1] 1West Palm Beach-Boca Raton, FL	0.9615	0.9735
Palm Beach, FL		
9000 [2] Wheeling, WV–OH (WV Hospitals)	0.8231	0.8752
Belmont, OH		
Marshall, WV		

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

Urban area (constituent counties)	Wage index	GAF
Ohio, WV		
9000 [2] Wheeling, WV–OH (OH Hospitals)	0.8670	0.9069
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9544	0.9685
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7668	0.8337
Archer, TX		
Wichita, TX		
9140 [2] Williamsport, PA	0.8578	0.9003
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1191	1.0801
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9402	0.9587
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0434	1.0295
Yakima, WA		
9270 Yolo, CA	1.0199	1.0136
Yolo, CA		
9280 York, PA	0.9264	0.9490
York, PA		
9320 Youngstown-Warren, OH	0.9543	0.9685
Columbiana, OH		
Mahoning, OH Trumbull, OH		
9340 Yuba City, CA	1.0706	1.0478
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9529	0.9675
Yuma, AZ		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2001.

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

Nonurban area	Wage index	GAF
Alabama	0.7528	0.8233
Alaska	1.2392	1.1582
Arizona	0.8317	0.8814
Arkansas	0.7445	0.8171
California	0.9861	0.9905
Colorado	0.8968	0.9281
Connecticut	1.1715	1.1145
Delaware	0.9074	0.9356
Florida	0.8928	0.9253
Georgia	0.8329	0.8823
Hawaii	1.1059	1.0714
Idaho	0.8678	0.9075
Illinois	0.8160	0.8700
Indiana	0.8602	0.9020
Iowa	0.8030	0.8605

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

Nonurban area	Wage index	GAF
Kansas	0.7605	0.8290
Kentucky	0.7931	0.8532
Louisiana	0.7713	0.8371
Maine	0.8766	0.9138
Maryland	0.8651	0.9055
Massachusetts	1.1204	1.0810
Michigan	0.9021	0.9319
Minnesota	0.8881	0.9219
Mississippi	0.7491	0.8205
Missouri	0.7707	0.8366
Montana	0.8688	0.9082
Nebraska	0.8109	0.8663
Nevada	0.9232	0.9467
New Hampshire	0.9845	0.9894
New Jersey [1]	.....	.....
New Mexico	0.8497	0.8945
New York	0.8499	0.8946
North Carolina	0.8441	0.8904
North Dakota	0.7716	0.8373
Ohio	0.8670	0.9069
Oklahoma	0.7491	0.8205
Oregon	1.0132	1.0090
Pennsylvania	0.8578	0.9003
Puerto Rico	0.4264	0.5578
Rhode Island [1]	.....	.....
South Carolina	0.8370	0.8853
South Dakota	0.7570	0.8264
Tennessee	0.7838	0.8464
Texas	0.7507	0.8217
Utah	0.9037	0.9330
Vermont	0.9427	0.9604
Virginia	0.8189	0.8721
Washington	1.0434	1.0295
West Virginia	0.8231	0.8752
Wisconsin	0.8880	0.9219
Wyoming	0.8817	0.9174

[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

Area	Wage index	GAF
Abilene, TX	0.8240	0.8758
Akron, OH	0.9736	0.9818
Alexandria, LA	0.8170	0.8707
Amarillo, TX	0.8715	0.9101
Anchorage, AK	1.2865	1.1883
Ann Arbor, MI	1.1064	1.0717
Atlanta, GA	1.0096	1.0066
Atlantic-Cape May, NJ	1.0822	1.0556
Augusta-Aiken, GA–SC	0.9160	0.9417
Baton Rouge, LA	0.8734	0.9115
Benton Harbor, MI	0.9021	0.9319
Bergen-Passaic, NJ	1.1605	1.1073
Billings, MT	0.9591	0.9718
Binghamton, NY	0.8690	0.9083
Birmingham, AL	0.8477	0.8930
Bismarck, ND	0.7897	0.8507
Bloomington-Normal, IL	0.9156	0.9414
Boise City, ID	0.9042	0.9334

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

Area	Wage index	GAF
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH, RI, and VT Hospitals)	1.1160	1.0781
Burlington, VT	1.0550	1.0373
Casper, WY	0.8817	0.9174
Champaign-Urbana, IL	0.9084	0.9363
Charleston-North Charleston, SC	0.9067	0.9351
Charleston, WV	0.8904	0.9236
Charlotte-Gastonia-Rock Hill, NC–SC	0.9391	0.9579
Chattanooga, TN–GA	0.9624	0.9741
Chicago, IL	1.1015	1.0684
Cincinnati, OH–KY–IN	0.9415	0.9596
Clarksville-Hopkinsville, TN–KY	0.8277	0.8785
Cleveland-Lorain-Elyria, OH	0.9593	0.9719
Columbia, MO	0.8756	0.9130
Columbia, SC	0.9433	0.9608
Columbus, OH	0.9619	0.9737
Dallas, TX	0.9913	0.9940
Danville, VA	0.8212	0.8738
Davenport-Moline-Rock Island, IA–IL	0.8898	0.9232
Dayton-Springfield, OH	0.9442	0.9614
Denver, CO	1.0181	1.0124
Des Moines, IA	0.9011	0.9312
Dothan, AL	0.8013	0.8592
Dover, DE	0.9769	0.9841
Duluth-Superior, MN–WI	1.0043	1.0029
Eau Claire, WI	0.8880	0.9219
Erie, PA	0.8985	0.9293
Eugene-Springfield, OR	1.0965	1.0651
Fargo-Moorhead, ND–MN	0.8517	0.8959
Fayetteville, NC	0.8469	0.8924
Flagstaff, AZ–UT	1.0525	1.0357
Flint, MI	1.1058	1.0713
Florence, AL	0.7652	0.8325
Florence, SC	0.8777	0.9145
Fort Collins-Loveland, CO	1.0647	1.0439
Ft. Lauderdale, FL	1.0152	1.0104
Fort Pierce-Port St. Lucie, FL	0.9622	0.9740
Fort Smith, AR–OK	0.7947	0.8544
Fort Walton Beach, FL	0.9358	0.9556
Fort Wayne, IN	0.8665	0.9065
Forth Worth-Arlington, TX	0.9527	0.9674
Gadsden, AL	0.8423	0.8891
Grand Forks, ND–MN	0.8954	0.9271
Grand Junction, CO	0.9471	0.9635
Grand Rapids-Muskegon-Holland, MI	1.0248	1.0169
Great Falls, MT	0.9331	0.9537
Greeley, CO	0.9573	0.9706
Green Bay, WI	0.9308	0.9521
Greensboro-Winston-Salem-High Point, NC	0.9124	0.9391
Greenville, NC	0.9172	0.9425
Greenville-Spartanburg-Anderson, SC	0.9003	0.9306
Harrisburg-Lebanon-Carlisle, PA	0.9386	0.9575

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

Area	Wage index	GAF
Hartford, CT (MA Hospital)	1.1420	1.0952
Hattiesburg, MS	0.7491	0.8205
Hickory-Morganton-Lenoir, NC	0.8577	0.9002
Honolulu, HI	1.1866	1.1243
Houston, TX	0.9732	0.9816
Huntington-Ashland, WV–KY–OH	0.9605	0.9728
Huntsville, AL	0.8779	0.9147
Indianapolis, IN	0.9787	0.9854
Jackson, MS	0.8698	0.9089
Jackson, TN	0.8796	0.9159
Jacksonville, FL	0.9208	0.9451
Jersey City, NJ	1.1573	1.1052
Johnson City-Kingsport-Bristol, TN–VA	0.8328	0.8822
Joplin, MO	0.8148	0.8691
Kalamazoo-Battlecreek, MI	1.0311	1.0212
Kansas City, KS–MO	0.9498	0.9653
Knoxville, TN	0.8340	0.8831
Kokomo, IN	0.9525	0.9672
Lafayette, LA	0.8490	0.8940
Lansing-East Lansing, MI	0.9934	0.9955
Las Cruces, NM	0.8510	0.8954
Las Vegas, NV–AZ	1.0796	1.0538
Lexington, KY	0.8712	0.9099
Lima, OH	0.9320	0.9529
Lincoln, NE	0.9666	0.9770
Little Rock-North Little Rock, AR	0.8791	0.9155
Longview-Marshall, TX	0.8732	0.9113
Los Angeles-Long Beach, CA	1.2033	1.1351
Louisville, KY–IN	0.9350	0.9550
Lynchburg, VA	0.8749	0.9125
Macon, GA	0.8974	0.9285
Madison, WI	1.0271	1.0185
Mansfield, OH	0.8690	0.9083
Memphis, TN–AR–MS	0.8584	0.9007
Milwaukee-Waukesha, WI	0.9767	0.9840
Minneapolis-St. Paul, MN–WI	1.1017	1.0686
Missoula, MT	0.9332	0.9538
Mobile, AL	0.8163	0.8702
Monmouth-Ocean, NJ	1.1283	1.0862
Montgomery, AL	0.7653	0.8326
Myrtle Beach, SC (NC Hospital)	0.8441	0.8904
Nashville, TN	0.9301	0.9516
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2034	1.1352
New London-Norwich, CT	1.1926	1.1282
New Orleans, LA	0.9295	0.9512
New York, NY	1.4463	1.2875
Newburgh, NY–PA	1.0666	1.0451
Norfolk-Virginia Beach-Newport News, VA–NC	0.8441	0.8904
Oakland, CA	1.4983	1.3190
Ocala, FL	0.9243	0.9475
Odessa-Midland, TX	0.9074	0.9356
Oklahoma City, OK	0.8822	0.9177
Omaha, NE–IA	0.9572	0.9705
Orange County, CA	1.1411	1.0946
Orlando, FL	0.9610	0.9731
Peoria-Pekin, IL	0.8646	0.9052
Philadelphia, PA–NJ	1.0937	1.0633
Pine Bluff, AR	0.7680	0.8346
Pittsburgh, PA	0.9575	0.9707
Pittsfield, MA (VT Hospital)	0.9914	0.9941
Pocatello, ID	0.8715	0.9101
Portland, ME	0.9629	0.9744
Portland-Vancouver, OR–WA	1.0910	1.0615
Provo-Orem, UT	1.0041	1.0028
Raleigh-Durham-Chapel Hill, NC	0.9646	0.9756
Rapid City, SD	0.8865	0.9208
Redding, CA	1.1664	1.1112
Reno, NV	1.0438	1.0298
Richland-Kennewick-Pasco, WA	1.1147	1.0772
Roanoke, VA	0.8782	0.9149
Rochester, MN	1.1315	1.0883
Rockford, IL	0.8819	0.9175
Sacramento, CA	1.1957	1.1302
Saginaw-Bay City-Midland, MI	0.9575	0.9707
St. Cloud, MN	1.0016	1.0011
St. Joseph, MO	0.8848	0.9196
St. Louis, MO–IL	0.9049	0.9339
Salinas, CA	1.4502	1.2899
Salt Lake City-Ogden, UT	0.9811	0.9870
San Diego, CA	1.1784	1.1190
Santa Cruz-Watsonville, CA	1.3897	1.2528
Santa Fe, NM	1.0000	1.0000
Santa Rosa, CA	1.2398	1.1586
Seattle-Bellevue-Everett, WA	1.1016	1.0685
Sherman-Denison, TX	0.8795	0.9158
Sioux City, IA–NE	0.8473	0.8927
South Bend, IN	1.0029	1.0020
Spokane, WA	1.0333	1.0227
Springfield, IL	0.8685	0.9080
Springfield, MO	0.8212	0.8738
Syracuse, NY	0.9594	0.9720
Tampa-St. Petersburg-Clearwater, FL	0.9099	0.9374
Texarkana, AR-Texarkana, TX	0.8427	0.8894
Toledo, OH	0.9664	0.9769
Topeka, KS	0.9117	0.9387
Tucson, AZ	0.8821	0.9177
Tulsa, OK	0.8454	0.8914
Tuscaloosa, AL	0.8064	0.8630
Tyler, TX	0.9141	0.9403
Victoria, TX	0.8154	0.8696
Washington, DC–MD–VA–WV	1.0755	1.0511
Waterloo-Cedar Falls, IA	0.8802	0.9163
Wausau, WI	0.9426	0.9603
Wichita, KS	0.9262	0.9489
Rural Alabama	0.7528	0.8233
Rural Florida	0.8928	0.9253
Rural Illinois	0.8160	0.8700
Rural Louisiana	0.7713	0.8371
Rural Michigan	0.9021	0.9319
Rural Minnesota	0.8881	0.9219
Rural Missouri	0.7707	0.8366
Rural Montana	0.8688	0.9082
Rural Oregon	1.0132	1.0090
Rural Texas	0.7507	0.8217
Rural Washington	1.0434	1.0295
Rural West Virginia	0.8231	0.8752
Rural Wisconsin	0.8880	0.9219
Rural Wyoming (NE Hospital)	0.8671	0.9070

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	17.9387
Aguadilla, PR	9.5583
Akron, OH	21.1962
Albany, GA	21.6247
Albany-Schenectady-Troy, NY	18.6106
Albuquerque, NM	19.8899
Alexandria, LA	17.7452
Allentown-Bethlehem-Easton, PA	21.8571
Altoona, PA	20.3472
Amarillo, TX	18.9724
Anchorage, AK	27.8515
Ann Arbor, MI	24.5003
Anniston, AL	18.0347
Appleton-Oshkosh-Neenah, WI	19.7058
Arecibo, PR	9.8505
Asheville, NC	20.7157
Athens, GA	21.2027
Atlanta, GA	21.9792
Atlantic-Cape May, NJ	24.3440
Auburn-Opelika, AL	17.6461
Augusta-Aiken, GA–SC	19.9424
Austin-San Marcos, TX	20.8502
Bakersfield, CA	21.0688
Baltimore, MD	20.3888
Bangor, ME	20.8150
Barnstable-Yarmouth, MA	30.1277
Baton Rouge, LA	19.2487
Beaumont-Port Arthur, TX	19.0352
Bellingham, WA	24.9039
Benton Harbor, MI	18.8768
Bergen-Passaic, NJ	25.7937
Billings, MT	20.8676
Biloxi-Gulfport-Pascagoula, MS	17.9290
Binghamton, NY	18.9175
Birmingham, AL	18.4002
Bismarck, ND	16.7742
Bloomington,IN	19.0130
Bloomington-Normal, IL	19.8003
Boise City, ID	19.6053
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	24.2959
Boulder-Longmont, CO	21.1843
Brazoria, TX	18.8483
Bremerton, WA	23.8918
Brownsville-Harlingen-San Benito, TX	18.9870

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Bryan-College Station, TX	17.9324
Buffalo-Niagara Falls, NY	20.8552
Burlington, VT	23.3707
Caguas, PR	9.9325
Canton-Massillon, OH	18.6867
Casper, WY	18.9923
Cedar Rapids, IA	19.0186
Champaign-Urbana, IL	20.0245
Charleston-North Charleston, SC	19.6765
Charleston, WV	20.1160
Charlotte-Gastonia-Rock Hill, NC–SC	20.4436
Charlottesville, VA	23.4885
Chattanooga, TN–GA	21.4064
Cheyenne, WY	18.0869
Chicago, IL	24.2653
Chico-Paradise, CA	21.5925
Cincinnati, OH–KY–IN	20.4967
Clarksville-Hopkinsville, TN–KY	17.8606
Cleveland-Lorain-Elyria, OH	20.8921
Colorado Springs, CO	21.1114
Columbia, MO	19.5074
Columbia, SC	20.7995
Columbus, GA–AL	18.6521
Columbus, OH	20.9403
Corpus Christi, TX	18.9962
Corvallis, OR	24.6574
Cumberland, MD–WV	18.2190
Dallas, TX	21.5801
Danville, VA	18.6983
Davenport-Moline-Rock Island, IA–IL	19.3712
Dayton-Springfield, OH	20.5545
Daytona Beach, FL	20.0282
Decatur, AL	18.5791
Decatur, IL	17.6894
Denver, CO	22.1647
Des Moines, IA	19.8508
Detroit, MI	22.8814
Dothan, AL	17.2926
Dover, DE	21.9391
Dubuque, IA	19.0397
Duluth-Superior, MN–WI	21.8388
Dutchess County, NY	22.3121
Eau Claire, WI	19.1358
El Paso, TX	20.3455
Elkhart-Goshen, IN	19.9093
Elmira, NY	18.6041
Enid, OK	18.7450
Erie, PA	19.5597
Eugene-Springfield, OR	23.8704
Evansville, Henderson, IN–KY	17.7939
Fargo-Moorhead, ND–MN	19.0467
Fayetteville, NC	18.8418
Fayetteville-Springdale-Rogers, AR	17.2213
Flagstaff, AZ–UT	23.2631
Flint, MI	24.3942
Florence, AL	16.5808
Florence, SC	19.1069
Fort Collins-Loveland, CO	23.1791
Fort Lauderdale, FL	22.0334
Fort Myers-Cape Coral, FL	20.1312
Fort Pierce-Port St. Lucie, FL	20.7635
Fort Smith, AR–OK	17.5292
Fort Walton Beach, FL	20.9154
Fort Wayne, IN	18.8629
Fort Worth-Arlington, TX	20.7411
Fresno, CA	21.9976

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Gadsden, AL	18.3371
Gainesville, FL	21.9311
Galveston-Texas City, TX	21.5917
Gary, IN	20.5814
Glens Falls, NY	18.2029
Goldsboro, NC	18.3380
Grand Forks, ND–MN	19.1930
Grand Junction, CO	19.8299
Grand Rapids-Muskegon-Holland, MI	22.3091
Great Falls, MT	19.7346
Greeley, CO	21.3659
Green Bay, WI	20.0839
Greensboro-Winston-Salem-High Point, NC	19.8775
Greenville, NC	20.4282
Greenville-Spartanburg-Anderson, SC	19.5991
Hagerstown, MD	20.4841
Hamilton-Middletown, OH	19.7254
Harrisburg-Lebanon-Carlisle, PA	20.4334
Hartford, CT	24.7589
Hattiesburg, MS	16.3068
Hickory-Morganton-Lenoir, NC	19.6096
Honolulu, HI	25.8269
Houma, LA	17.6029
Houston, TX	21.1868
Huntington-Ashland, WV–KY–OH	21.4993
Huntsville, AL	19.4455
Indianapolis, IN	21.3060
Iowa City, IA	21.0244
Jackson, MI	19.8852
Jackson, MS	19.1842
Jackson, TN	19.1498
Jacksonville, FL	20.0465
Jacksonville, NC	16.9298
Jamestown, NY	17.0195
Janesville-Beloit, WI	20.8677
Jersey City, NJ	25.0412
Johnson City-Kingsport-Bristol, TN–VA	18.0083
Johnstown, PA	19.2587
Jonesboro, AR	17.0500
Joplin, MO	17.7376
Kalamazoo-Battlecreek, MI	22.7571
Kankakee, IL	21.5573
Kansas City, KS–MO	20.6781
Kenosha, WI	20.9242
Killeen-Temple, TX	22.0298
Knoxville, TN	18.1556
Kokomo, IN	20.7207
La Crosse, WI–MN	20.0533
Lafayette, LA	18.4838
Lafayette, IN	19.2317
Lake Charles, LA	16.1070
Lakeland-Winter Haven, FL	20.1126
Lancaster, PA	20.1576
Lansing-East Lansing, MI	21.6264
Laredo, TX	17.7822
Las Cruces, NM	18.8479
Las Vegas, NV–AZ	23.5027
Lawrence, KS	17.8290
Lawton, OK	19.5850
Lewiston-Auburn, ME	19.6724
Lexington, KY	19.3007
Lima, OH	20.2889
Lincoln, NE	20.9569
Little Rock-North Little Rock, AR	19.3875
Longview-Marshall, TX	19.4243

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Los Angeles-Long Beach, CA	26.1164
Louisville, KY–IN	20.3544
Lubbock, TX	19.2404
Lynchburg, VA	19.3031
Macon, GA	19.5357
Madison, WI	22.3606
Mansfield, OH	18.9191
Mayaguez, PR	9.9900
McAllen-Edinburg-Mission, TX	18.6487
Medford-Ashland, OR	22.5185
Melbourne-Titusville-Palm Bay, FL	21.0904
Memphis, TN–AR–MS	18.9896
Merced, CA	20.9989
Miami, FL	21.8997
Middlesex-Somerset-Hunterdon, NJ	24.1094
Milwaukee-Waukesha, WI	21.2638
Minneapolis-St. Paul, MN–WI	23.9833
Missoula, MT	20.1896
Mobile, AL	17.7700
Modesto, CA	22.6325
Monmouth-Ocean, NJ	24.5529
Monroe, LA	18.2776
Montgomery, AL	16.6605
Muncie, IN	23.8791
Myrtle Beach, SC	18.3751
Naples, FL	21.0332
Nashville, TN	20.6601
Nassau-Suffolk, NY	30.3304
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	26.7711
New London-Norwich, CT	26.2605
New Orleans, LA	20.2347
New York, NY	31.8954
Newark, NJ	25.7698
Newburgh, NY–PA	23.6150
Norfolk-Virginia Beach-Newport News, VA–NC	18.3132
Oakland, CA	32.6189
Ocala, FL	20.1230
Odessa-Midland, TX	20.0403
Oklahoma City, OK	19.2048
Olympia, WA	23.2441
Omaha, NE–IA	20.8374
Orange County, CA	24.9648
Orlando, FL	20.9206
Owensboro, KY	17.7626
Panama City, FL	19.6150
Parkersburg-Marietta, WV–OH	18.0122
Pensacola, FL	17.7997
Peoria-Pekin, IL	18.8206
Philadelphia, PA–NJ	23.8095
Phoenix-Mesa, AZ	21.0494
Pine Bluff, AR	16.9610
Pittsburgh, PA	21.2070
Pittsfield, MA	22.3968
Pocatello, ID	19.7591
Ponce, PR	10.8985
Portland, ME	21.2220
Portland-Vancouver, OR–WA	23.7513
Providence-Warwick, RI	23.6503
Provo-Orem, UT	21.8338
Pueblo, CO	19.1909
Punta Gorda, FL	20.9268
Racine, WI	20.1287
Raleigh-Durham-Chapel Hill, NC	21.0003
Rapid City, SD	19.2995
Reading, PA	19.9251
Redding, CA	25.3926

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Reno, NV	22.9669
Richland-Kennewick-Pasco, WA	24.9481
Richmond-Petersburg, VA	20.9366
Riverside-San Bernardino, CA	24.4685
Roanoke, VA	19.0494
Rochester, MN	24.6337
Rochester, NY	19.9884
Rockford, IL	19.1994
Rocky Mount, NC	19.2653
Sacramento, CA	26.0143
Saginaw-Bay City-Midland, MI	20.8446
St. Cloud, MN	21.8042
St. Joseph, MO	19.7467
St. Louis, MO–IL	19.6997
Salem, OR	22.1817
Salinas, CA	31.5702
Salt Lake City-Ogden, UT	21.3500
San Angelo, TX	17.5980
San Antonio, TX	18.6797
San Diego, CA	25.6544
San Francisco, CA	30.8184
San Jose, CA	29.7210
San Juan-Bayamon, PR	10.2110
San Luis Obispo-Atascadero-Paso Robles, CA	23.2360
Santa Barbara-Santa Maria-Lompoc, CA	23.0707
Santa Cruz-Watsonville, CA	30.5664
Santa Fe, NM	22.9400
Santa Rosa, CA	27.5311
Sarasota-Bradenton, FL	21.3554
Savannah, GA	21.1099
Scranton-Wilkes Barre-Hazleton, PA	18.3332
Seattle-Bellevue-Everett, WA	23.9393
Sharon, PA	17.2591
Sheboygan, WI	18.2407
Sherman-Denison, TX	18.9273
Shreveport-Bossier City, LA	19.0499
Sioux City, IA–NE	18.4457
Sioux Falls, SD	19.1359
South Bend, IN	21.7709
Spokane, WA	22.8867
Springfield, IL	18.9066
Springfield, MO	18.4778
Springfield, MA	23.1578
State College, PA	19.6769
Steubenville-Weirton, OH–WV	18.6092
Stockton-Lodi, CA	23.1397
Sumter, SC	18.0057

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Syracuse, NY	20.7876
Tacoma, WA	25.1749
Tallahassee, FL	18.6017
Tampa-St. Petersburg-Clearwater, FL	19.5532
Terre Haute, IN	18.0773
Texarkana, AR-Texarkana, TX	18.2062
Toledo, OH	21.4050
Topeka, KS	19.8476
Trenton, NJ	22.0690
Tucson, AZ	19.1447
Tulsa, OK	18.4038
Tuscaloosa, AL	17.5550
Tyler, TX	20.4737
Utica-Rome, NY	18.6360
Vallejo-Fairfield-Napa, CA	27.9688
Ventura, CA	24.0125
Victoria, TX	17.7514
Vineland-Millville-Bridgeton, NJ	22.8607
Visalia-Tulare-Porterville, CA	20.7921
Waco, TX	18.1006
Washington, DC–MD–VA–WV	23.4147
Waterloo-Cedar Falls, IA	18.2949
Wausau, WI	20.5039
West Palm Beach-Boca Raton, FL	21.0777
Wheeling, OH–WV	16.8341
Wichita, KS	20.7776
Wichita Falls, TX	16.6925
Williamsport, PA	18.2688
Wilmington-Newark, DE–MD	24.3629
Wilmington, NC	20.4690
Yakima, WA	21.5675
Yolo, CA	22.2042
York, PA	20.1674
Youngstown-Warren, OH	20.7757
Yuba City, CA	23.3065
Yuma, AZ	20.7458

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	16.3047
Alaska	26.9769
Arizona	18.1056
Arkansas	16.2080

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
California	21.4673
Colorado	19.5235
Connecticut	25.5035
Delaware	19.7543
Florida	19.4165
Georgia	18.1321
Hawaii	24.0749
Idaho	18.8912
Illinois	17.7653
Indiana	18.7277
Iowa	17.4823
Kansas	16.5568
Kentucky	17.2663
Louisiana	16.6925
Maine	19.0838
Maryland	18.8330
Massachusetts	24.3924
Michigan	19.5659
Minnesota	19.3332
Mississippi	16.3073
Missouri	16.7596
Montana	18.9143
Nebraska	17.6541
Nevada	20.0985
New Hampshire	21.4334
New Jersey [1]	.....
New Mexico	18.4985
New York	18.5034
North Carolina	18.3772
North Dakota	16.7982
Ohio	18.8756
Oklahoma	16.3084
Oregon	22.0574
Pennsylvania	18.6739
Puerto Rico	9.2817
Rhode Island [1]	.....
South Carolina	18.2215
South Dakota	16.4806
Tennessee	17.0628
Texas	16.3317
Utah	19.6740
Vermont	20.1891
Virginia	17.8284
Washington	22.7144
West Virginia	17.9182
Wisconsin	19.3321
Wyoming	19.1944

[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	0.9380	0.9571	.....	.....
Arecibo, PR	0.9667	0.9771	.....	.....
Caguas, PR	0.9747	0.9826	.....	.....
Mayaguez, PR	0.9803	0.9865	.....	.....
Ponce, PR	1.0695	1.0471	.....	.....
San Juan-Bayamon, PR	1.0020	1.0014	.....	.....
Rural Puerto Rico	0.9108	0.9380	.....	.....

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0970	6.3	9.1
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.1142	7.3	9.7
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9629	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.2918	4.8	7.4
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.4321	2.3	3.3
6	01	SURG	CARPAL TUNNEL RELEASE	.8246	2.2	3.2
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.5919	6.9	10.3
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.3948	2.1	3.0
9	01	MED	SPINAL DISORDERS & INJURIES	1.3134	4.7	6.6
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2273	4.9	6.7
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8345	3.1	4.2
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8925	4.5	6.1
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7644	4.1	5.1
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.2070	4.7	6.1
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7480	2.9	3.6
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1652	4.7	6.2
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6539	2.6	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9600	4.3	5.6
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6963	2.9	3.7
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7744	7.9	10.6
21	01	MED	VIRAL MENINGITIS	1.4966	5.2	6.9
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0082	3.8	5.0
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8027	3.2	4.2
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9914	3.7	5.0
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.6043	2.6	3.3
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6441	2.4	3.2
27	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR	1.2912	3.2	5.1
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3102	4.5	6.3
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE ≤17 W/O CC	.7015	2.8	3.7
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	.3320	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8715	3.1	4.2
32	01	MED	CONCUSSION AGE >17 W/O CC	.5422	2.1	2.7
33	01	MED	*CONCUSSION AGE 0–17	.2086	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0099	3.8	5.2
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6027	2.7	3.4
36	02	SURG	RETINAL PROCEDURES	.6639	1.2	1.4
37	02	SURG	ORBITAL PROCEDURES	1.0016	2.6	3.7
38	02	SURG	PRIMARY IRIS PROCEDURES	.4833	1.8	2.5
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5778	1.5	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8635	2.3	3.6
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3380	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6478	1.6	2.2
43	02	MED	HYPHEMA	.4977	2.6	3.4
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6337	4.1	5.0
45	02	MED	NEUROLOGICAL EYE DISORDERS	.7022	2.7	3.3
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7749	3.5	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.5085	2.5	3.3
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2977	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.8301	3.5	5.0
50	03	SURG	SIALOADENECTOMY	.8537	1.6	2.0
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.7934	1.8	2.5
52	03	SURG	CLEFT LIP & PALATE REPAIR	.8410	1.6	2.1
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2118	2.3	3.7
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4826	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.9039	1.9	2.9
56	03	SURG	RHINOPLASTY	.9451	2.1	3.1
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0704	2.5	4.0
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2740	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.6943	1.8	2.5
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	.2087	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2660	2.8	4.8
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2955	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3402	3.0	4.3
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2288	4.3	6.5
65	03	MED	DYSEQUILIBRIUM	.5385	2.3	2.9

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
66	03	MED	EPISTAXIS	.5590	2.5	3.2
67	03	MED	EPIGLOTTITIS	.8105	2.8	3.5
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6750	3.4	4.2
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5152	2.7	3.3
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.4628	2.4	2.9
71	03	MED	LARYNGOTRACHEITIS	.7712	3.0	3.9
72	03	MED	NASAL TRAUMA & DEFORMITY	.6428	2.6	3.3
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7777	3.3	4.4
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	.3358	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1331	7.8	10.0
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7908	8.4	11.3
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1887	3.5	5.0
78	04	MED	PULMONARY EMBOLISM	1.3698	6.0	7.0
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6501	6.6	8.5
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9373	4.7	5.8
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5204	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3799	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	.9808	4.4	5.6
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5539	2.8	3.4
85	04	MED	PLEURAL EFFUSION W CC	1.2198	4.9	6.4
86	04	MED	PLEURAL EFFUSION W/O CC	.6984	2.9	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3781	4.8	6.3
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9317	4.2	5.2
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0647	5.0	6.0
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6590	3.6	4.2
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.6890	2.8	3.4
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1863	5.0	6.3
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7309	3.3	4.1
94	04	MED	PNEUMOTHORAX W CC	1.1704	4.8	6.3
95	04	MED	PNEUMOTHORAX W/O CC	.6098	3.0	3.7
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7871	3.9	4.7
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5873	3.1	3.7
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.8768	3.2	4.7
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.7117	2.5	3.2
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5437	1.8	2.2
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8563	3.3	4.4
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5550	2.1	2.7
103	PRE	SURG	HEART TRANSPLANT	19.0098	30.7	51.8
104	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	7.1843	8.9	11.7
105	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	5.6567	7.4	9.3
106	05	SURG	CORONARY BYPASS W PTCA	7.5203	9.3	11.2
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3762	9.2	10.3
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.6525	8.0	10.6
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0198	6.8	7.7
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1358	7.1	9.5
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2410	4.7	5.5
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.8677	2.6	3.8
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7806	9.8	12.8
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5656	6.0	8.3
115	05	SURG	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR PR.	3.4711	6.0	8.4
116	05	SURG	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	2.4190	2.6	3.7
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.2966	2.6	4.0
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.4939	1.9	2.8
119	05	SURG	VEIN LIGATION & STRIPPING	1.2600	2.9	4.9
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0352	4.9	8.1
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6194	5.5	6.7
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0884	3.3	4.0
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5528	2.8	4.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
124 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4134	3.3	4.4
125 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0606	2.2	2.8
126 ...	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5379	9.3	12.0
127 ...	05	MED	HEART FAILURE & SHOCK	1.0130	4.2	5.4
128 ...	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7651	5.0	5.8
129 ...	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0968	1.8	2.9
130 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9471	4.7	5.9
131 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5898	3.6	4.4
132 ...	05	MED	ATHEROSCLEROSIS W CC	.6707	2.4	3.1
133 ...	05	MED	ATHEROSCLEROSIS W/O CC	.5663	1.9	2.4
134 ...	05	MED	HYPERTENSION	.5917	2.6	3.3
135 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.9083	3.3	4.5
136 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.6065	2.2	2.9
137 ...	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8192	3.3	3.3
138 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8291	3.1	4.0
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5141	2.0	2.5
140 ...	05	MED	ANGINA PECTORIS	.5740	2.2	2.7
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7219	2.9	3.7
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5552	2.2	2.7
143 ...	05	MED	CHEST PAIN	.5402	1.8	2.2
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1668	3.8	5.4
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6322	2.2	2.8
146 ...	06	SURG	RECTAL RESECTION W CC	2.7430	8.9	10.2
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.6221	6.0	6.6
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4347	10.1	12.1
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5667	6.1	6.7
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8523	9.1	11.2
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3427	4.8	5.9
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9462	6.8	8.2
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.2080	4.9	5.5
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1475	10.1	13.3
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3751	3.3	4.4
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8436	6.0	6.0
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2388	3.9	5.5
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6638	2.1	2.6
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3347	3.8	5.0
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7837	2.2	2.7
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1017	2.9	4.2
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6229	1.6	2.0
163 ...	06	SURG	HERNIA PROCEDURES AGE 0–17	.6921	2.4	2.9
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3760	7.1	8.4
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2838	4.3	4.9
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4802	4.0	5.1
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8937	2.3	2.7
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.2141	3.2	4.7
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.7455	1.9	2.4
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8686	7.7	11.2
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1975	3.6	4.8
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.3485	5.1	7.0
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7700	2.8	3.9
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9985	3.9	4.8
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5501	2.5	2.9
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.1052	4.1	5.3
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8998	3.7	4.6
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6604	2.6	3.1
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.0576	4.7	6.0
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9423	4.2	5.4
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5304	2.8	3.4
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7922	3.4	4.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5717	2.4	3.0
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.5119	2.5	3.3
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8621	3.3	4.5
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3216	2.9	2.9
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7649	2.9	3.8
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1005	4.1	5.6
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5796	2.4	3.1
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.9884	4.1	6.0
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3914	10.5	14.2
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7916	5.3	6.6
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.3861	10.3	12.6
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6191	5.6	6.8
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.9062	8.3	9.9
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6593	4.9	5.7
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4544	7.2	8.7
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2339	3.9	4.5
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3584	7.2	9.7
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.2262	7.0	10.8
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.4035	10.2	13.9
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3001	4.9	6.5
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3250	5.0	6.7
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2018	4.5	5.9
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2048	4.7	6.3
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6751	3.0	3.9
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1032	4.0	5.2
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6538	2.3	2.9
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.0912	4.6	5.2
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8152	6.0	6.9
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2647	4.5	4.9
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	.8472	11.1	11.1
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7726	6.4	8.7
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.	2.2042	7.1	9.8
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	2.9230	8.9	13.2
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.5337	4.2	5.4
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0255	2.7	3.3
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5844	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.	.9585	2.0	2.6
224 ...	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.7997	1.7	2.1
225 ...	08	SURG	FOOT PROCEDURES	1.0851	3.3	4.7
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4770	4.3	6.3
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8036	2.1	2.7
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.0664	2.4	3.6
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.7169	1.8	2.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.2490	3.4	5.1
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.3825	3.2	4.8
232 ...	08	SURG	ARTHROSCOPY	1.0828	2.3	3.6
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0890	5.3	7.7
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2661	2.7	3.6
235 ...	08	MED	FRACTURES OF FEMUR	.7582	3.8	5.2
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7218	4.0	5.0
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5681	3.0	3.7
238 ...	08	MED	OSTEOMYELITIS	1.3496	6.4	8.6
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	.9745	4.9	6.2
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2712	4.9	6.6
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6177	3.1	3.9
242 ...	08	MED	SEPTIC ARTHRITIS	1.0724	5.1	6.6
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7262	3.7	4.7
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7155	3.7	4.8
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4832	2.8	3.6
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5570	2.9	3.6
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5696	2.6	3.5
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7864	3.7	4.8
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6913	2.6	3.8
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6929	3.3	4.3
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4995	2.4	3.0
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	.2538	1.8	1.8
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	.7253	3.7	4.7
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	.4413	2.6	3.2
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17.	.2956	2.9	2.9
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7959	3.8	5.2
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9107	2.3	2.8
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7232	1.8	2.0
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.9068	1.8	2.8
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6532	1.3	1.4
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9362	1.7	2.2
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8754	2.7	3.8
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.1219	8.9	12.2
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1479	5.4	7.2
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5309	4.3	6.6
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8707	2.4	3.3
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	1.0792	3.1	5.2
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1405	2.4	3.7
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7004	5.8	8.3
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7670	2.3	3.3
271 ...	09	MED	SKIN ULCERS	1.0104	5.5	7.1
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	.9994	4.8	6.3
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6179	3.2	4.2
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.2061	4.9	7.0
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5301	2.4	3.4
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6899	3.6	4.6
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8396	4.7	5.7
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5522	3.6	4.3
279 ...	09	MED	*CELLULITIS AGE 0–17	.6644	4.2	4.2
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6788	3.2	4.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4729	2.4	3.1
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2570	2.2	2.2
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.6917	3.5	4.6
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4336	2.5	3.2
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	1.9961	7.7	10.5
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.1299	4.9	6.2
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8283	7.8	10.5
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1607	4.5	5.7
289 ...	10	SURG	PARATHYROID PROCEDURES	.9914	2.0	3.1
290 ...	10	SURG	THYROID PROCEDURES	.9193	1.8	2.4
291 ...	10	SURG	THYROGLOSSAL PROCEDURES	.5487	1.4	1.6
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4538	6.9	10.0
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2289	3.6	5.1
294 ...	10	MED	DIABETES AGE >35	.7589	3.6	4.7
295 ...	10	MED	DIABETES AGE 0–35	.7587	2.9	3.9
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8594	4.0	5.2
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5179	2.8	3.5
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.5269	2.5	3.1
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.9632	4.0	5.6
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.0829	4.7	6.1
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.6133	2.9	3.7
302 ...	11	SURG	KIDNEY TRANSPLANT	3.4241	7.9	9.4
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.4602	7.0	8.5
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3407	6.4	8.9
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1825	3.1	3.8
306 ...	11	SURG	PROSTATECTOMY W CC	1.2489	3.7	5.5
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6460	1.9	2.3
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6449	4.2	6.4
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9339	2.0	2.5
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1172	3.0	4.4
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6174	1.6	1.9
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0173	3.0	4.5
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6444	1.7	2.1
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4953	2.3	2.3
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0474	4.2	7.5
316 ...	11	MED	RENAL FAILURE	1.3424	4.9	6.7
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.7395	2.1	3.2
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1313	4.3	6.0
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6040	2.2	2.9
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8621	4.3	5.4
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5686	3.2	3.8
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.4939	3.3	4.1
323 ...	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7996	2.4	3.2
324 ...	11	MED	URINARY STONES W/O CC	.4509	1.6	1.9
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6460	3.0	3.9
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4297	2.1	2.7
327 ...	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3543	3.1	3.1
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7455	2.8	3.9
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.5253	1.7	2.0
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3191	1.6	1.6
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0221	4.1	5.6
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.5997	2.5	3.3
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.8247	3.5	5.0
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5591	4.2	4.9
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1697	3.2	3.4
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8880	2.7	3.5
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6152	1.9	2.2
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.1900	3.5	5.3
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0769	3.0	4.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2835	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.1709	2.1	3.2
342	12	SURG	CIRCUMCISION AGE >17	.8240	2.5	3.1
343	12	SURG	*CIRCUMCISION AGE 0–17	.1541	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.1519	1.6	2.3
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8800	2.6	3.8
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9756	4.3	5.8
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5922	2.4	3.4
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7142	3.2	4.2
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4380	2.0	2.6
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6992	3.6	4.4
351	12	MED	*STERILIZATION, MALE	.2364	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6858	2.8	3.8
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9292	5.3	6.7
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5284	4.9	5.9
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9278	3.1	3.3
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7846	2.1	2.4
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3628	6.9	8.5
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2263	3.7	4.4
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8593	2.6	2.8
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8860	2.4	3.0
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.2318	2.2	3.5
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3022	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.8136	2.5	3.5
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.7530	2.6	3.6
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8425	4.9	7.3
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2467	4.8	6.8
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5676	2.4	3.2
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1205	5.0	6.7
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5704	2.4	3.2
370	14	SURG	CESAREAN SECTION W CC	1.0631	4.4	5.7
371	14	SURG	CESAREAN SECTION W/O CC	.7157	3.3	3.6
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.6077	2.7	3.5
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4169	2.0	2.3
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7565	2.6	3.4
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6860	4.4	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5224	2.6	3.5
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.8899	2.6	3.8
378	14	MED	ECTOPIC PREGNANCY	.7664	2.0	2.3
379	14	MED	THREATENED ABORTION	.3959	2.0	3.1
380	14	MED	ABORTION W/O D&C	.4843	1.8	2.2
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.5331	1.5	1.9
382	14	MED	FALSE LABOR	.2127	1.3	1.5
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.5137	2.7	3.9
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3161	1.6	2.3
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3767	1.8	1.8
386	15	MED	*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5400	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.1007	13.3	13.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8709	8.6	8.6
389	15	MED	*FULL TERM NEONATE W MAJOR PROBLEMS	1.8408	4.7	4.7
390	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	.9471	3.0	4.0
391	15	MED	*NORMAL NEWBORN	.1527	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.1739	7.1	9.5
393	16	SURG	*SPLENECTOMY AGE 0–17	1.3486	9.1	9.1

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
394 ...	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.5969	4.1	6.7
395 ...	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8257	3.3	4.5
396 ...	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	1.1573	2.5	3.8
397 ...	16	MED	COAGULATION DISORDERS	1.2278	3.8	5.2
398 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2750	4.7	6.0
399 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6881	2.8	3.6
400 ...	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6309	5.8	9.1
401 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.7198	7.8	11.2
402 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0985	2.8	4.0
403 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7594	5.7	8.1
404 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8480	3.1	4.2
405 ...	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	1.9120	4.9	4.9
406 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.8275	7.6	10.3
407 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.3179	3.6	4.4
408 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.0008	4.8	7.7
409 ...	17	MED	RADIOTHERAPY	1.1215	4.4	5.9
410 ...	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.9468	2.9	3.7
411 ...	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3305	2.0	2.3
412 ...	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4841	2.0	2.7
413 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3645	5.3	7.3
414 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7548	3.0	4.1
415 ...	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5925	10.4	14.3
416 ...	18	MED	SEPTICEMIA AGE >17	1.5278	5.5	7.4
417 ...	18	MED	SEPTICEMIA AGE 0–17	1.1717	3.7	6.0
418 ...	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0074	4.8	6.2
419 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8709	3.7	4.8
420 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6057	3.0	3.6
421 ...	18	MED	VIRAL ILLNESS AGE >17	.6796	3.1	3.9
422 ...	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.7854	2.8	5.1
423 ...	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.7250	5.9	8.2
424 ...	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.2810	8.7	13.5
425 ...	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION.	.7031	3.0	4.1
426 ...	19	MED	DEPRESSIVE NEUROSES	.5301	3.3	4.6
427 ...	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5637	3.3	5.0
428 ...	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7342	4.4	7.1
429 ...	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8530	4.9	6.7
430 ...	19	MED	PSYCHOSES	.7644	5.8	8.2
431 ...	19	MED	CHILDHOOD MENTAL DISORDERS	.6392	4.8	6.6
432 ...	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.6546	3.2	4.8
433 ...	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2824	2.2	3.0
434 ...	20	MED	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7256	3.9	5.1
435 ...	20	MED	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4176	3.4	4.3
436 ...	20	MED	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.7433	10.3	12.9
437 ...	20	MED	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.6606	7.5	9.0
438 ...	20		NO LONGER VALID	.0000	.0	.0
439 ...	21	SURG	SKIN GRAFTS FOR INJURIES	1.7092	5.3	8.2
440 ...	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9096	5.8	8.9
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9463	2.2	3.3
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.3403	5.4	8.3
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9978	2.5	3.4
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7243	3.2	4.2
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.5076	2.4	3.0
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2964	2.4	2.4
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.5166	1.9	2.5
448 ...	21	MED	*ALLERGIC REACTIONS AGE 0–17	.0975	2.9	2.9

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8076	2.6	3.7
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4406	1.6	2.0
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2632	2.1	2.1
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0152	3.5	5.0
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4987	2.2	2.8
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8593	3.2	4.6
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4672	2.0	2.6
456 ...			NO LONGER VALID	.0000	.0	.0
457 ...			NO LONGER VALID	.0000	.0	.0
458 ...			NO LONGER VALID	.0000	.0	.0
459 ...			NO LONGER VALID	.0000	.0	.0
460 ...			NO LONGER VALID	.0000	.0	.0
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.2101	2.4	4.6
462 ...	23	MED	REHABILITATION	1.2401	9.4	11.7
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.6936	3.3	4.3
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.4775	2.4	3.1
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5756	2.1	3.4
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6840	2.3	3.9
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.5112	2.3	4.1
468 ...			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6399	9.2	13.0
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.	3.1957	5.0	5.7
472 ...			NO LONGER VALID	.0000	.0	.0
473 ...	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5822	7.6	13.2
474 ...			NO LONGER VALID	.0000	.0	.0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6936	8.1	11.3
476 ...		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2547	8.4	11.7
477 ...		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8204	5.4	8.1
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3333	4.9	7.3
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4326	2.8	3.6
480 ...	PRE	SURG	LIVER TRANSPLANT	9.4744	14.7	19.5
481 ...	PRE	SURG	BONE MARROW TRANSPLANT	8.6120	23.8	26.6
482 ...	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.5785	10.0	12.9
483 ...	PRE	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	15.9677	33.7	41.2
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5606	8.8	13.1
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.0998	7.7	9.5
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.9048	8.1	12.2
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0604	5.6	7.8
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.5574	11.5	17.0
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.7414	6.0	8.6
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9680	3.7	5.1
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6685	2.9	3.5
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.2467	10.9	16.1
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8180	4.3	5.7
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0388	2.0	2.5
495 ...	PRE	SURG	LUNG TRANSPLANT	8.6087	13.4	20.5
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.5532	7.8	10.0
497 ...	08	SURG	SPINAL FUSION W CC	2.9441	4.9	6.2
498 ...	08	SURG	SPINAL FUSION W/O CC	1.9057	2.8	3.4
499 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4572	3.6	4.8
500 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9805	2.2	2.7
501 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6283	8.4	10.6
502 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4434	4.9	6.0
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2156	3.1	4.0
504 ...	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	12.6064	24.1	30.5

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
505 ...	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0166	2.5	4.7
506 ...	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.4825	12.9	17.6
507 ...	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8560	6.6	9.3
508 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.3302	5.1	7.3
509 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8071	4.1	6.2
510 ...	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.4088	5.2	7.9
511 ...	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.6536	3.1	4.5

*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 PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
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
007.5	Cyclosporiasis	N	6	182, 183,184
082.40	Unspecified ehrlichiosis	N	18	423
082.41	Ehrlichiosis Chafiensis (E. Chafiensis)	N	18	423
082.49	Other ehrlichiosis	N	18	423
285.21	Anemia in end-stage renal disease	N	16	395, 396
285.22	Anemia in neoplastic disease	N	16	395, 396
285.29	Anemia of other chronic illness	N	16	395, 396
294.10	Dementia in conditions classified elsewhere without behavioral disturbance	N	19	429
294.11	Dementia in conditions classified elsewhere with behavioral disturbance	N	19	429
372.81	Conjunctivochalasis	N	2	46, 47, 48
372.89	Other disorders of conjunctiva	N	2	46, 47, 48
477.1	Allergic rhinitis, due to food	N	3	68, 69, 70
493.02	Extrinsic asthma, with acute exacerbation	Y	4	96, 97, 98
493.12	Intrinsic asthma, with acute exacerbation	Y	4	96, 97, 98
493.22	Chronic obstructive asthma, with acute exacerbation	Y	4	88
493.92	Unspecified asthma, with acute exacerbation	Y	4	96, 97, 98
494.0	Bronchiectasis without acute exacerbation	N	4	88
494.1	Bronchiectasis with acute exacerbation	Y	4	88
558.3	Allergic gastroenteritis and colitis	N	6	182, 183, 184
600.0	Hypertrophy (benign) of prostate	N	12	348, 349
600.1	Nodular prostate	N	12	348, 349
600.2	Benign localized hyperplasia of prostate	N	12	348, 349
600.3	Cyst of prostate	N	12	348, 349
600.9	Unspecified hyperplasia of prostate	N	12	348, 349
645.10	Post term pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.11	Post term pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.13	Post term pregnancy, antepartum condition or complication	N	14	383, 384
645.20	Prolonged pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.21	Prolonged pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.23	Prolonged pregnancy, antepartum condition or complication	N	14	383, 384
692.75	Disseminated superficial actinic porokeratosis (DSAP)	N	9	283, 284
707.10	Unspecified ulcer of lower limb	Y	9	263, 264, 271
707.11	Ulcer of thigh	Y	9	263, 264, 271
707.12	Ulcer of calf	Y	9	263, 264, 271
707.13	Ulcer of ankle	Y	9	263, 264, 271
707.14	Ulcer of heel and midfoot	Y	9	263, 264, 271
707.15	Ulcer of other part of foot	Y	9	263, 264, 271
707.19	Ulcer of other part of lower limb	Y	9	263, 264, 271
727.83	Plica syndrome	N	8	248
781.91	Loss of height	N	1	34, 35
781.92	Abnormal posture	N	1	34, 35
781.99	Other symptoms involving nervous and musculoskeletal systems	N	1	34, 35
783.21	Loss of weight	N	10	296, 297, 298
783.22	Underweight	N	10	296, 297, 298
783.40	Unspecified lack of normal physiological development	N	10	296, 297, 298

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
783.41	Failure to thrive	N	10	296, 297, 298
783.42	Delayed milestones	N	10	296, 297, 298
783.43	Short stature	N	10	296, 297, 298
783.7	Adult failure to thrive	N	10	296, 297, 298
790.01	Precipitous drop in hematocrit	N	16	395, 396
790.09	Other abnormality of red blood cells	N	16	395, 396
792.5	Cloudy (hemodialysis) (peritoneal) dialysis effluent	N	23	463, 464
995.7	Other adverse food reactions, not elsewhere classified	N	21	454, 455
996.87	Complications of transplanted organ, intestine	Y	21	452, 453
V15.01	Allergy to peanuts	N	23	467
V15.02	Allergy to milk products	N	23	467
V15.03	Allergy to eggs	N	23	467
V15.04	Allergy to seafood	N	23	467
V15.05	Allergy to other foods	N	23	467
V15.06	Allergy to insects	N	23	467
V15.07	Allergy to latex	N	23	467
V15.08	Allergy to radiographic dye	N	23	467
V15.09	Other allergy, other than to medicinal agents	N	23	467
V21.30	Unspecified low birth weight status	N	23	467
V21.31	Low birth weight status, less than 500 grams	N	23	467
V21.32	Low birth weight status, 500–999 grams	N	23	467
V21.33	Low birth weight status, 1000–1499 grams	N	23	467
V21.34	Low birth weight status, 1500–1999 grams	N	23	467
V21.35	Low birth weight status, 2000–2500 grams	N	23	467
V26.21	Fertility testing	N	23	467
V26.22	Aftercare following sterilization reversal	N	23	467
V26.29	Other investigation and testing	N	23	467
V42.84	Organ or tissue replaced by transplant, intestines	Y	23	467
V45.74	Acquired absence of organ, other parts of urinary tract	N	11	331, 332, 333
V45.75	Acquired absence of organ, stomach	N	23	467
V45.76	Acquired absence of organ, lung	N	4	101, 102
V45.77	Acquired absence of organ, genital organs	N	12	352
			13	358, 359, 369
V45.78	Acquired absence of organ, eye	N	2	46, 47, 48
V45.79	Other acquired absence of organ	N	23	467
V49.81	Postmenopausal status (age-related) (natural)	N	23	467
V49.89	Other specified conditions influencing health status	N	23	467
V56.31	Encounter for adequacy testing for hemodialysis	N	11	317
V56.32	Encounter for adequacy testing for peritoneal dialysis	N	11	317
V58.83	Encounter for therapeutic drug monitoring	N	23	465, 466
V67.00	Follow-up examination, following unspecified surgery	N	23	465, 466
V67.01	Following surgery, follow-up vaginal pap smear	N	23	465, 466
V67.09	Follow-up examination, following other surgery	N	23	465, 466
V71.81	Observation for suspected abuse and neglect	N	23	467
V71.89	Observation for other specified suspected conditions	N	23	467
V76.46	Special screening for malignant neoplasms, ovary	N	23	467
V76.47	Special screening for malignant neoplasms, Vagina	N	23	467
V76.50	Special screening for malignant neoplasms, unspecified intestine	N	23	467
V76.51	Special screening for malignant neoplasms, colon	N	23	467
V76.52	Special screening for malignant neoplasms, small intestine	N	23	467
V76.81	Special screening for malignant neoplasms, nervous system	N	23	467
V76.89	Special screening for other malignant neoplasm	N	23	467
V77.91	Screening for lipoid disorders	N	23	467
V77.99	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders.	N	23	467
V82.81	Special screening for osteoporosis	N	23	467
V82.89	Special screening for other specified conditions	N	23	467

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
39.71	Endovascular implantation of graft in abdominal aorta	Y	5	110, 111
			11	315
			21	442, 443
			24	486

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
39.79	Other endovascular graft repair of aneurysm	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443
			24	486
41.07	Autologous hematopoietic stem cell transplant with purging	Y	PRE	481
41.08	Allogeneic hematopoietic stem cell transplant with purging	Y	PRE	481
41.09	Autologous bone marrow transplant with purging	Y	PRE	481
46.97	Transplant of intestine	Y	6	148, 149
			7	201
			17	400, 406, 407
			21	442, 443
			24	486
60.96	Transurethral destruction of prostate tissue by microwave thermotherapy	Y	11	306, 307
			12	1336, 337
			UNR	476
60.97	Other transurethral destruction of prostate tissue by other thermotherapy	Y	11	306, 307
			12	336, 337
			UNR	476
99.75	Administration of neuroprotective agent	N		

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
294.1	Dementia in conditions classified elsewhere	N	19	429
372.8	Other disorders of conjunctiva	N	2	46, 47, 48
494	Bronchiectasis	Y	4	88
600	Hyperplasia of prostate	N	12	348, 349
645.00	Prolonged pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.01	Prolonged pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.03	Prolonged pregnancy, antepartum condition or complication	N	14	383, 384
707.1	Ulcer of lower limb, except decubitus	Y	9	263, 264, 271
781.9	Other symptoms involving nervous and musculoskeletal systems	N	1	34, 35
783.2	Abnormal loss of weight	N	10	296, 297, 298
783.4	Lack of expected normal physiological development	N	10	296, 297, 298
790.0	Abnormality of red blood cells	N	16	395, 396
V15.0	Allergy, other than to medicinal agents	N	23	467
V26.2	Investigation and testing	N	23	467
V49.8	Other specified problems influencing health status	N	23	467
V67.0	Follow-up examination following surgery	N	23	465, 466
V71.8	Observation for other specified suspected conditions	N	23	467
V76.8	Special screening for malignant neoplasms, other neoplasm	N	23	467
V77.9	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders.	N	23	467
V82.8	Special screening for other specified conditions	N	23	467

TABLE 6D.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
564.1	Irritable bowel syndrome	N	6	182
				183
				184
V26.3	Genetic counseling and testing	N	23	467
V76.49	Special screening for malignant, other sites	N	23	467

TABLE 6E.—REVISED PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
41.01	Autologous bone marrow transplant without purging	Y	PRE	481
41.04	Autologous hematopoietic stem cell transplant without purging	Y	PRE	481
41.05	Allogeneic hematopoietic stem cell transplant without purging	Y	PRE	481

TABLE 6E.—REVISED PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
86.59	Closure of skin and subcutaneous tissue other sites	N		

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST

[CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*0075	2818	70713	49312	01170	4870	01152	4829
00841	2824	70714	49322	01171	4950	01153	4830
00842	28260	70715	49392	01172	4951	01154	4831
00843	28261	70719	*49391	01173	4952	01155	4838
00844	28262	*4871	49302	01174	4953	01156	4841
00845	28263	4941	49312	01175	4954	01160	4843
00846	28269	*49300	49322	01176	4955	01161	4845
00847	2830	49302	49392	01180	4956	01162	4846
00849	28310	49312	*49392	01181	4957	01163	4847
*01790	28311	49322	49301	01182	4958	01164	4848
4941	28319	49392	49302	01183	4959	01165	485
*01791	2832	*49301	49311	01184	496	01166	486
4941	2839	49302	49312	01185	5060	01170	4870
*01792	2840	49312	49320	01186	5061	01171	4941
4941	2848	49322	49321	01190	5070	01172	4950
*01793	2849	49392	49322	01191	5071	01173	4951
4941	2850	*49302	49391	01192	5078	01174	4952
*01794	2851	49301	49392	01193	5080	01175	4953
4941	*29410	49302	*4940	01194	5081	01176	4954
*01795	2910	49311	01100	01195	515	01180	4955
4941	2911	49312	01101	01196	5160	01181	4956
*01796	2912	49320	01102	01200	5161	01182	4957
4941	2913	49321	01103	01201	5162	01183	4958
*28521	2914	49322	01104	01202	5163	01184	4959
2800	29181	49391	01105	01203	5168	01185	496
2814	29189	49392	01106	01204	5169	01186	5060
2818	2919	*49310	01110	01205	5171	01190	5061
2824	2920	49302	01111	01206	5172	01191	5070
28260	29211	49312	01112	01210	5178	01192	5071
28261	29212	49322	01113	01211	74861	01193	5078
28262	2922	49392	01114	01212	*4941	01194	5080
28263	29281	*49311	01115	01213	01100	01195	5081
28269	29282	49302	01116	01214	01101	01196	515
2830	29283	49312	01120	01215	01102	01200	5160
28310	29284	49322	01121	01216	01103	01201	5161
28311	29289	49392	01122	0310	01104	01202	5162
28319	2929	*49312	01123	11505	01105	01203	5163
2832	29381	49301	01124	11515	01106	01204	5168
2839	29382	49302	01125	1304	01110	01205	5169
2840	29383	49311	01126	1363	01111	01206	5171
2848	29384	49312	01130	481	01112	01210	5172
2849	*29411	49320	01131	4820	01113	01211	5178
2850	2910	49321	01132	4821	01114	01212	74861
2851	2911	49322	01133	4822	01115	01213	*496
*28522	2912	49391	01134	48230	01116	01214	4941
2800	2913	49392	01135	48231	01120	01215	*5061
2814	2914	*49320	01136	48232	01121	01216	4941
2818	29181	49302	01140	48239	01122	0310	*5064
2824	29189	49312	01141	48240	01123	11505	4941
28260	2919	49322	01142	48241	01124	11515	*5069
28261	2920	49392	01143	48249	01125	1304	4941
28262	29211	*49321	01144	48281	01126	1363	*5178
28263	29212	49302	01145	48282	01130	481	49302
28269	2922	49312	01146	48283	01131	4820	49312
2830	29281	49322	01150	48284	01132	4821	49322
28310	29282	49392	01151	48289	01133	4822	49392
28311	29283	*49322	01152	4829	01134	48230	*51889
28319	29284	49301	01153	4830	01135	48231	49302
2832	29289	49302	01154	4831	01136	48232	49312
2839	2929	49311	01155	4838	01140	48239	49322
2840	29381	49312	01156	4841	01141	48240	49392
2848	29382	49320	01160	4843	01142	48241	*5198
2849	29383	49321	01161	4845	01143	48249	49302
2850	29384	49322	01162	4846	01144	48281	49312
2851	*44023	49391	01163	4847	01145	48282	49322
*28529	70710	49392	01164	4848	01146	48283	49392
2800	70711	*49390	01165	485	01150	48284	*5199
2814	70712	49302	01166	486	01151	48289	49302
49312	*70712	V421					
49322	70710	V426					
49392	70711	V427					
*5583	70712	V4281					

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

00841	70713	V4282
00842	70714	V4283
00843	70715	V4289
00844	70719	V432
00845	*70713	*99689
00846	70710	V4284
00847	70711	*99791
00849	70712	99687
*6000	70713	*99799
5960	70714	99687
5996	70715	*V4284
6010	70719	V4284
6012	*70714	*V4289
6013	70710	V4284
6021	70711	*V429
78820	70712	V4284
78829	70713	
*6001	70714	
5960	70715	
5996	70719	
6010	*70715	
6012	70710	
6013	70711	
6021	70712	
78820	70713	
78829	70714	
*6002	70715	
5960	70719	
5996	*70719	
6010	70710	
6012	70711	
6013	70712	
6021	70713	
78820	70714	
78829	70715	
*6003	70719	
5960	*7078	
5996	70710	
6010	70711	
6012	70712	
6013	70713	
6021	70714	
78820	70715	
78829	70719	
*6009	*7079	
5960	70710	
5996	70711	
6010	70712	
6012	70713	
6013	70714	
6021	70715	
78820	70719	
78829	*7098	
*70710	70710	
70710	70711	
70711	70712	
70712	70713	
70713	70714	
70714	70715	
70715	70719	
70719	*74861	
*70711	4941	
70710	*99680	
70711	99687	
70712	V4284	
70713	*99687	
70714	99680	
70715	99687	
70719	V420	

TABLE 6G.—DELETIONS TO THE CC EXCLUSIONS LIST

[CCs that are deleted from the list are in Table 6G—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*01790	01135	48231	6021
494	01136	48232	78820
*01791	01140	48239	78829
494	01141	48240	*7071
*01792	01142	48241	7071
494	01143	48249	*7078
*01793	01144	48281	7071
494	01145	48282	*7079
*01794	01146	48283	7071
494	01150	48284	*7098
*01795	01151	48289	7071
494	01152	4829	*74861
*01796	01153	4830	494
494	01154	4831	
*2941	01155	4838	
2910	01156	4841	
2911	01160	4843	
2912	01161	4845	
2913	01162	4846	
2914	01163	4847	
29181	01164	4848	
29189	01165	485	
2919	01166	486	

TABLE 6G.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in Table 6G—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

2920	01170	4870
29211	01171	494
29212	01172	4950
2922	01173	4951
29281	01174	4952
29282	01175	4953
29283	01176	4954
29284	01180	4955
29289	01181	4956
2929	01182	4957
29381	01183	4958
29382	01184	4959
29383	01185	496
29384	01186	5060
*44023	01190	5061
7071	01191	5070
*4871	01192	5071
494	01193	5078
*494	01194	5080
01100	01195	5081
01101	01196	515
01102	01200	5160
01103	01201	5161

TABLE 6G.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in Table 6G—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

01104	01202	5162
01105	01203	5163
01106	01204	5168
01110	01205	5169
01111	01206	5171
01112	01210	5172
01113	01211	5178
01114	01212	74861
01115	01213	*496
01116	01214	494
01120	01215	*5061
01121	01216	494
01122	0310	*5064
01123	11505	494
01124	11515	*5069
01125	1304	494
01126	1363	*600
01130	481	5960
01131	4820	5996
01132	4821	6010
01133	4822	6012
01134	48230	6013

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35352	9.1033	2	3	6	12	19
2	7158	9.6855	3	5	7	12	19
4	6095	7.3505	1	2	5	9	16
5	95604	3.2875	1	1	2	4	7
6	341	3.2405	1	1	2	4	7
7	12148	10.2934	2	4	7	13	21
8	3705	3.0103	1	1	2	4	7
9	1657	6.4484	1	3	5	8	12
10	18437	6.5993	2	3	5	8	13
11	3331	4.1654	1	2	3	5	8
12	45110	6.0509	2	3	4	7	11
13	6256	5.0973	2	3	4	6	9
14	331649	5.9608	2	3	5	7	11
15	140366	3.6304	1	2	3	5	7
16	11170	6.1346	2	3	5	7	12
17	3453	3.3687	1	2	3	4	6
18	26134	5.5426	2	3	4	7	10
19	8011	3.7410	1	2	3	5	7
20	5780	10.2894	3	5	8	13	20
21	1368	6.8575	2	3	5	9	13
22	2519	4.9389	2	2	4	6	9
23	8375	4.2302	1	2	3	5	8
24	52871	5.0135	1	2	4	6	10
25	24604	3.3081	1	2	3	4	6
26	20	3.2000	1	1	2	3	7
27	3645	5.1084	1	1	3	6	12
28	10833	6.2260	1	3	5	8	13
29	3985	3.7064	1	2	3	5	7
31	3301	4.2293	1	2	3	5	8
32	1585	2.7356	1	1	2	3	5
34	19657	5.1974	1	2	4	6	10
35	5225	3.4195	1	2	3	4	6
36	4249	1.3641	1	1	1	1	2
37	1494	3.6921	1	1	3	5	8
38	115	2.5304	1	1	1	3	5
39	1160	1.9112	1	1	1	2	4
40	1765	3.5955	1	1	2	4	8
41	1	4.0000	4	4	4	4	4
42	2723	2.2277	1	1	1	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
43	86	3.3605	1	2	3	4	7
44	1237	4.9871	2	3	4	6	9
45	2509	3.2790	1	2	3	4	6
46	2971	4.5796	1	2	4	6	9
47	1180	3.3034	1	1	3	4	6
49	2245	4.9675	1	2	4	6	9
50	2587	1.9849	1	1	1	2	3
51	264	2.5303	1	1	1	3	6
52	198	2.1414	1	1	1	2	5
53	2594	3.6727	1	1	2	4	8
54	4	1.5000	1	1	1	1	3
55	1573	2.8843	1	1	1	3	6
56	533	3.0507	1	1	2	4	6
57	587	3.9642	1	1	2	4	8
59	115	2.5304	1	1	2	3	5
60	2	1.0000	1	1	1	1	1
61	212	4.8302	1	1	2	6	13
62	2	3.5000	2	2	5	5	5
63	3207	4.2728	1	2	3	5	9
64	3189	6.5124	1	2	4	8	14
65	31923	2.8964	1	1	2	4	5
66	6984	3.1714	1	1	3	4	6
67	482	3.5270	1	2	3	4	7
68	13482	4.1567	1	2	3	5	8
69	4254	3.2795	1	2	3	4	6
70	33	2.9091	1	2	3	4	5
71	105	3.8667	1	2	3	6	7
72	824	3.2961	1	2	3	4	6
73	6461	4.3439	1	2	3	5	8
75	39513	10.0058	3	5	8	12	20
76	40171	11.2717	3	5	9	14	21
77	2385	4.8776	1	2	4	7	10
78	30651	6.9464	3	5	6	8	11
79	183896	8.4642	3	4	7	11	16
80	8331	5.6766	2	3	5	7	10
81	5	9.2000	2	2	10	10	19
82	64149	6.9422	2	3	5	9	14
83	6603	5.5326	2	3	4	7	10
84	1549	3.3719	1	2	3	4	6
85	20158	6.3636	2	3	5	8	12
86	1940	3.7845	1	2	3	5	7
87	63294	6.2499	1	3	5	8	12
88	405792	5.2217	2	3	4	7	9
89	526310	6.0247	2	3	5	7	11
90	51516	4.2278	2	3	4	5	7
91	49	3.3469	1	2	3	4	5
92	13842	6.2457	2	3	5	8	12
93	1557	3.9878	1	2	3	5	7
94	12470	6.3005	2	3	5	8	12
95	1589	3.6916	1	2	3	5	7
96	65180	4.7269	2	3	4	6	8
97	31758	3.6849	1	2	3	5	7
98	20	4.7000	1	1	3	6	7
99	18316	3.2260	1	1	2	4	6
100	7279	2.2124	1	1	2	3	4
101	19889	4.4315	1	2	3	6	8
102	5030	2.7356	1	1	2	3	5
103	461	49.5466	9	12	30	68	118
104	33364	11.6306	3	6	10	15	22
105	29546	9.2855	4	5	7	11	17
106	3820	11.2010	5	7	9	13	19
107	91043	10.3489	5	7	9	12	17
108	5267	10.5590	3	5	8	13	20
109	61942	7.7332	4	5	6	9	13
110	55263	9.4599	2	5	8	11	18
111	7172	5.4762	2	4	5	7	8
112	61239	3.7597	1	1	3	5	8
113	44445	12.0916	3	6	9	15	24
114	8543	8.2800	2	4	7	10	16
115	14129	8.4099	1	4	7	11	16

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
116	309840	3.7279	1	1	3	5	8
117	3419	4.0433	1	1	2	5	9
118	6687	2.8065	1	1	1	3	6
119	1461	4.8542	1	1	3	6	12
120	36980	8.1173	1	2	5	10	18
121	164131	6.4386	2	3	5	8	12
122	81181	3.8293	1	2	3	5	7
123	41102	4.5805	1	1	3	6	11
124	135568	4.3735	1	2	3	6	8
125	75438	2.7854	1	1	2	4	5
126	5171	11.7343	3	6	9	14	23
127	683849	5.3364	2	3	4	7	10
128	11601	5.8042	3	4	5	7	9
129	4224	2.8570	1	1	1	3	7
130	89606	5.8064	2	3	5	7	10
131	27035	4.3769	1	3	4	6	7
132	153726	3.0483	1	1	2	4	6
133	7633	2.3958	1	1	2	3	4
134	33046	3.2976	1	2	3	4	6
135	7144	4.4709	1	2	3	5	9
136	1170	2.9103	1	1	2	4	6
138	192439	4.0078	1	2	3	5	8
139	77691	2.5071	1	1	2	3	5
140	76921	2.7133	1	1	2	3	5
141	86225	3.7087	1	2	3	5	7
142	42891	2.6783	1	1	2	3	5
143	186941	2.1669	1	1	2	3	4
144	79553	5.3212	1	2	4	7	11
145	6948	2.8094	1	1	2	4	5
146	11289	10.1758	5	7	9	12	17
147	2427	6.6135	3	5	6	8	10
148	135012	12.1210	5	7	10	14	22
149	17660	6.6535	4	5	6	8	10
150	20425	11.1526	4	7	9	14	20
151	4513	5.9280	2	3	5	8	10
152	4470	8.1953	3	5	7	10	14
153	1931	5.4604	3	4	5	7	8
154	29554	13.2574	4	7	10	16	25
155	6109	4.3495	1	2	3	6	8
156	2	28.0000	28	28	28	28	28
157	8234	5.4966	1	2	4	7	11
158	4427	2.6286	1	1	2	3	5
159	16536	5.0206	1	2	4	6	10
160	11065	2.7237	1	1	2	4	5
161	11551	4.1674	1	2	3	5	9
162	7067	1.9544	1	1	1	2	4
163	10	2.9000	1	1	3	3	6
164	4748	8.3981	4	5	7	10	14
165	1953	4.8561	2	3	5	6	8
166	3332	5.0789	2	3	4	6	9
167	2935	2.7097	1	2	2	3	5
168	1530	4.6556	1	2	3	6	9
169	810	2.4247	1	1	2	3	5
170	11351	11.1690	2	5	8	14	23
171	1132	4.8012	1	2	4	6	9
172	30708	6.9805	2	3	5	9	14
173	2516	3.8557	1	1	3	5	8
174	237582	4.8236	2	3	4	6	9
175	28223	2.9429	1	2	3	4	5
176	15708	5.2687	2	3	4	6	10
177	9539	4.5524	2	2	4	6	8
178	3601	3.1427	1	2	3	4	6
179	12290	6.0134	2	3	5	7	11
180	85528	5.3979	2	3	4	7	10
181	24458	3.4102	1	2	3	4	6
182	234044	4.3621	1	2	3	5	8
183	79010	2.9636	1	1	2	4	6
184	99	3.2525	1	2	3	4	5
185	4361	4.5015	1	2	3	6	9
186	2	4.5000	2	2	7	7	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
187	747	3.8220	1	2	3	5	8
188	75016	5.5813	1	2	4	7	11
189	11186	3.1402	1	1	2	4	6
190	70	5.9857	2	3	4	6	11
191	9437	14.1379	4	7	10	18	28
192	984	6.5996	2	4	6	8	11
193	5705	12.5550	5	7	10	15	23
194	763	6.7720	2	4	6	8	12
195	4898	9.8944	4	6	8	12	17
196	1197	5.6942	2	4	5	7	9
197	20367	8.7332	3	5	7	11	16
198	6123	4.5065	2	3	4	6	8
199	1745	9.6682	3	4	8	13	19
200	1084	10.7694	2	4	8	14	22
201	1483	13.8206	3	6	11	18	27
202	25781	6.5065	2	3	5	8	13
203	29166	6.6874	2	3	5	9	13
204	55210	5.8583	2	3	4	7	11
205	22715	6.2907	2	3	5	8	12
206	1792	3.8337	1	2	3	5	7
207	30992	5.1140	1	2	4	6	10
208	9690	2.8994	1	1	2	4	6
209	343780	5.1256	3	3	4	6	8
210	127326	6.8134	3	4	6	8	11
211	31422	4.9172	3	4	4	6	7
212	7	3.0000	2	2	2	3	4
213	8933	8.7283	2	4	7	11	17
216	5871	9.7808	2	4	7	12	20
217	17768	13.1592	3	5	9	16	28
218	21587	5.3674	2	3	4	6	10
219	19362	3.2518	1	2	3	4	5
220	3	2.3333	1	1	2	4	4
223	17578	2.5862	1	1	2	3	5
224	8041	2.0520	1	1	2	3	4
225	5639	4.7074	1	2	3	6	10
226	5033	6.3012	1	2	4	8	13
227	4462	2.6627	1	1	2	3	5
228	2477	3.5620	1	1	2	4	8
229	1092	2.4011	1	1	2	3	5
230	2116	5.0865	1	2	3	6	10
231	10738	4.8361	1	2	3	6	10
232	571	3.5692	1	1	2	4	9
233	4608	7.7129	2	3	6	10	16
234	2701	3.5724	1	2	3	4	7
235	5378	5.1264	1	2	4	6	10
236	38845	4.8570	1	3	4	6	9
237	1587	3.7284	1	2	3	5	7
238	7674	8.4730	3	4	6	10	16
239	51992	6.2172	2	3	5	8	12
240	11950	6.5921	2	3	5	8	13
241	2981	3.9410	1	2	3	5	7
242	2498	6.5524	2	3	5	8	12
243	85571	4.7006	1	3	4	6	9
244	11962	4.7800	1	2	4	6	9
245	4967	3.7246	1	2	3	4	7
246	1344	3.6384	1	2	3	4	7
247	15158	3.4474	1	1	3	4	7
248	9412	4.7385	1	2	4	6	9
249	10792	3.7782	1	1	3	5	8
250	3543	4.2484	1	2	3	5	8
251	2382	2.9866	1	1	3	4	5
252	1	2.0000	2	2	2	2	2
253	19064	4.6962	1	3	4	6	9
254	10447	3.2049	1	2	3	4	6
255	1	1.0000	1	1	1	1	1
256	5875	5.1384	1	2	4	6	10
257	16895	2.8284	1	2	2	3	5
258	15820	2.0011	1	1	2	2	3
259	3743	2.7919	1	1	1	3	6
260	4815	1.4332	1	1	1	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
261	1766	2.1682	1	1	1	2	4
262	686	3.7886	1	1	3	5	7
263	24706	11.6014	3	5	8	14	23
264	3910	6.9575	2	3	5	8	14
265	3905	6.6197	1	2	4	8	14
266	2557	3.3136	1	1	2	4	7
267	257	5.2140	1	1	3	6	12
268	915	3.6907	1	1	2	4	8
269	8941	8.2543	2	3	6	10	16
270	2767	3.2754	1	1	2	4	7
271	21233	7.1222	2	4	6	8	13
272	5503	6.3353	2	3	5	8	12
273	1346	4.2132	1	2	3	5	8
274	2381	6.9475	2	3	5	9	14
275	229	3.3886	1	1	2	4	7
276	1089	4.6272	1	2	4	6	9
277	84246	5.7203	2	3	5	7	10
278	28748	4.3341	2	3	4	5	7
279	5	5.4000	2	2	5	5	11
280	15232	4.1962	1	2	3	5	8
281	6791	3.0711	1	1	3	4	6
283	5370	4.5551	1	2	3	6	9
284	1858	3.1975	1	1	2	4	6
285	6174	10.4691	3	5	8	13	20
286	2009	6.2225	2	3	5	7	11
287	6029	10.5382	3	5	8	13	20
288	2316	5.6973	2	3	4	6	9
289	4349	3.1474	1	1	2	3	7
290	8262	2.4317	1	1	2	2	4
291	58	1.6379	1	1	1	2	2
292	4999	9.9930	2	4	7	13	21
293	326	5.0644	1	2	4	7	10
294	84584	4.7150	1	2	4	6	9
295	3506	3.8811	1	2	3	5	7
296	233633	5.2417	2	3	4	6	10
297	41115	3.4726	1	2	3	4	6
298	112	3.1429	1	2	2	4	6
299	1067	5.6148	1	2	4	6	11
300	15674	6.1301	2	3	5	8	12
301	3130	3.7089	1	2	3	5	7
302	7834	9.3957	4	5	7	11	16
303	19520	8.4840	4	5	7	10	15
304	12114	8.9145	2	4	7	11	18
305	2886	3.8486	1	2	3	5	7
306	7971	5.4874	1	2	3	7	12
307	2231	2.2761	1	1	2	3	4
308	7729	6.3946	1	2	4	8	14
309	3973	2.4896	1	1	2	3	5
310	23848	4.3651	1	2	3	5	9
311	8261	1.8895	1	1	1	2	3
312	1576	4.5184	1	1	3	6	10
313	633	2.1137	1	1	1	3	4
314	2	1.0000	1	1	1	1	1
315	28842	7.5038	1	1	5	10	17
316	97171	6.6773	2	3	5	8	13
317	1237	3.1997	1	1	2	3	6
318	5569	6.0084	1	3	4	7	12
319	468	2.8782	1	1	2	4	6
320	182681	5.3860	2	3	4	7	10
321	28362	3.8457	1	2	3	5	7
322	72	4.1111	1	2	3	5	7
323	16489	3.2195	1	1	2	4	7
324	7423	1.8792	1	1	1	2	3
325	7844	3.8986	1	2	3	5	7
326	2434	2.6619	1	1	2	3	5
327	8	8.2500	1	1	1	4	13
328	724	3.8909	1	1	3	5	8
329	106	2.0472	1	1	1	3	4
331	43627	5.5325	1	2	4	7	11
332	4854	3.2701	1	1	2	4	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
333	306	5.0163	1	2	3	6	10
334	12207	4.8955	2	3	4	6	8
335	11491	3.4115	2	3	3	4	5
336	40724	3.5245	1	2	3	4	7
337	30688	2.1779	1	1	2	3	3
338	1647	5.3024	1	2	3	7	12
339	1514	4.5594	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3866	3.2219	1	1	2	3	7
342	778	3.1221	1	2	2	4	6
344	3962	2.2532	1	1	1	2	4
345	1285	3.7681	1	1	2	5	8
346	4659	5.8032	1	3	4	7	11
347	399	3.3734	1	1	2	4	7
348	3125	4.2074	1	2	3	5	8
349	595	2.6101	1	1	2	3	5
350	6202	4.3955	2	2	4	5	8
352	651	3.8218	1	2	3	5	8
353	2646	6.7154	3	3	5	8	13
354	8252	5.8838	3	3	4	7	10
355	5732	3.3217	2	3	3	4	5
356	26097	2.4163	1	1	2	3	4
357	5799	8.5049	3	4	7	10	16
358	21776	4.3958	2	3	3	5	8
359	29307	2.8120	2	2	3	3	4
360	16206	2.9646	1	2	2	3	5
361	427	3.4637	1	1	2	4	7
362	2	2.0000	1	1	3	3	3
363	3100	3.4668	1	2	2	3	7
364	1626	3.5689	1	1	2	5	7
365	1936	7.2758	1	3	5	9	16
366	4266	6.7203	1	3	5	8	14
367	478	3.1695	1	1	2	4	7
368	2889	6.7196	2	3	5	8	13
369	2858	3.1963	1	1	2	4	6
370	1175	5.7174	3	3	4	5	9
371	1232	3.6445	2	3	3	4	5
372	942	3.4809	1	2	2	3	5
373	3992	2.2856	1	2	2	2	3
374	138	3.3696	1	2	2	3	5
375	6	2.6667	2	2	2	3	3
376	260	3.4577	1	2	2	4	7
377	54	3.8333	1	1	2	5	8
378	156	2.3333	1	1	2	3	4
379	370	3.0676	1	1	2	3	6
380	77	2.1688	1	1	2	2	4
381	179	1.9441	1	1	1	2	3
382	43	1.4884	1	1	1	2	2
383	1582	3.8957	1	1	3	5	8
384	128	2.2969	1	1	1	2	4
389	8	5.8750	3	3	4	8	10
390	20	3.9500	1	1	3	6	8
392	2524	9.4624	3	4	7	12	19
393	2	7.5000	7	7	8	8	8
394	1742	6.6791	1	2	4	8	15
395	81014	4.5335	1	2	3	6	9
396	20	3.8000	1	1	2	5	7
397	18191	5.2238	1	2	4	7	10
398	18207	5.9565	2	3	5	7	11
399	1633	3.5536	1	2	3	4	7
400	6897	9.0738	1	3	6	12	20
401	5881	11.1770	2	5	8	14	23
402	1501	3.9480	1	1	3	5	8
403	33467	8.0557	2	3	6	10	17
404	4520	4.2199	1	2	3	6	9
406	2572	10.3476	3	4	7	13	21
407	701	4.4051	1	2	4	6	8
408	2260	7.7088	1	2	5	10	18
409	3308	5.9344	2	3	4	6	11
410	41166	3.7183	1	2	3	5	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
411	13	2.3077	1	1	2	4	4
412	29	2.7241	1	1	2	3	6
413	6216	7.2497	2	3	6	9	14
414	721	4.0902	1	2	3	5	8
415	40206	14.2110	4	6	11	18	28
416	196848	7.3514	2	4	6	9	14
417	36	5.8889	1	1	4	6	13
418	22285	6.1233	2	3	5	7	11
419	15990	4.8206	2	2	4	6	9
420	3108	3.5618	1	2	3	4	6
421	12326	3.8695	1	2	3	5	7
422	98	5.2551	1	2	2	5	7
423	8137	8.1292	2	3	6	10	17
424	1368	13.4561	2	5	9	16	28
425	15108	4.0764	1	2	3	5	8
426	4357	4.5582	1	2	3	6	9
427	1679	4.9803	1	2	3	6	10
428	849	7.0813	1	2	4	8	15
429	27615	6.4861	2	3	5	8	12
430	58361	8.1902	2	3	6	10	16
431	297	6.5758	2	3	5	8	13
432	394	4.8020	1	2	3	5	9
433	5831	3.0045	1	1	2	4	6
434	22063	5.0861	1	2	4	6	9
435	14652	4.3057	1	2	4	5	8
436	3548	12.8503	4	7	11	17	25
437	9841	8.9511	3	5	8	11	15
439	1306	8.1646	1	3	5	10	17
440	5063	8.8766	2	3	6	10	19
441	585	3.2496	1	1	2	4	7
442	16061	8.2365	1	3	6	10	17
443	3586	3.3943	1	1	2	4	7
444	5210	4.2263	1	2	3	5	8
445	2276	2.9921	1	1	2	4	5
447	4891	2.5113	1	1	2	3	5
448	1	4.0000	4	4	4	4	4
449	26785	3.6730	1	1	3	4	7
450	6439	2.0449	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	21849	4.9674	1	2	3	6	10
453	4499	2.8137	1	1	2	3	5
454	4999	4.5603	1	2	3	6	9
455	1083	2.6214	1	1	2	3	5
461	3396	4.6184	1	1	2	5	11
462	12718	11.5531	4	6	9	15	21
463	19068	4.2743	1	2	3	5	8
464	5509	3.0764	1	1	2	4	6
465	228	3.3509	1	1	2	3	7
466	1752	3.9258	1	1	2	4	8
467	1320	4.0485	1	1	2	4	7
468	58920	12.9558	3	6	10	17	26
471	11488	5.7349	3	4	5	6	9
473	7674	12.8610	2	3	7	19	32
475	109697	11.1882	2	5	9	15	22
476	4474	11.6623	2	5	10	15	22
477	25946	8.1242	1	3	6	10	17
478	111979	7.3211	1	3	5	9	15
479	22533	3.6234	1	2	3	5	7
480	500	19.4980	7	9	14	23	39
481	274	26.7372	16	19	23	31	43
482	6178	12.8124	4	7	10	15	24
483	43726	39.1790	14	21	32	49	71
484	340	13.0853	2	5	10	18	28
485	3002	9.4867	4	5	7	11	18
486	2127	12.1208	1	5	9	16	25
487	3666	7.6328	1	3	6	10	15
488	779	16.9718	4	7	12	21	34
489	14444	8.5516	2	3	6	10	18
490	5357	5.1286	1	2	4	6	10
491	11403	3.4912	2	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
492	2695	16.1221	4	5	9	26	34
493	54404	5.7190	1	3	5	7	11
494	27453	2.4829	1	1	2	3	5
495	156	20.5000	6	8	12	19	33
496	1293	10.0093	4	5	7	12	18
497	22769	6.2233	2	3	5	7	11
498	19358	3.4145	1	2	3	4	6
499	30924	4.7726	1	2	4	6	9
500	42404	2.6896	1	1	2	3	5
501	1959	10.5630	4	5	8	13	20
502	621	5.9775	2	3	5	7	10
503	5625	3.9733	1	2	3	5	7
504	124	30.4677	10	15	25	40	63
505	155	4.7161	1	1	2	6	12
506	968	17.5651	4	8	14	24	37
507	285	9.2491	2	4	7	13	19
508	648	7.1605	2	3	5	9	15
509	167	6.0719	1	2	4	8	12
510	1673	7.8171	2	3	5	9	17
511	605	4.4413	1	1	3	6	10
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TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35352	9.1033	2	3	6	12	19
2	7158	9.6855	3	5	7	12	19
4	6095	7.3505	1	2	5	9	16
5	95604	3.2875	1	1	2	4	7
6	341	3.2405	1	1	2	4	7
7	12147	10.2938	2	4	7	13	21
8	3706	3.0108	1	1	2	4	7
9	1657	6.4484	1	3	5	8	12
10	18433	6.5983	2	3	5	8	13
11	3335	4.1739	1	2	3	5	8
12	45110	6.0509	2	3	4	7	11
13	6256	5.0973	2	3	4	6	9
14	331649	5.9608	2	3	5	7	11
15	140366	3.6304	1	2	3	5	7
16	11166	6.1358	2	3	5	7	12
17	3457	3.3679	1	2	3	4	6
18	26127	5.5433	2	3	4	7	10
19	8018	3.7403	1	2	3	5	7
20	5780	10.2894	3	5	8	13	20
21	1368	6.8575	2	3	5	9	13
22	2519	4.9389	2	2	4	6	9
23	8375	4.2302	1	2	3	5	8
24	52856	5.0134	1	2	4	6	10
25	24619	3.3092	1	2	3	4	6
26	20	3.2000	1	1	2	3	7
27	3645	5.1084	1	1	3	6	12
28	10832	6.2250	1	3	5	8	13
29	3985	3.7064	1	2	3	5	7
31	3299	4.2301	1	2	3	5	8
32	1587	2.7360	1	1	2	3	5
34	19649	5.1979	1	2	4	6	10
35	5233	3.4204	1	2	3	4	6
36	4249	1.3641	1	1	1	1	2
37	1494	3.6921	1	1	3	5	8
38	115	2.5304	1	1	1	3	5
39	1160	1.9112	1	1	1	2	4
40	1765	3.5955	1	1	2	4	8
41	1	4.0000	4	4	4	4	4
42	2723	2.2277	1	1	1	3	5
43	86	3.3605	1	2	3	4	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
44	1237	4.9871	2	3	4	6	9
45	2509	3.2790	1	2	3	4	6
46	2970	4.5805	1	2	4	6	9
47	1181	3.3023	1	1	3	4	6
49	2245	4.9675	1	2	4	6	9
50	2587	1.9849	1	1	1	2	3
51	264	2.5303	1	1	1	3	6
52	198	2.1414	1	1	1	2	5
53	2594	3.6727	1	1	2	4	8
54	4	1.5000	1	1	1	1	3
55	1573	2.8843	1	1	1	3	6
56	533	3.0507	1	1	2	4	6
57	587	3.9642	1	1	2	4	8
59	115	2.5304	1	1	2	3	5
60	2	1.0000	1	1	1	1	1
61	212	4.8302	1	1	2	6	13
62	2	3.5000	2	2	5	5	5
63	3207	4.2728	1	2	3	5	9
64	3189	6.5124	1	2	4	8	14
65	31923	2.8964	1	1	2	4	5
66	6984	3.1714	1	1	3	4	6
67	482	3.5270	1	2	3	4	7
68	13468	4.1556	1	2	3	5	7
69	4268	3.2856	1	2	3	4	6
70	33	2.9091	1	2	3	4	5
71	105	3.8667	1	2	3	6	7
72	824	3.2961	1	2	3	4	6
73	6461	4.3439	1	2	3	5	8
75	39513	10.0058	3	5	8	12	20
76	40109	11.2755	3	5	9	14	21
77	2447	4.9775	1	2	4	7	10
78	30651	6.9464	3	5	6	8	11
79	183420	8.4683	3	4	7	11	16
80	8807	5.7434	2	3	5	7	10
81	5	9.2000	2	2	10	10	19
82	64149	6.9422	2	3	5	9	14
83	6599	5.5342	2	3	4	7	10
84	1553	3.3709	1	2	3	4	6
85	20150	6.3637	2	3	5	8	12
86	1948	3.7936	1	2	3	5	7
87	63294	6.2499	1	3	5	8	12
88	405792	5.2217	2	3	4	7	9
89	525499	6.0257	2	3	5	7	11
90	52326	4.2457	2	3	4	5	7
91	49	3.3469	1	2	3	4	5
92	13772	6.2509	2	3	5	8	12
93	1627	4.0412	1	2	3	5	7
94	12463	6.3016	2	3	5	8	12
95	1596	3.6942	1	2	3	5	7
96	65045	4.7268	2	3	4	6	8
97	31893	3.6895	1	2	3	5	7
98	20	4.7000	1	1	3	6	7
99	18262	3.2254	1	1	2	4	6
100	7333	2.2215	1	1	2	3	4
101	19863	4.4312	1	2	3	6	8
102	5056	2.7455	1	1	2	3	5
103	480	51.7875	9	13	31	70	121
104	33648	11.6443	3	6	10	15	22
105	29689	9.3034	4	5	7	11	17
106	3805	11.2100	5	7	9	13	19
107	90905	10.3450	5	7	9	12	17
108	5246	10.5442	3	5	8	13	20
109	61881	7.7309	4	5	6	9	13
110	55081	9.4414	2	5	8	11	18
111	7168	5.4788	2	4	5	7	8
112	61237	3.7595	1	1	3	5	8
113	44445	12.0916	3	6	9	15	24
114	8543	8.2800	2	4	7	10	16
115	14129	8.4099	1	4	7	11	16
116	309839	3.7278	1	1	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
117	3419	4.0433	1	1	2	5	9
118	6687	2.8065	1	1	1	3	6
119	1461	4.8542	1	1	3	6	12
120	36979	8.1175	1	2	5	10	18
121	164131	6.4386	2	3	5	8	12
122	81181	3.8293	1	2	3	5	7
123	41101	4.5805	1	1	3	6	11
124	135568	4.3735	1	2	3	6	8
125	75438	2.7854	1	1	2	4	5
126	5171	11.7343	3	6	9	14	23
127	683849	5.3364	2	3	4	7	10
128	11601	5.8042	3	4	5	7	9
129	4224	2.8570	1	1	1	3	7
130	89585	5.8066	2	3	5	7	10
131	27056	4.3774	1	3	4	6	7
132	153720	3.0483	1	1	2	4	6
133	7639	2.3961	1	1	2	3	4
134	33046	3.2976	1	2	3	4	6
135	7143	4.4714	1	2	3	5	9
136	1171	2.9086	1	1	2	4	6
138	192312	4.0086	1	2	3	5	8
139	77818	2.5076	1	1	2	3	5
140	76921	2.7133	1	1	2	3	5
141	86200	3.7088	1	2	3	5	7
142	42916	2.6786	1	1	2	3	5
143	186941	2.1669	1	1	2	3	4
144	79537	5.3212	1	2	4	7	11
145	6964	2.8153	1	1	2	4	6
146	11289	10.1758	5	7	9	12	17
147	2427	6.6135	3	5	6	8	10
148	134992	12.1212	5	7	10	14	22
149	17679	6.6565	4	5	6	8	10
150	20422	11.1531	4	7	9	14	20
151	4516	5.9289	2	3	5	8	10
152	4469	8.1962	3	5	7	10	14
153	1932	5.4596	3	4	5	7	8
154	29550	13.2586	4	7	10	16	25
155	6113	4.3496	1	2	3	6	8
156	2	28.0000	28	28	28	28	28
157	8234	5.4966	1	2	4	7	11
158	4427	2.6286	1	1	2	3	5
159	16531	5.0216	1	2	4	6	10
160	11070	2.7232	1	1	2	4	5
161	11547	4.1684	1	2	3	5	9
162	7071	1.9542	1	1	1	2	4
163	10	2.9000	1	1	3	3	6
164	4747	8.3994	4	5	7	10	14
165	1954	4.8547	2	3	5	6	8
166	3331	5.0793	2	3	4	6	9
167	2936	2.7101	1	2	2	3	5
168	1530	4.6556	1	2	3	6	9
169	810	2.4247	1	1	2	3	5
170	11351	11.1690	2	5	8	14	23
171	1132	4.8012	1	2	4	6	9
172	30705	6.9802	2	3	5	9	14
173	2519	3.8626	1	1	3	5	8
174	237539	4.8239	2	3	4	6	9
175	28266	2.9435	1	2	3	4	5
176	15708	5.2687	2	3	4	6	10
177	9537	4.5531	2	2	4	6	8
178	3603	3.1415	1	2	3	4	6
179	12290	6.0134	2	3	5	7	11
180	85505	5.3984	2	3	4	7	10
181	24481	3.4105	1	2	3	4	6
182	233949	4.3625	1	2	3	5	8
183	79105	2.9644	1	1	2	4	6
184	99	3.2525	1	2	3	4	5
185	4361	4.5015	1	2	3	6	9
186	2	4.5000	2	2	7	7	7
187	747	3.8220	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
188	75007	5.5817	1	2	4	7	11
189	11195	3.1401	1	1	2	4	6
190	70	5.9857	2	3	4	6	11
191	9434	14.1406	4	7	10	18	28
192	987	6.5968	2	4	6	8	11
193	5705	12.5550	5	7	10	15	23
194	763	6.7720	2	4	6	8	12
195	4898	9.8944	4	6	8	12	17
196	1197	5.6942	2	4	5	7	9
197	20365	8.7337	3	5	7	11	16
198	6125	4.5063	2	3	4	6	8
199	1745	9.6682	3	4	8	13	19
200	1084	10.7694	2	4	8	14	22
201	1483	13.8206	3	6	11	18	27
202	25781	6.5065	2	3	5	8	13
203	29166	6.6874	2	3	5	9	13
204	55210	5.8583	2	3	4	7	11
205	22715	6.2907	2	3	5	8	12
206	1792	3.8337	1	2	3	5	7
207	30984	5.1140	1	2	4	6	10
208	9698	2.9013	1	1	2	4	6
209	343780	5.1256	3	3	4	6	8
210	127278	6.8141	3	4	6	8	11
211	31470	4.9173	3	4	4	6	7
212	7	3.0000	2	2	2	3	4
213	8933	8.7283	2	4	7	11	17
216	5871	9.7808	2	4	7	12	20
217	17768	13.1592	3	5	9	16	28
218	21572	5.3690	2	3	4	6	10
219	19377	3.2517	1	2	3	4	5
220	3	2.3333	1	1	2	4	4
223	17575	2.5861	1	1	2	3	5
224	8044	2.0525	1	1	2	3	4
225	5639	4.7074	1	2	3	6	10
226	4927	6.3028	1	2	4	8	13
227	4410	2.6689	1	1	2	3	5
228	2477	3.5620	1	1	2	4	8
229	1092	2.4011	1	1	2	3	5
230	2274	5.0721	1	2	3	6	10
231	10738	4.8361	1	2	3	6	10
232	571	3.5692	1	1	2	4	9
233	4607	7.7141	2	3	6	10	16
234	2702	3.5718	1	2	3	4	7
235	5378	5.1264	1	2	4	6	10
236	38845	4.8570	1	3	4	6	9
237	1587	3.7284	1	2	3	5	7
238	7674	8.4730	3	4	6	10	16
239	51992	6.2172	2	3	5	8	12
240	11944	6.5936	2	3	5	8	13
241	2987	3.9404	1	2	3	5	7
242	2498	6.5524	2	3	5	8	12
243	85571	4.7006	1	3	4	6	9
244	11961	4.7800	1	2	4	6	9
245	4968	3.7246	1	2	3	4	7
246	1344	3.6384	1	2	3	4	7
247	15158	3.4474	1	1	3	4	7
248	9412	4.7385	1	2	4	6	9
249	10792	3.7782	1	1	3	5	8
250	3542	4.2490	1	2	3	5	8
251	2383	2.9862	1	1	3	4	5
252	1	2.0000	2	2	2	2	2
253	19051	4.6967	1	3	4	6	9
254	10460	3.2059	1	2	3	4	6
255	1	1.0000	1	1	1	1	1
256	5875	5.1384	1	2	4	6	10
257	16871	2.8291	1	2	2	3	5
258	15844	2.0016	1	1	2	2	3
259	3741	2.7928	1	1	1	3	6
260	4817	1.4330	1	1	1	2	2
261	1766	2.1682	1	1	1	2	4

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
262	686	3.7886	1	1	3	5	7
263	24706	11.6014	3	5	8	14	23
264	3910	6.9575	2	3	5	8	14
265	3904	6.6201	1	2	4	8	14
266	2558	3.3143	1	1	2	4	7
267	257	5.2140	1	1	3	6	12
268	915	3.6907	1	1	2	4	8
269	8938	8.2558	2	3	6	10	16
270	2770	3.2762	1	1	2	4	7
271	21233	7.1222	2	4	6	8	13
272	5501	6.3356	2	3	5	8	12
273	1348	4.2151	1	2	3	5	8
274	2381	6.9475	2	3	5	9	14
275	229	3.3886	1	1	2	4	7
276	1089	4.6272	1	2	4	6	9
277	84223	5.7207	2	3	5	7	10
278	28771	4.3340	2	3	4	5	7
279	5	5.4000	2	2	5	5	11
280	15227	4.1968	1	2	3	5	8
281	6796	3.0705	1	1	3	4	6
283	5368	4.5561	1	2	3	6	9
284	1860	3.1962	1	1	2	4	6
285	6166	10.4710	3	5	8	13	20
286	2009	6.2225	2	3	5	7	11
287	6029	10.5382	3	5	8	13	20
288	2324	5.7087	2	3	4	6	9
289	4349	3.1474	1	1	2	3	7
290	8262	2.4317	1	1	2	2	4
291	58	1.6379	1	1	1	2	2
292	4999	9.9930	2	4	7	13	21
293	326	5.0644	1	2	4	7	10
294	84584	4.7150	1	2	4	6	9
295	3506	3.8811	1	2	3	5	7
296	233520	5.2416	2	3	4	6	10
297	41231	3.4777	1	2	3	4	6
298	112	3.1429	1	2	2	4	6
299	1067	5.6148	1	2	4	6	11
300	15669	6.1305	2	3	5	8	12
301	3135	3.7107	1	2	3	5	7
302	7834	9.3957	4	5	7	11	16
303	19520	8.4840	4	5	7	10	15
304	12114	8.9145	2	4	7	11	18
305	2886	3.8486	1	2	3	5	7
306	7970	5.4877	1	2	3	7	12
307	2232	2.2764	1	1	2	3	4
308	7725	6.3969	1	2	4	8	14
309	3977	2.4891	1	1	2	3	5
310	23844	4.3654	1	2	3	5	9
311	8265	1.8897	1	1	1	2	3
312	1576	4.5184	1	1	3	6	10
313	633	2.1137	1	1	1	3	4
314	2	1.0000	1	1	1	1	1
315	28842	7.5038	1	1	5	10	17
316	97170	6.6773	2	3	5	8	13
317	1237	3.1997	1	1	2	3	6
318	5569	6.0084	1	3	4	7	12
319	468	2.8782	1	1	2	4	6
320	182655	5.3861	2	3	4	7	10
321	28388	3.8467	1	2	3	5	7
322	72	4.1111	1	2	3	5	7
323	16486	3.2195	1	1	2	4	7
324	7426	1.8796	1	1	1	2	3
325	7844	3.8986	1	2	3	5	7
326	2434	2.6619	1	1	2	3	5
327	8	8.2500	1	1	1	4	13
328	724	3.8909	1	1	3	5	8
329	106	2.0472	1	1	1	3	4
331	43621	5.5330	1	2	4	7	11
332	4860	3.2687	1	1	2	4	7
333	306	5.0163	1	2	3	6	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
334	12201	4.8961	2	3	4	6	8
335	11497	3.4117	2	3	3	4	5
336	40717	3.5248	1	2	3	4	7
337	30695	2.1778	1	1	2	3	3
338	1647	5.3024	1	2	3	7	12
339	1514	4.5594	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3866	3.2219	1	1	2	3	7
342	778	3.1221	1	2	2	4	6
344	3962	2.2532	1	1	1	2	4
345	1285	3.7681	1	1	2	5	8
346	4659	5.8032	1	3	4	7	11
347	399	3.3734	1	1	2	4	7
348	3125	4.2074	1	2	3	5	8
349	595	2.6101	1	1	2	3	5
350	6202	4.3955	2	2	4	5	8
352	651	3.8218	1	2	3	5	8
353	2646	6.7154	3	3	5	8	13
354	8251	5.8841	3	3	4	7	10
355	5733	3.3216	2	3	3	4	5
356	26097	2.4163	1	1	2	3	4
357	5799	8.5049	3	4	7	10	16
358	21754	4.3966	2	3	3	5	8
359	29329	2.8125	2	2	3	3	4
360	16206	2.9646	1	2	2	3	5
361	427	3.4637	1	1	2	4	7
362	2	2.0000	1	1	3	3	3
363	3100	3.4668	1	2	2	3	7
364	1626	3.5689	1	1	2	5	7
365	1936	7.2758	1	3	5	9	16
366	4266	6.7203	1	3	5	8	14
367	478	3.1695	1	1	2	4	7
368	2889	6.7196	2	3	5	8	13
369	2858	3.1963	1	1	2	4	6
370	1175	5.7174	3	3	4	5	9
371	1232	3.6445	2	3	3	4	5
372	952	3.4758	2	2	2	3	5
373	3982	2.2838	1	2	2	2	3
374	138	3.3696	1	2	2	3	5
375	6	2.6667	2	2	2	3	3
376	260	3.4577	1	2	2	4	7
377	54	3.8333	1	1	2	5	8
378	156	2.3333	1	1	2	3	4
379	370	3.0676	1	1	2	3	6
380	77	2.1688	1	1	2	2	4
381	179	1.9441	1	1	1	2	3
382	43	1.4884	1	1	1	2	2
383	1582	3.8957	1	1	3	5	8
384	128	2.2969	1	1	1	2	4
389	8	5.8750	3	3	4	8	10
390	20	3.9500	1	1	3	6	8
392	2524	9.4624	3	4	7	12	19
393	2	7.5000	7	7	8	8	8
394	1742	6.6791	1	2	4	8	15
395	81014	4.5335	1	2	3	6	9
396	20	3.8000	1	1	2	5	7
397	18191	5.2238	1	2	4	7	10
398	18199	5.9577	2	3	5	7	11
399	1641	3.5521	1	2	3	4	7
400	6893	9.0730	1	3	6	12	20
401	5865	11.1758	2	5	8	14	23
402	1503	3.9508	1	1	3	5	8
403	33074	8.0664	2	3	6	10	17
404	4484	4.2219	1	2	3	6	9
406	2574	10.3528	3	4	7	13	21
407	703	4.4040	1	2	4	6	8
408	2275	7.7354	1	2	5	10	18
409	3308	5.9344	2	3	4	6	11
410	41165	3.7184	1	2	3	5	6
411	13	2.3077	1	1	2	4	4

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
412	29	2.7241	1	1	2	3	6
413	6605	7.2450	2	3	6	9	14
414	761	4.0933	1	2	3	5	8
415	40206	14.2110	4	6	11	18	28
416	196848	7.3514	2	4	6	9	14
417	36	5.8889	1	1	4	6	13
418	22285	6.1233	2	3	5	7	11
419	15984	4.8204	2	2	4	6	9
420	3114	3.5649	1	2	3	4	6
421	12326	3.8695	1	2	3	5	7
422	98	5.2551	1	2	2	5	7
423	8137	8.1292	2	3	6	10	17
424	1368	13.4561	2	5	9	16	28
425	15108	4.0764	1	2	3	5	8
426	4357	4.5582	1	2	3	6	9
427	1679	4.9803	1	2	3	6	10
428	849	7.0813	1	2	4	8	15
429	27615	6.4861	2	3	5	8	12
430	58361	8.1902	2	3	6	10	16
431	297	6.5758	2	3	5	8	13
432	394	4.8020	1	2	3	5	9
433	5831	3.0045	1	1	2	4	6
434	22061	5.0864	1	2	4	6	9
435	14654	4.3052	1	2	4	5	8
436	3548	12.8503	4	7	11	17	25
437	9841	8.9511	3	5	8	11	15
439	1306	8.1646	1	3	5	10	17
440	5063	8.8766	2	3	6	10	19
441	585	3.2496	1	1	2	4	7
442	16061	8.2365	1	3	6	10	17
443	3586	3.3943	1	1	2	4	7
444	5206	4.2274	1	2	3	5	8
445	2280	2.9917	1	1	2	4	5
447	4891	2.5113	1	1	2	3	5
448	1	4.0000	4	4	4	4	4
449	26781	3.6732	1	1	3	4	7
450	6443	2.0449	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	21847	4.9676	1	2	3	6	10
453	4501	2.8136	1	1	2	3	5
454	4997	4.5603	1	2	3	6	9
455	1085	2.6249	1	1	2	3	5
461	3397	4.6194	1	1	2	5	11
462	12718	11.5531	4	6	9	15	21
463	19065	4.2742	1	2	3	5	8
464	5511	3.0766	1	1	2	4	6
465	228	3.3509	1	1	2	3	7
466	1752	3.9258	1	1	2	4	8
467	1320	4.0485	1	1	2	4	7
468	58922	12.9489	3	6	10	17	26
471	11488	5.7349	3	4	5	6	9
473	7674	12.8610	2	3	7	19	32
475	109695	11.1883	2	5	9	15	22
476	4474	11.6623	2	5	10	15	22
477	25946	8.1242	1	3	6	10	17
478	111969	7.3211	1	3	5	9	15
479	22542	3.6236	1	2	3	5	7
480	500	19.4980	7	9	14	23	39
481	273	26.5641	16	19	23	31	41
482	6195	12.8199	4	7	10	15	24
483	43695	39.1662	14	22	32	49	71
484	340	13.0853	2	5	10	18	28
485	3002	9.4867	4	5	7	11	18
486	2127	12.1208	1	5	9	16	25
487	3666	7.6328	1	3	6	10	15
488	779	16.9718	4	7	12	21	34
489	14444	8.5516	2	3	6	10	18
490	5354	5.1291	1	2	4	6	10
491	11403	3.4912	2	2	3	4	6
492	2695	16.1221	4	5	9	26	34

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR update 03/00 Grouper V.18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
493	54388	5.7197	1	3	5	7	11
494	27469	2.4832	1	1	2	3	5
495	156	20.5000	6	8	12	19	33
496	1293	10.0093	4	5	7	12	18
497	22761	6.2244	2	3	5	7	11
498	19366	3.4143	1	2	3	4	6
499	30892	4.7750	1	2	4	6	9
500	42436	2.6894	1	1	2	3	5
501	1959	10.5630	4	5	8	13	20
502	621	5.9775	2	3	5	7	10
503	5625	3.9733	1	2	3	5	7
504	124	30.4677	10	15	25	40	63
505	155	4.7161	1	1	2	6	12
506	968	17.5651	4	8	14	24	37
507	285	9.2491	2	4	7	13	19
508	648	7.1605	2	3	5	9	15
509	167	6.0719	1	2	4	8	12
510	1673	7.8171	2	3	5	9	17
511	605	4.4413	1	1	3	6	10
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2000

State	Urban	Rural
ALABAMA	0.401	0.355
ALASKA	0.470	0.723
ARIZONA	0.373	0.517
ARKANSAS	0.478	0.454
CALIFORNIA	0.342	0.441
COLORADO	0.436	0.559
CONNECTICUT	0.495	0.503
DELAWARE	0.507	0.449
DISTRICT OF COLUMBIA	0.521	.....
FLORIDA	0.363	0.381
GEORGIA	0.475	0.486
HAWAII	0.409	0.554
IDAHO	0.549	0.571
ILLINOIS	0.425	0.509
INDIANA	0.532	0.544
IOWA	0.493	0.624
KANSAS	0.444	0.652
KENTUCKY	0.478	0.493
LOUISIANA	0.410	0.496
MAINE	0.597	0.550
MARYLAND	0.759	0.821
MASSACHUSETTS	0.526	0.538
MICHIGAN	0.466	0.572
MINNESOTA	0.509	0.591
MISSISSIPPI	0.456	0.454
MISSOURI	0.413	0.507
MONTANA	0.524	0.572
NEBRASKA	0.468	0.623
NEVADA	0.292	0.486
NEW HAMPSHIRE	0.541	0.579
NEW JERSEY	0.401	.....
NEW MEXICO	0.452	0.498
NEW YORK	0.529	0.611
NORTH CAROLINA	0.540	0.489
NORTH DAKOTA	0.622	0.661
OHIO	0.511	0.578
OKLAHOMA	0.423	0.509
OREGON	0.607	0.582

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2000—Continued

State	Urban	Rural
PENNSYLVANIA	0.396	0.517
PUERTO RICO	0.479	0.579
RHODE ISLAND	0.522	.....
SOUTH CAROLINA	0.447	0.451
SOUTH DAKOTA	0.537	0.600
TENNESSEE	0.441	0.482
TEXAS	0.404	0.503
UTAH	0.504	0.619
VERMONT	0.623	0.595
VIRGINIA	0.466	0.498
WASHINGTON	0.576	0.653
WEST VIRGINIA	0.575	0.532
WISCONSIN	0.551	0.621
WYOMING	0.475	0.682

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2000

State	Ratio
ALABAMA	0.040
ALASKA	0.070
ARIZONA	0.041
ARKANSAS	0.050
CALIFORNIA	0.036
COLORADO	0.046
CONNECTICUT	0.036
DELAWARE	0.051
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.045
GEORGIA	0.056
HAWAII	0.043
IDAHO	0.049
ILLINOIS	0.042
INDIANA	0.057
IOWA	0.056

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2000—Continued

State	Ratio
KANSAS	0.054
KENTUCKY	0.046
LOUISIANA	0.050
MAINE	0.039
MARYLAND	0.013
MASSACHUSETTS	0.055
MICHIGAN	0.045
MINNESOTA	0.049
MISSISSIPPI	0.045
MISSOURI	0.046
MONTANA	0.055
NEBRASKA	0.054
NEVADA	0.030
NEW HAMPSHIRE	0.061
NEW JERSEY	0.036
NEW MEXICO	0.044
NEW YORK	0.051
NORTH CAROLINA	0.050
NORTH DAKOTA	0.074
OHIO	0.050
OKLAHOMA	0.048
OREGON	0.049
PENNSYLVANIA	0.040
PUERTO RICO	0.043
RHODE ISLAND	0.030
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.066
TENNESSEE	0.051
TEXAS	0.048
UTAH	0.049
VERMONT	0.051
VIRGINIA	0.058
WASHINGTON	0.064
WEST VIRGINIA	0.047
WISCONSIN	0.053
WYOMING	0.057

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 relating to the annual update in payment rates and policy changes for hospital inpatient services and the implementation of the specified changes under Public Law 106–113 will be to increase payments to hospitals by approximately $1.5 billion in FY 2001. We estimate that the impact of the final changes relating to the Medicare inpatient DSH adjustment calculation (a finalization of the January 20, 2000 interim final rule) to be $350 million for FY 2001. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a final rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes in this final rule will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that the final rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local or tribal governments, in the aggregate, or by the private sector, of $100 million. This final rule does not mandate any requirements for State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

II. Changes in the Final Rule

Since we published the proposed rule, the market basket estimates for hospitals subject to the prospective payment system and hospitals and units excluded from the system have both risen by 0.3 percentage points. With the exception of these changes, we are generally implementing the policy and statutory provisions discussed in the proposed rule.

III. Limitations of Our Analysis

As has been the case in our 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 2001, 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

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 45 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 July 2000, we have included 4,888 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 20 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. The impacts of our final policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of July 2000, there were 1,068 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. Broken down by specialty, there were 529 psychiatric, 196 rehabilitation, 242 long-term care, 74 children's, 17 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,468 psychiatric units and 918 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 36 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 2001 will be between 0 and 3.4 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

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.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. 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.

VI. Graduate Medical Education Impact of National Average Per Resident Amount (PRA)

As discussed in section IV.G. of the preamble, this final rule implements statutory provisions enacted by section 311 of Public Law 106–113 that establish a methodology for the use of a national average PRA in computing direct graduate medical education (GME) payments for cost reporting

periods beginning on or after October 1, 2000 and on or before September 30, 2005. The methodology establishes a ''floor'' and ''ceiling'' based on a locality-adjusted, updated national average PRA. Under section 1886(h)(2)(D)(iii) of the Act, as added by section 311(a) of Public Law 106–113, the PRA for a hospital for the cost reporting period beginning during FY 2001 cannot be below 70 percent of the locality-adjusted, updated national average PRA. Thus, if a hospital's PRA for the cost reporting period beginning during FY 2001 would otherwise be below the floor, the hospital's PRA for that cost reporting period is equal to 70 percent of the locality-adjusted, national average PRA. Under section 1886(h)(2)(D)(iv) of the Act, as added by section 311(a) of Public Law 106–113, if a hospital's PRA exceeds 140 percent of the locality-adjusted, updated national average PRA, the hospital's PRA is frozen (for FYs 2001 and 2002) or subject to a 2-percent reduction to the otherwise applicable update (for FYs 2003 through 2005). See section IV.G. of the preamble for a fuller explanation of this policy.

For purposes of the final rule, we have calculated an estimated impact of this policy on teaching hospitals' PRAs for FY 2001 making assumptions about update factors and geographic adjustment factors (GAF) for each hospital. Generally, utilizing FY 1997 data, we calculated a floor and a ceiling and estimated the impact on hospitals. This impact was then inflated to FY 2001 to estimate the total impact on the Medicare program for FY 2001. The estimated numbers for this impact should not be used by hospitals in calculating their own individual PRAs; hospitals must use the methodology stated in section IV.G. of this final rule to revise (if appropriate) their individual PRAs.

In calculating this impact, we utilized Medicare cost report data for all cost reports ending in FY 1997. We excluded hospitals that file manual cost reports because we did not have access to their Medicare utilization data. We also excluded all teaching hospitals in Maryland because these hospitals are paid under a Medicare waiver. For those hospitals that had two cost reporting periods ending in FY 1997, we used the later of the two periods. A total of 1,231 teaching hospitals were included in this analysis.

The impact in this final rule differs slightly from the impact in the proposed rule because we have determined a different weighted average PRA for this final rule, and we used the most recent CPI–U update factors to determine the impact for FY 2001. An explanation of why the weighted average PRA has changed for this final rule may be found in section IV.G.2 of this preamble.

Utilizing the FY 1997 weighted average PRA of $68,464, we calculated a FY 1997 70-percent floor of $47,925 and a FY 1997 140-percent ceiling of $95,850. We then estimated that, for cost reporting periods ending in FY 1997, 336 hospitals had PRAs that were below $47,925 (27.3 percent of 1,231 hospitals), and 180 hospitals had PRAs above $95,850 (14.6 percent of 1,231 hospitals). Thus, for example, to illustrate the extremes in impact for a hospital with PRAs below the floor, Hospital A had a FY 1997 primary care PRA of $22,000 and a non-primary care PRA of $20,000. When these PRAs are replaced by a single PRA of $47,925, the hospital gains approximately 110 percent in payments per resident. For a hospital with PRAs above the ceiling, Hospital B had a FY 1997 primary care PRA of $150,000 and a non-primary care PRA of $148,000. When these PRAs are frozen and not updated for inflation in FY 2001, the percentage loss in payments per resident that year would be equal to the CPI–U percentage that would otherwise have been used to update the PRA.

For the 336 hospitals that had PRAs below the FY 1997 $47,925 floor, we estimated that the total cost to the Medicare program for FY 2001 of applying the floor would be $33.2 million. For the 180 hospitals that had PRAs above the FY 1997 $95,850 ceiling, we estimated that the total savings to the Medicare program for FY 2001 would be $16 million. Subtracting the estimated savings of $16 million from the estimated costs of $33.2 million yields an estimated total net cost to the Medicare program for FY 2001 of $17.2 million.

VII. 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, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate impact 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 1999 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 categorize hospitals. 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 1999 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 FY 2001 changes to the capital prospective payment system are discussed in section IX of this Appendix.

The final changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the diagnosis-related group (DRG) relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1997 data).
- The effects of removing from the wage index the costs and hours associated with teaching physicians paid under Medicare Part A, residents, and certified registered nurse anesthetists (CRNAs) during the second year of a 5-year phase-out, by calculating a wage index based on 40 percent of hospitals' average hourly wages after removing these costs and hours, and 60 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2001.
- The total change in payments based on FY 2001 policies relative to payments based on FY 2000 policies.

To illustrate the impacts of the FY 2001 final changes, our analysis begins with a FY 2000 baseline simulation model using: the FY 2000 DRG GROUPER (version 17.0); the FY 2000 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2001 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 2000 to FY 2001. Five factors have significant impacts here. The first is the update to the standardized amounts. 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 2001 using the most recently forecasted hospital market basket increase for FY 2001 of 3.4 percent minus 1.1 percentage points (for an update of 2.3 percent).

Under section 1886(b)(3) of the Act, as amended by section 406 of Public Law 106–113, the updates to the average standardized amounts and the hospital-specific amounts for sole community hospitals (SCHs) will be equal to the full market basket increase for FY 2001. Consequently, the update factor used for SCHs in this impact analysis is 3.4 percent. Under section 1886(b)(3)(D) of the Act, the update factor for the hospital-specific amounts for MDHs is equal to the market basket increase of 3.4 percent minus 1.1 percentage points (for an update of 2.3 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2000 to FY 2001 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 2000 that are no longer reclassified in FY

2001 may have a negative payment impact going from FY 2000 to FY 2001; conversely, hospitals not reclassified in FY 2000 that are reclassified in FY 2001 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 change in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 2000 will be 6.2 percent of actual total DRG payments. When the FY 2000 final rule was published, we projected FY 2000 outlier payments would be 5.1 percent of total DRG payments; the standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2000 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2000 payments per case to estimated FY 2001 payments per case.

Fourth, section 111 of Public Law 106–113 revised section 1886(d)(5)(B)(ii) of the Act so that the IME adjustment changes from FY 2000 to FY 2001 from approximately a 6.5 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio during FY 2000 to approximately a 6.2 percent increase in FY 2001. Similarly, section 112 of Public Law 106–113 revised section 1886(d)(5)(F)(ix) of the Act so that the DSH adjustment for FY 2001 is reduced by 3 percent from what would otherwise have been paid (this is the same percentage reduction that was applied in FY 2000). Additionally, the January 20, 2000 interim final rule with comment revised policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.

Finally, section 405 of Public Law 106–113 provided that certain SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during FY 1996. To be eligible, a SCH must have received payment on the basis of its hospital-specific rate for its cost reporting period beginning during 1999. For FY 2001, eligible SCHs that elect rebasing receive a hospital-specific rate comprised of 75-percent of the higher of their FY 1982 or FY 1987 hospital-specific rate, and 25-percent of their FY 1996 hospital-specific rate.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,888 hospitals included in the analysis. This number is 34 fewer hospitals than were included in the impact analysis in the FY 2000 final rule (64 FR 41624).

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 2,752 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,571 hospitals located in large urban areas (populations over 1 million), and 1,181 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,136 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 2001 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 that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,833, 1,665, 1,168, and 2,055, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,770 nonteaching hospitals in our analysis, 876 teaching hospitals with fewer than 100 residents, and 242 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 or for purposes of the DSH adjustment. (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 five rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (150), SCHs (661), MDHs (352), and SCH and RRCs (57) shown here were not reclassified for purposes of the standardized amount. There are 26 RRCs, 1 MDH, 4 SCHs and 3 SCH and RRCs that will be reclassified as urban for the standardized amount in FY 2001 and, therefore, are not included in these rows.

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 1998 Medicare cost report files, if available (otherwise FY 1997 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 2 and 85 hospitals, respectively. For the most part, these are new hospitals.

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 2000 and FY 2001, or for only one of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2001 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 2001 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case)

	Number of hosps.[1]	DRG recalib.[2]	New wage data[3]	Phase out of GME and CRNA costs[4]	DRG and WI changes[5]	MGCRB reclassification[6]	All FY 2001 changes[7]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)
(BY GEOGRAPHIC LOCATION):							
ALL HOSPITALS	4,888	0.0	0.2	0.1	0.0	0.0	1.5
URBAN HOSPITALS	2,752	0.0	0.1	0.0	−0.1	−0.4	1.4
LARGE URBAN AREAS	1,571	0.0	0.1	0.0	−0.1	−0.5	1.3
OTHER URBAN AREAS	1,181	0.0	0.1	0.1	0.0	−0.3	1.5
RURAL HOSPITALS	2,136	0.2	0.6	0.1	0.6	2.5	2.5
BED SIZE (URBAN):							
0–99 BEDS	716	0.2	0.1	0.1	0.3	−0.6	1.6
100–199 BEDS	944	0.1	0.1	0.1	0.1	−0.5	1.5
200–299 BEDS	548	0.1	0.1	0.1	−0.1	−0.4	1.3
300–499 BEDS	401	0.0	0.0	0.1	−0.2	−0.4	1.1

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2001 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case)

	Number of hosps.[1]	DRG recalib.[2]	New wage data[3]	Phase out of GME and CRNA costs[4]	DRG and WI changes[5]	MGCRB reclassification[6]	All FY 2001 changes[7]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)
500 OR MORE BEDS	143	−0.1	0.4	0.0	0.0	−0.4	1.6
BED SIZE (RURAL):							
0–49 BEDS	1,233	0.2	0.6	0.1	0.6	0.2	3.1
50–99 BEDS	535	0.2	0.6	0.1	0.6	0.8	2.6
100–149 BEDS	219	0.2	0.6	0.1	0.6	3.4	2.1
150–199 BEDS	81	0.2	0.7	0.1	0.6	5.2	2.6
200 OR MORE BEDS	68	0.1	0.6	0.1	0.5	4.5	2.2
URBAN BY CENSUS DIVISION:							
NEW ENGLAND	146	0.0	−0.9	0.1	−0.3	−0.2	0.9
MIDDLE ATLANTIC	421	0.1	0.1	−0.1	−0.2	−0.3	1.2
SOUTH ATLANTIC	404	0.0	0.0	0.1	−0.2	−0.6	1.1
EAST NORTH CENTRAL	463	0.0	0.5	0.0	0.2	−0.3	2.0
EAST SOUTH CENTRAL	161	0.0	−0.1	0.0	−0.5	−0.6	0.8
WEST NORTH CENTRAL	188	−0.1	0.3	0.0	−0.1	−0.6	1.4
WEST SOUTH CENTRAL	351	0.0	1.3	0.1	1.0	−0.6	2.3
MOUNTAIN	133	0.0	0.3	0.1	0.0	−0.5	1.6
PACIFIC	440	0.0	−0.5	0.2	−0.6	−0.5	0.7
PUERTO RICO	45	0.1	−0.1	0.0	−0.1	−0.6	1.7
RURAL BY CENSUS DIVISION:							
NEW ENGLAND	52	0.1	−0.1	0.0	−0.3	2.8	2.2
MIDDLE ATLANTIC	80	0.2	−0.1	0.0	−0.2	2.5	2.2
SOUTH ATLANTIC	277	0.2	1.0	0.1	1.0	2.9	2.8
EAST NORTH CENTRAL	283	0.2	0.6	0.1	0.5	2.2	2.6
EAST SOUTH CENTRAL	266	0.2	0.6	0.1	0.5	2.8	2.6
WEST NORTH CENTRAL	492	0.1	0.5	0.1	0.4	2.3	2.5
WEST SOUTH CENTRAL	340	0.2	1.0	0.1	1.0	3.0	2.1
MOUNTAIN	201	0.2	0.4	0.1	0.3	1.6	2.7
PACIFIC	140	0.2	0.3	0.1	0.3	1.9	2.3
PUERTO RICO	5	0.2	0.3	−0.2	0.1	−0.7	0.2
(BY PAYMENT CATEGORIES):							
URBAN HOSPITALS	2,833	0.0	0.1	0.0	−0.1	−0.4	1.4
LARGE URBAN	1,665	0.0	0.1	0.0	−0.1	−0.3	1.4
OTHER URBAN	1,168	0.0	0.2	0.1	0.0	−0.4	1.3
RURAL HOSPITALS	2,055	0.2	0.6	0.1	0.6	2.2	2.6
TEACHING STATUS:							
NON-TEACHING	3,770	0.1	0.2	0.1	0.2	0.3	1.6
FEWER THAN 100 RESIDENTS	876	0.0	0.2	0.0	−0.1	−0.3	1.4
100 OR MORE RESIDENTS	242	−0.1	0.2	0.0	−0.2	−0.3	1.6
DISPROPORTIONATE SHARE HOSPITALS (DSH):							
NON-DSH	3,070	0.1	0.1	0.1	−0.1	0.3	1.5
URBAN DSH							
100 BEDS OR MORE	1,390	0.0	0.2	0.0	0.0	−0.4	1.5
FEWER THAN 100 BEDS	72	0.1	0.4	0.1	0.4	−0.5	1.9
RURAL DSH							
SOLE COMMUNITY (SCH)	149	0.3	0.9	0.1	0.9	0.2	3.6
REFERRAL CENTERS (RRC)	56	0.2	0.8	0.1	0.8	5.2	2.4
OTHER RURAL DSH HOSPITALS							
100 BEDS OR MORE	48	0.3	1.1	0.1	1.1	1.4	2.9
FEWER THAN 100 BEDS	103	0.3	0.9	0.1	1.0	0.3	2.3
URBAN TEACHING AND DSH:							
BOTH TEACHING AND DSH	726	0.0	0.2	0.0	0.0	−0.5	1.6
TEACHING AND NO DSH	327	0.0	0.0	0.0	−0.4	−0.2	1.2
NO TEACHING AND DSH	736	0.1	0.2	0.1	0.2	−0.3	1.3
NO TEACHING AND NO DSH	1,044	0.1	0.0	0.1	−0.1	−0.3	1.0
RURAL HOSPITAL TYPES:							
NONSPECIAL STATUS HOSPITALS	835	0.2	0.9	0.1	0.9	1.0	2.4
RRC	150	0.2	0.8	0.1	0.7	6.1	2.4
SCH	661	0.2	0.4	0.1	0.3	0.2	3.3
MDH	352	0.2	0.7	0.1	0.6	0.3	2.7
SCH AND RRC	57	0.1	0.3	0.0	0.1	1.6	2.2
TYPE OF OWNERSHIP:							
VOLUNTARY	2,840	0.0	0.2	0.0	0.0	−0.1	1.5
PROPRIETARY	745	0.1	0.2	0.1	0.1	−0.1	1.3
GOVERNMENT	1,301	0.1	0.2	0.1	0.0	0.2	1.8
UNKNOWN	2	0.0	0.5	0.1	0.3	−0.4	2.7

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2001 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case)

	Number of hosps.[1]	DRG recalib.[2]	New wage data[3]	Phase out of GME and CRNA costs[4]	DRG and WI changes[5]	MGCRB reclassification[6]	All FY 2001 changes[7]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:							
0—25	381	0.0	0.2	0.1	.....	−0.3	1.8
25—50	1,830	0.0	0.1	0.0	−0.1	−0.3	1.4
50—65	1,893	0.1	0.3	0.1	0.2	0.2	1.6
OVER 65	699	0.1	0.2	0.1	0.1	0.3	1.4
UNKNOWN	85	−0.1	0.5	−0.1	0.1	−0.6	1.2
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:							
RECLASSIFICATION STATUS DURING FY 2000 AND FY 2001							
RECLASSIFIED DURING BOTH FY 2000 AND FY 2001	377	0.1	0.4	0.1	0.4	6.0	1.8
URBAN	53	0.0	−0.1	0.1	0.1	5.8	1.7
RURAL	324	0.1	0.6	0.1	0.5	6.2	1.9
RECLASSIFIED DURING FY 2001 ONLY	149	0.1	0.4	0.1	0.3	4.8	7.1
URBAN	35	0.1	0.1	0.1	−0.1	4.7	6.6
RURAL	114	0.2	0.8	0.1	0.7	4.9	7.6
RECLASSIFIED DURING FY 2000 ONLY	172	0.1	0.5	0.1	0.3	−0.9	−1.7
URBAN	70	0.0	0.4	0.1	0.1	−1.1	−0.8
RURAL	102	0.2	0.7	0.1	0.7	−0.5	−3.1
FY 2000 RECLASSIFICATIONS:							
ALL RECLASSIFIED HOSPITALS	527	0.1	0.4	0.1	0.4	5.8	3.0
STANDARDIZED AMOUNT ONLY	66	0.2	0.6	0.1	0.6	4.1	4.1
WAGE INDEX ONLY	386	0.1	0.5	0.1	0.4	4.8	0.6
BOTH	46	0.2	0.1	0.1	0.0	4.3	2.6
NONRECLASSIFIED	4,364	0.0	0.2	0.0	0.0	−0.5	1.6
ALL URBAN RECLASSIFIED	88	0.0	0.0	0.1	0.1	5.4	3.2
STANDARDIZED AMOUNT ONLY	17	0.2	0.0	0.0	−0.1	0.7	0.9
WAGE INDEX ONLY	38	0.0	−0.1	0.1	0.2	5.8	2.5
BOTH	33	0.0	0.1	0.1	−0.1	6.2	5.1
NONRECLASSIFIED	2,638	0.0	0.1	0.0	−0.1	−0.7	1.3
ALL RURAL RECLASSIFIED	439	0.1	0.6	0.1	0.5	5.9	2.9
STANDARDIZED AMOUNT ONLY	54	0.1	0.6	0.1	0.5	4.2	−0.1
WAGE INDEX ONLY	358	0.2	0.6	0.1	0.6	5.8	3.2
BOTH	27	0.1	0.3	0.1	0.1	9.4	2.9
NONRECLASSIFIED	1,697	0.2	0.6	0.1	0.6	−0.5	2.2
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.2	−0.4	0.0	−0.4	1.0	1.3

[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 1999, and hospital cost report data are from reporting periods beginning in FY 1997 and FY 1998.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1999 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1997 cost reports.

[4] This column displays the impact of removing 60 percent of the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[5] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised 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 1, 2 and 3, and the FY 2001 budget neutrality factor of .997225.

[6] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2001 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2001. Reclassification for prior years has no bearing on the payment impacts shown here.

[7] This column shows changes in payments from FY 2000 to FY 2001. It incorporates all of the changes displayed in columns 4 and 5 (the changes displayed in columns 1, 2, and 3 are included in column 4). It also displays the impact of the FY 2001 update (including the higher update for SCHs), changes in hospitals' reclassification status in FY 2001 compared to FY 2000, the difference in outlier payments from FY 2000 to FY 2001, and the reductions to payments through the IME adjustment taking effect during FY 2001. It also reflects section 405 of Public law 106–113, which permitted certain SCHs to rebase for a 1996 hospital-specific rate. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 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. Section 1886(d)(4)(C)(i) of the Act requires us to annually 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 2000 DRG relative weights (GROUPER version 17) to aggregate payments using the

FY 2001 DRG relative weights (GROUPER version 18). Overall payments are unaffected by the DRG reclassification and recalibration. Consistent with the minor changes we made in the FY 2001 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.0 percent impact for large and other urban hospitals; a 0.2 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.2 percent increase for hospitals with fewer than 100 beds), and small decreases for larger hospitals (a 0.1 percent decrease for hospitals with more than 500 beds). Among rural hospitals, most hospital categories experienced small positive changes, 0.2 percent increases for hospitals with fewer than 200 beds and 0.1 percent increases for hospitals with more than 200 beds.

The breakdown by urban census division shows that the small decrease among urban hospitals is confined to the West North Central region. Payments to urban hospitals in most other regions are unchanged, while payments to urban hospitals in the Middle Atlantic and Puerto Rico regions rise by 0.1 percent. All rural hospital census divisions experience payment increases ranging from 0.1 percent for hospitals in New England and West North Central regions to 0.2 percent for hospitals in the South Atlantic, Middle Atlantic, East North Central, East South Central, West South Central, Pacific, Mountain, and Puerto Rico regions.

C. Impact of Updating the Wage Data (Column 2)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2001 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997. 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 2 shows the percentage changes in payments when going from a model using the FY 2000 wage index (based on FY 1996 wage data before geographic reclassifications to a model using the FY 2001 prereclassification wage index based on FY 1997 wage data). Section 152 of Public Law 106–113 reclassified certain hospitals for purposes of the wage index and the standardized amounts. For purposes of this column, these hospitals are located in their prereclassification geographic location. The impacts of these statutory reclassifications are shown in column 5, when examining the impacts of geographic reclassification.

The wage data collected on the FY 1997 cost reports are similar to the data used in the calculation of the FY 2000 wage index. For a thorough discussion of the data used to calculate the wage index, see section III.B. of this final rule.

The results indicate that the new wage data have an overall impact of a 0.2 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 5). Rural hospitals appear to benefit from the update as their payments increase by 0.6 percent. These increases are attributable to positive increases in the wage index values for the rural areas of several States; California, Illinois, Indiana, Ohio, Texas and Minnesota all had increases of approximately 3 percent in their prereclassification wage index values.

Urban hospitals as a group are not significantly affected by the updated wage data. Hospitals in both other urban areas and large urban areas experienced a small positive increase (0.1 percent). Urban hospitals in New England experienced a 0.9 percent decrease from the updated wage data due to declines ranging from 5 to 1 percent in the wage index values for several MSAs in Connecticut and Massachusetts. Urban hospitals in the Pacific census region experience a 0.5 percent decline due to several MSAs in California with prereclassified FY 2001 wage indexes that fall by 5 percent or less.

The largest increases are seen in the rural census divisions. Rural South Atlantic and West South Central regions experience the greatest positive impact, 1.0 percent. Hospitals in five other census divisions receive positive impacts of 0.5 or greater: East North Central at 0.6, East South Central at 0.6, and West North Central at 0.5. The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 2001. This chart demonstrates the impact of the changes for the FY 2001 wage index relative to the FY 2000 wage index. The majority of labor market areas (339) experience less than a 5 percent change. A total of 21 labor market areas experience an increase of more than 5 percent with only 1 having an increase greater than 10 percent. A total of 15 areas experience decreases of more than 5 percent. Of those, only 1 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2000	FY 2001
Increase more than 10 percent	8	1
Increase more than 5 percent and less than 10 percent	22	20
Increase or decrease less than 5 percent	318	339
Decrease more than 5 percent and less than 10 percent	17	14
Decrease more than 10 percent	5	1

Among urban hospitals, 96 would experience an increase of between 5 and 10 percent and 2 more than 10 percent. No rural hospitals have increases greater than 5 percent. On the negative side, 106 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. One urban hospital has a decrease in their wage index value that is greater than 10 percent. Two rural hospitals have decreases in their wage index values that are greater than 5 percent but less than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	2	0
Increase more than 5 percent and less than 10 percent	96	0
Increase or decrease less than 5 percent	2547	2134
Decrease more than 5 percent and less than 10 percent	106	2
Decrease more than 10 percent	1	0

D. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNAs' Costs (Column 3)

As described in section III.C. of this preamble, the FY 2001 wage index is calculated by blending 60 percent of hospitals' average hourly wages calculated without removing teaching physician (paid under Medicare Part A), residents, or CRNA costs (and hours) and 40 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the second year of a 5-year phase-out of these costs and hours, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

In order to determine the impact of moving from the 80/20 blend percentage to the 60/40 blend percentage, we first estimated the payments for FY 2001 using the FY 2001 prereclassified wage index calculated using the 80/20 blend percentage (Column 2). We then estimated what the payments for FY 2001 would have been if the 60/40 blend percentage was applied to the FY 2001 prereclassified wage index. Column 3 compares the differences in these payment estimates and shows that the 60/40 blend percentage does not significantly impact overall payments (0.0 percent change). Although there were 165 labor market areas that experience a small percent decrease in their wage index, most of the decreases were less than 3 percent.

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. As noted in the Addendum to this final rule, we compared simulated aggregate payments using the FY 2000 DRG relative weights and wage index to simulated aggregate payments using the FY 2001 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.997225. 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 1, 2, and 3, minus approximately 0.3 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

F. Impact of MGCRB Reclassifications (Column 5)

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 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2001. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments.

Beginning in 1998, by February 28 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, or for FYs 1999 through 2001, for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The FY 2001 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2001. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process. Additional changes that resulted from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application are reflected in this final rule for FY 2001.

Section 152 of Public Law 106–113 reclassified certain hospitals for purposes of the wage index and the standardized amounts. The impacts of these statutory reclassifications are included in this column.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.993187 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.5 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.3 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among most of the rural hospital groups. The largest decrease among the rural census divisions is 0.7 percent for Puerto Rico. The largest increases are in rural West South Central and South Atlantic. These regions receive increases of 3.0 and 2.9 percent, respectively.

Among rural hospitals designated as RRCs, 179 hospitals are reclassified for purposes of the wage index only, leading to the 6.1 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 150–199 beds, which has a 5.2 percent increase in payments.

Rural hospitals reclassified for FY 2000 and FY 2001 experience a 6.2 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 2001 only experience a 4.9 percent increase in payments, while rural hospitals reclassified for FY 2000 only experience a 0.5 percent decrease in payments. Urban hospitals reclassified for FY 2001 but not FY 2000 experience a 4.7 percent increase in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 2001 experience a 1.1 percent decline in payments.

The FY 2001 Reclassification rows of Table I show the changes in payments per case for all FY 2001 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 a 9.4 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 5.8 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.9 percent for FY 2001.

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. Rural nonreclassified hospitals decrease by 0.5 percent, and urban nonreclassified hospitals lose 0.7 percent (the amount of the budget neutrality offset).

G. All Changes (Column 6)

Column 6 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2001 (including statutory changes), to our estimate of payments per case in FY 2000. It includes the effects of the 2.3 percent update to the standardized amounts and the hospital-specific rates for MDHs and the 3.4 percent update for SCHs. It also reflects the 1.1 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2000 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

Another change affecting the difference between FY 2000 and FY 2001 payments arises from section 1886(d)(5)(B) of the Act, as amended by Public Law 106–113. As noted in the introduction to this impact analysis, for FY 2001, the IME adjustment is decreased from last year (6.5 percent in FY 2000 and 6.2 percent in FY 2001).

We also note that column 6 includes the impacts of FY 2001 MGCRB reclassifications compared to the payment impacts of FY 2000 reclassifications. Therefore, when comparing FY 2001 payments to FY 2000, the percent changes due to FY 2001 reclassifications shown in column 5 need to be offset by the effects of reclassification on hospitals' FY 2000 payments(column 7 of Table 1, July 30, 1999 final rule (64 FR 41625)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 2001 payments was approximately a 2.5 percent increase, offsetting most of the 2.6 percent increase in column 7 for FY 2000. Therefore, the net change in FY 2001 payments due to reclassification for rural hospitals is actually a decrease of 0.1 percent relative to FY 2000. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

Finally, section 405 of Public Law 106–113 provided that certain SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. To be eligible, a SCH must have received payment for cost reporting periods beginning during 1999 on the basis of its hospital-specific rate. For FY 2001, eligible SCHs that elect rebasing receive a hospital-specific rate comprised of 75 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate, and 25 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 6 as well.

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 6 may not equal the sum of the changes in columns 4 and 5, plus the other impacts that we are able to identify.

The overall payment change from FY 2000 to FY 2001 for all hospitals is a 1.5 percent increase. This reflects the 2.3 percent update for FY 2001 (3.4 percent for SCHs), the 1.0 percent lower outlier payments in FY 2001 compared to FY 2000 (5.1 percent compared to 6.2 percent); the change in the IME

adjustment (6.5 in FY 2000 to 6.2 in FY 2001); and the rebasing of certain SCHs to their 1996 hospital-specific rate.

Hospitals in urban areas experience a 1.4 percent increase in payments per case compared to FY 2000. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 2000. Hospitals in rural areas, meanwhile, experience a 2.5 percent payment increase. As discussed previously, this is primarily due to the positive effect of the wage index and DRG changes and reclassifications.

Among urban census divisions, payments increased between 0.7 and 2.3 percent between FY 2000 and FY 2001. The rural census division experiencing the smallest increase in payments was Puerto Rico (0.2 percent). The largest increases by rural hospitals are in the South Atlantic and Mountain regions, 2.8 and 2.7 percent, respectively. Among other rural census divisions, the largest increases are in the East South Central and the East North Central, both with 2.6.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 3.3 percent, 2.7 percent, and 2.2 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in the percentage of outlier payments from FY 2000 to FY 2001 (from 6.2 of total DRG payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 2000 to FY 2001 are among hospitals that were reclassified for FY 2000 and are not reclassified for FY 2001. Overall, these hospitals lose 1.7 percent. The urban hospitals in this category lose 0.8 percent, while the rural hospitals lose 3.1 percent. On the other hand, hospitals reclassified for FY 2001 that were not reclassified for FY 2000 would experience the greatest payment increases: 7.1 percent overall; 7.6 percent for 114 rural hospitals in this category and 6.6 percent for 35 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000; OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 2000 payment per case (2)[1]	Average FY 2001 payment per case (3)[1]	All changes (4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	4,888	6,783	6,885	1.5
URBAN HOSPITALS	2,752	7,354	7,454	1.4
LARGE URBAN AREAS	1,571	7,895	7,996	1.3
OTHER URBAN AREAS	1,181	6,650	6,747	1.5
RURAL HOSPITALS	2,136	4,544	4,658	2.5
BED SIZE (URBAN):				
0–99 BEDS	716	4,947	5,025	1.6
100–199 BEDS	944	6,202	6,294	1.5
200–299 BEDS	548	7,042	7,132	1.3
300–499 BEDS	401	7,885	7,974	1.1
500 OR MORE BEDS	143	9,547	9,703	1.6
BED SIZE (RURAL):				
0–49 BEDS	1,233	3,784	3,901	3.1
50–99 BEDS	535	4,248	4,358	2.6
100–149 BEDS	219	4,648	4,746	2.1
150–199 BEDS	81	5,090	5,220	2.6
200 OR MORE BEDS	68	5,710	5,838	2.2
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	146	7,815	7,888	0.9
MIDDLE ATLANTIC	421	8,296	8,396	1.2
SOUTH ATLANTIC	404	7,022	7,098	1.1
EAST NORTH CENTRAL	463	7,006	7,144	2
EAST SOUTH CENTRAL	161	6,627	6,683	0.8
WEST NORTH CENTRAL	188	7,105	7,203	1.4
WEST SOUTH CENTRAL	351	6,760	6,917	2.3
MOUNTAIN	133	7,044	7,156	1.6
PACIFIC	440	8,572	8,633	0.7
PUERTO RICO	45	3,156	3,209	1.7
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,468	5,586	2.2
MIDDLE ATLANTIC	80	4,910	5,016	2.2
SOUTH ATLANTIC	277	4,680	4,813	2.8
EAST NORTH CENTRAL	283	4,591	4,710	2.6
EAST SOUTH CENTRAL	266	4,209	4,317	2.6
WEST NORTH CENTRAL	492	4,348	4,458	2.5
WEST SOUTH CENTRAL	340	4,061	4,144	2.1
MOUNTAIN	201	4,863	4,995	2.7
PACIFIC	140	5,583	5,712	2.3
PUERTO RICO	5	2,447	2,453	0.2
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,833	7,312	7,411	1.4
LARGE URBAN	1,665	7,797	7,905	1.4
OTHER URBAN	1,168	6,637	6,724	1.3
RURAL HOSPITALS	2,055	4,509	4,627	2.6
TEACHING STATUS:				
NON-TEACHING	3,770	5,464	5,550	1.6
FEWER THAN 100 RESIDENTS	876	7,125	7,223	1.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000; OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 2000 payment per case (2)[1]	Average FY 2001 payment per case (3)[1]	All changes (4)
100 OR MORE RESIDENTS	242	10,828	11,001	1.6
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,070	5,810	5,895	1.5
URBAN DSH:				
100 BEDS OR MORE	1,390	7,919	8,037	1.5
FEWER THAN 100 BEDS	72	4,927	5,019	1.9
RURAL DSH:				
SOLE COMMUNITY (SCH)	149	4,140	4,290	3.6
REFERRAL CENTERS (RRC)	56	5,415	5,543	2.4
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	48	4,097	4,218	2.9
FEWER THAN 100 BEDS	103	3,714	3,798	2.3
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	726	8,826	8,962	1.6
TEACHING AND NO DSH	327	7,322	7,409	1.2
NO TEACHING AND DSH	736	6,311	6,395	1.3
NO TEACHING AND NO DSH	1,044	5,668	5,727	1
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	835	3,922	4,017	2.4
RRC	150	5,257	5,382	2.4
SCH	661	4,502	4,650	3.3
MDH	352	3,784	3,885	2.7
SCH AND RRC	57	5,500	5,620	2.2
TYPE OF OWNERSHIP:				
VOLUNTARY	2,840	6,945	7,079	1.5
PROPRIETARY	745	6,300	6,384	1.3
GOVERNMENT	1,301	6,400	6,512	1.8
UNKNOWN	2	3,406	3,499	2.7
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0—25	381	9,013	9,172	1.8
25—50	1,830	7,858	7,968	1.4
50—65	1,893	5,910	6,007	1.6
OVER 65	699	5,260	5,336	1.4
UNKNOWN	85	9,997	10,116	1.2
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY 2000 AND FY 2001:				
RECLASSIFIED DURING BOTH FY 2000 AND FY 2001	377	5,851	5,958	1.8
URBAN	53	8,027	8,161	1.7
RURAL	324	5,249	5,348	1.9
RECLASSIFIED DURING FY 2001 ONLY	149	5,537	5,930	7.1
URBAN	35	6,971	7,428	6.6
RURAL	114	4,623	4,975	7.6
RECLASSIFIED DURING FY 2000 ONLY	172	6,011	5,909	−1.7
URBAN	70	7,454	7,394	−0.8
RURAL	102	4,620	4,476	−3.1
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	527	5,776	5,948	3
STANDARDIZED AMOUNT ONLY	66	4,697	4,888	4.1
WAGE INDEX ONLY	386	5,878	5,913	0.6
BOTH	46	6,295	6,457	2.6
NONRECLASSIFIED	4,364	6,912	7,019	1.6
ALL URBAN RECLASSIFIED	88	7,660	7,906	3.2
STANDARDIZED AMOUNT ONLY	17	5,333	5,379	0.9
WAGE INDEX ONLY	38	8,718	8,934	2.5
BOTH	33	7,217	7,584	5.1
NONRECLASSIFIED	2,638	7,355	7,449	1.3
ALL RURAL RECLASSIFIED	439	5,128	5,275	2.9
STANDARDIZED AMOUNT ONLY	54	4,785	4,779	−0.1
WAGE INDEX ONLY	358	5,153	5,316	3.2
BOTH	27	5,258	5,410	2.9
NONRECLASSIFIED	1,697	4,114	4,204	2.2
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,713	4,775	1.3

[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 2001 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2000 with the average estimated per case payments for FY 2001, 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 6 of Table I.

VIII. Impact of Organ, Tissue and Eye Procurement Condition of Participation on CAHs

In this final rule, we are adding a CoP for organ, tissue and eye procurement for CAHs. We estimate that the procurement costs for organ, eyes, and tissue for CAHs is negligible. This estimate is based on the following projections. There are several provisions in this condition that will impact CAHs to a greater or lesser degree. Specifically, CAHs are required to have written protocols; have agreements with an OPO, a tissue bank, and an eye bank; refer all deaths that occur in the CAH to the OPO or a third party designated by the OPO; ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as a designated requestor; and work cooperatively with the OPO, tissue bank, and eye bank in educating CAH staff, reviewing death records, and maintaining potential donors. It is important to note that because of the inherent flexibility of this condition, the extent of its economic impact is dependent upon decisions that will be made either by the CAH or by the CAH in conjunction with the OPO or the tissue and eye banks. Thus, the impact on individual CAHs will vary and is subject in large part to their decision making. The impact will also vary based on whether a CAH currently has an organ donation protocol and its level of compliance with existing law and regulations. For example, if a CAH was a Medicare hospital in compliance with the hospital CoP for organ, tissue, and eye procurement prior to converting to a CAH, there will be no additional impact.

The first requirement in the CoP is that CAHs have and implement written protocols that reflect the various other requirements of the CoP. Currently, under section 1138 of the Act, CAHs must have written protocols for organ donation. Most CAHs will need to rewrite their existing protocols to conform with this regulation; however, this is clearly not a requirement that imposes a significant economic burden.

In addition, a CAH must have an agreement with its designated OPO and with at least one tissue bank and at least one eye bank. CAHs are required under section 1138 of the Act to refer all potential donors to an OPO. Also, the OPO regulation at 42 CFR 486.306 requires, as a qualification for designation as an OPO, that the OPO have a working relationship with at least 75 percent of the hospitals in its service area that participate in the Medicare and Medicaid programs and that have an operating room and the equipment and personnel for retrieving organs. Therefore, some CAHs may already have an agreement with their designated OPO. Although CAHs may need to modify those existing agreements, the need to make modifications would not impose a significant economic burden. Although there is no statutory or regulatory requirement for a CAH to have agreements with tissue and eye banks, we must assume some CAHs have agreements with tissue and eye banks, since hospitals are the source for virtually all tissues and eyes.

The CoP requires CAHs to notify the OPO about every death that occurs in the CAH. The average Medicare hospital has approximately 165 beds and 200 deaths per year. However, by statute and regulation, CAHs may use no more than 15 beds for acute care services. Assuming that the number of deaths in a hospital is related to the number of acute care beds, there should be approximately 18 deaths per year in the average CAH. Thus, the economic impact for a CAH of referring all deaths would be small.

Under the CoP, a CAH may agree to have the OPO determine medical suitability for tissue and eye donation or may have alternative arrangements with a tissue bank and an eye bank. These alternative arrangements could include the CAH's direct notification of the tissue and eye bank of potential tissue and eye donors or direct notification of all deaths. Again, the impact is small, and the regulation permits the CAH to decide how this process will take place. We recognize that many communities already have a one-phone-call system in place. In addition, some OPOs are also tissue banks or eye banks or both. A CAH that chose to use the OPO's tissue and eye bank services in these localities would need to make only one telephone call on every death.

This CoP requires that the individual who initiates a request for donation to the family of a potential donor must be an OPO representative or a designated requestor. A designated requestor is an individual who has taken a course offered or approved by the OPO in the methodology for approaching families of potential donors and requesting donation. The CAH would need to arrange for designated requestor training. Most OPOs have trained designated requestors as part of the hospital CoP for organ, tissue, and eye procurement. Even if the CAH wants to have a sufficient number of designated requestors to ensure that all shifts are covered, this provision of the regulation would not have a significant economic impact on CAHs. In addition, the CAH may be able to choose to have donation requests initiated by the OPO, the tissue bank, or the eye bank staff rather than CAH staff, in which case there is no economic impact.

The regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in educating CAH staff. We do not believe education of CAH staff will demand a significant amount of staff time. In addition, most OPOs already give educational presentations for the staff in their hospitals.

The regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in reviewing death records. Most OPOs currently conduct extensive CAH death record reviews. The CAH's assistance is required only to provide lists of CAH deaths and facilitate access to records.

Finally, the regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in maintaining potential donors while necessary testing and placement of potential donated organs and tissues take place. It is possible that because of the CoP, some CAHs may have their first organ donors. Therefore, we considered the impact on a CAH of maintaining a brain dead potential donor on a ventilator until the organs can be placed. CAHs with full ventilator capability should have no trouble maintaining a potential donor until the organs are placed. However, some CAHs have ventilator capability only so that a patient can be maintained until he or she is transferred to a larger facility for treatment. These CAHs would have the equipment and staffing to maintain a potential donor until transfer to another facility occurs. Some CAHs do not have ventilator capability and would be unable to maintain a potential donor. However, CAHs without ventilator capability would still be obligated to notify the OPO, or a third party designated by the OPO, of all individuals whose death is imminent or who have died in the CAH because there is a potential to obtain a tissue or an eye donation. We do not believe there will be a significant impact on CAHs no matter what their situation—full ventilator capability, ventilator capability only for patients who are to be transferred to a larger facility, or no ventilator capability.

Although, as stated previously, there are several requirements in this CoP that will impact CAHs to a greater or lesser degree, we assert that the potential benefits to beneficiaries exceed the associated costs of requiring CAHs to comply with this standard. As stated in the Hospital Conditions of Participation; Identification of Potential Organ, Tissue, and Eye Donors and Transplant Hospitals' Provision of Transplant-Related Data regulation published on June 22, 1998 in the **Federal Register** (63 FR 33872), there were 3.11 organs transplanted for every donor recovered. Further, we do not believe there will be a significant impact on CAHs no matter what their situation—full ventilator capability, ventilator capability only for patients who are to be transferred to a larger facility, or no ventilator capability. Based on a HCFA actuarial opinion, the cost for CAHs to implement this requirement is negligible. We reviewed the comprehensive analysis in the impact section for the hospital CoP discussed in the above referenced regulation and determined that the analysis and assumptions made at that time are valid for this CAH CoP.

We expect that this regulation will increase tissue and eye donations as well as organ donations. A study of the impact of the Pennsylvania routine referral legislation on tissue and eye donations was presented at the Fourth International Society for Organ Sharing Congress and Transplant Congress in July 1997. (Nathan, HM, Abrams, J. Sparkman BA, *et al.* ''Comprehensive State Legislation Increases Organ and Tissue

Donations'') This study used data from the Delaware Valley Transplant Program, the OPO for Southeastern Pennsylvania, and found that although the maximum donor age was lowered from <66 to <60, tissue donations increased 14 percent from 1994 through 1996. The study also showed that eye donations increased 28 percent during the same period, despite more restrictive donor criteria. This virtually eliminated the waiting list for suitable corneas. North Carolina's routine referral legislation became effective in October 1997. The Carolina Organ Procurement Agency (one of three North Carolina OPOs) has seen heart valve donations increase by 109 percent and other tissue donations increase 114 percent through May 1998.

We did not receive any public comments on the impact of this provision.

IX. Impact of Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation Policy Change in the Treatment of Certain Medicaid Patient Days in States With 1115 Expansion Waivers

As discussed in the January 20, 2000 interim final rule with comment period, we revised the policy for the Medicare disproportionate share hospital adjustment provision set forth under section 1886(d)(5)(F) of the Act to allow hospitals located in states with section 1115 expansion waivers to include the patient days of all populations eligible for title XIX matching payments under a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.

There are currently eight States with section 1115 expansion waivers (Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont). Under the provisions of this final rule, hospitals in these eight States will be allowed to include in the Medicaid percentage portion of their Medicare DSH calculation the inpatient hospital days attributable to patients who are eligible under the State's section 1115 expansion waiver. Because our policy was that these days were not allowable prior to January 20, 2000, by allowing hospitals to begin to include these days in their Medicare DSH calculation, the impact will be to increase the DSH payments these hospitals will receive compared to what they would receive absent this change.

We have estimated the impact of this change to be $270 million in higher FY 2000 prospective payments system payments (total FY 2000 DSH payments are projected to be $4.6 billion), and $370 million in FY 2001 payments. Thus the total impact of this change for the period from FY 2001 through FY 2005 is estimated to be $2.14 billion.

X. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 7th year of the capital prospective payment system (cost reports beginning in FY 1998) available through the March 2000 update of the 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, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of 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.
- 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 fiscal 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 2001 capital cost projections. In Appendix B of this final rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2001 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2001. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 2001 capital payment policies by the standard prospective payment system hospital groupings. 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 still 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 2001 capital costs for individual hospitals, but with the most recent data on hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the FY 2001 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 2000 to FY 2001 using a capital cost model. The FY 2001 model, as described in Appendix B of this final rule, 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 1998 as reported on the March 2000 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 April 1, 2000 in the provider-specific file. We used these data to determine the FY 2001 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 1998, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1998. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 2001 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1999	3.12
2000	3.31
2001	2.95

- We estimate that the Medicare case-mix index will increase by 0.5 percent in FY 2000 and in FY 2001.
- The Federal capital rate and the hospital-specific rate were updated in FY 1996 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 FY 2001 update is 0.9 percent (see section IV. of the Addendum to this final rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 2000 to FY 2001. 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 and the applicable Federal 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 FOR FY 2001

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	67	62	56	61
High Cost Hospital	33	38	44	39

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 into 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 continue 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 2000 to FY 2001 using the above described actuarial model. With the Federal rate, we estimate aggregate Medicare capital payments will increase by 5.48 percent in FY 2001. This increase is noticeably higher than last year's (3.64 percent) due to the combination of the increase in the number of hospital admissions, the increase in case-mix, and the increase in the Federal blend percentage from 90 percent to 100 percent and a decrease in the hospital-specific rate percentage from 10 percent to 0 percent for fully prospective payment hospitals.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2001 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hopital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 2000
FY 2000 Payments per Discharge:									
Low Cost Hospitals	3,194	6,723,732	$574.73	90.41	$30.18	$2.95	$7.84	$615.72	.....
Fully Prospective	3,020	6,252,299	571.02	90.00	32.46	.....	7.45	610.93	.....
100% Federal Rate	159	438,006	635.95	100.00	.....	.....	3.42	639.38	.....
Hold Harmless	15	33,426	467.66	54.25	.....	594.40	139.14	1,201.21	.....
High Cost Hospitals	1,598	4,078,374	650.66	97.86	.....	19.26	13.05	682.97	.....
100% Federal Rate	1,383	3,717,412	665.24	100.00	.....	.....	6.98	672.22	.....
Hold Harmless	215	360,962	500.42	75.67	.....	217.62	75.58	793.63	.....
Total Hospitals	4,792	10,802,106	603.40	93.30	18.79	9.11	9.81	641.11	.....
FY 2001 Payments per Discharge:									
Low Cost Hospitals	3,194	6,835,654	$637.91	99.74	.....	$2.42	$9.69	$650.02	5.57
Fully Prospective	3,020	6,356,377	638.58	100.00	.....	.....	9.20	647.78	6.03
100% Federal Rate	159	445,296	638.34	100.00	.....	.....	4.35	642.69	0.52
Hold Harmless	15	33,981	506.60	60.11	.....	486.54	170.96	1,164.09	−3.09
High Cost Hospitals	1,598	4,146,181	653.32	98.38	.....	15.35	21.47	690.15	1.05
100% Federal Rate	1,394	3,793,349	664.47	100.00	.....	.....	10.65	675.12	0.43
Hold Harmless	204	352,832	533.52	80.86	.....	180.41	137.76	851.69	7.32
Total Hospitals	4,792	10,981,835	643.73	99.21	.....	7.30	14.14	665.17	3.75

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 6.03 percent, and high capital cost hospitals will experience an average increase of 1.05 percent. These results are due to the change in the blended percentages to the payment system to 100 percent adjusted Federal rate and 0 percent hospital-specific rate.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 90 percent to 100 percent and the hospital-specific rate payment percentage will decrease from 10 to 0 percent in FY 2001. 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 75.67 percent to 80.86 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 86.55 percent to 87.23 percent. We estimate that the few remaining high cost hold-harmless hospitals (204) will experience an increase in payments of 7.32 percent from FY 2000 to FY 2001. This increase reflects our estimate that exception payments per discharge will increase 82.27 percent from FY 2000 to FY 2001 for high cost hold-harmless hospitals. While we estimate that this group's regular hold-harmless payments for old capital will decline by 17.10 percent due to the retirement of old capital, we estimate that its high overall capital costs will cause an increase in these hospitals' exceptions payments from $75.58 per discharge in FY 2000 to $137.76 per discharge in FY 2001. This is primarily due to the estimated decrease in outlier payments, which will cause an estimated increase in exceptions payments to cover unmet capital costs.

We estimate that the average hospital-specific rate payment per discharge will decrease from $32.46 in FY 2000 to $0.00 in FY 2001. This decrease is due to the decrease in the hospital-specific rate payment percentage from 10 percent in FY 2000 to 0 percent in FY 2001 for fully prospective payment hospitals.

We have made no changes in our exceptions policies for FY 2001. As a result, the minimum payment levels would be—

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or

• 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.53 percent of total capital payments in FY 2000 to 2.13 percent of payments in FY 2001. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2001 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	201	43
High Capital Cost	214	57
Total	415	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment metholology. This distribution is generated by our acturarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2001)

	(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	4,792	4.6	32.4	63.0
Large urban areas (populations over 1 million)	1,524	4.3	41.0	54.7
Other urban areas (populations of 1 million or fewer)	1,149	5.8	39.5	54.7
Rural areas	2,119	4.1	22.4	73.5
Urban hospitals	2,673	4.9	40.4	54.7
0–99 beds	658	6.2	33.9	59.9
100–199 beds	929	7.2	45.5	47.3
200–299 beds	543	3.3	41.4	55.2
300–499 beds	400	0.8	37.0	62.3
500 or more beds	143	2.1	42.0	55.9
Rural hospitals	2,119	4.1	22.4	73.5
0–49 beds	1,220	2.9	16.6	80.6
50–99 beds	531	6.8	26.7	66.5
100–149 beds	219	5.9	35.2	58.9
150–199 beds	81	2.5	25.9	71.6
200 or more beds	68	1.5	47.1	51.5
By Region:				
Urban by Region	2,673	4.9	40.4	54.7
New England	145	0.7	25.5	73.8
Middle Atlantic	408	2.9	34.8	62.3
South Atlantic	398	5.5	51.8	42.7
East North Central	454	4.2	29.7	66.1
East South Central	154	8.4	46.1	45.5
West North Central	182	6.0	36.8	57.1
West South Central	328	8.8	58.2	32.9
Mountain	124	4.8	48.4	46.8
Pacific	435	4.1	36.3	59.5
Puerto Rico	45	2.2	26.7	71.1
Rural by Region	2,119	4.1	22.4	73.5
New England	52	0.0	23.1	76.9
Middle Atlantic	78	5.1	19.2	75.6
South Atlantic	276	2.2	33.3	64.5
East North Central	279	3.9	16.5	79.6
East South Central	265	3.4	32.8	63.8
West North Central	491	3.3	14.5	82.3
West South Central	334	4.5	26.3	69.2
Mountain	200	9.5	15.0	75.5
Pacific	139	5.0	23.7	71.2
By Payment Classification:				
Large urban areas (populations over 1 million)	1,618	4.2	41.3	54.5
Other urban areas (populations of 1 million or fewer)	1,136	6.0	38.8	55.2
Rural areas	2,038	4.1	21.8	74.1
Teaching Status:				
Non-teaching	3,682	5.1	31.6	63.3
Fewer than 100 Residents	871	2.9	35.9	61.2
100 or more Residents	239	2.1	32.2	65.7
Disproportionate share hospitals (DSH):	2,988	4.7	28.3	67.0
By Geographic Location:				
All hospitals	4,792	4.6	32.4	63.0

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2001)—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)	
Non-DSH				
Urban DSH:				
100 or more beds	1,379	4.6	42.5	52.9
Less than 100 beds	70	4.3	25.7	70.0
Rural DSH:				
Sole Community (SCH/EACH)	149	5.4	20.1	74.5
Referral Center (RRC/EACH)	56	3.6	51.8	44.6
OTHER RURAL:				
100 OR MORE BEDS	48	.....	39.6	60.4
Less than 100 beds	102	2.0	23.5	74.5
Urban teaching and DSH:				
Both teaching and DSH	720	2.5	36.7	60.8
Teaching and no DSH	325	3.1	33.8	63.1
No teaching and DSH	729	6.7	46.6	46.6
No teaching and no DSH	980	6.0	40.3	53.7
Rural Hospital Types:				
Non special status hospitals	819	1.5	24.1	74.5
RRC/EACH	150	2.7	36.0	61.3
SCH/EACH	661	8.5	18.2	73.4
Medicare-dependent hospitals (MDH)	351	1.4	16.5	82.1
SCH, RRC and EACH	57	10.5	26.3	63.2
Type of Ownership:				
Voluntary	2,520	4.5	32.4	63.1
Proprietary	655	7.2	57.1	35.7
Government	1,093	4.1	19.2	76.7
Medicare Utilization as a Percent of Inpatient Days:				
0–25	369	5.4	27.6	66.9
25–50	1,820	4.3	35.1	60.7
50–65	1,882	4.7	31.2	64.1
Over 65	688	4.8	32.1	63.1

As we explain in Appendix B of this final rule, we were not able to use 96 of the 4,888 hospitals in our database due to insufficient (missing or unusable) data. Consequently, the payment methodology distribution is based on 4,792 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 the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 32.4 percent in FY 2001.

Table IV indicates that 63.0 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 67 percent for low cost capital hospitals in the chart on ''Capital Transition Payment Methodology for FY 2001,'' in section VII.B.2. of this impact analysis takes into account the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (74.1 percent and 76.7 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 35.7 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 2001 actuarial model to estimate the potential impact of our changes for FY 2001 on total capital payments per case, using a universe of 4,792 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 2000 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 2001 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 2000 and FY 2001. Column 5 shows the total percentage change in payments from FY 2000 to FY 2001. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.33 percent increase in the Federal rate, a 0.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including the change from 90 percent to 100 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 increase 3.8 percent in FY 2001. The results show that the effect of the Federal

rate change alone is to increase payments by 0.3 percent. In addition to the increase attributable to the Federal rate change, a 3.5 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (3.6 percent and 4.6 percent, respectively). This difference is due to the lower rate of increase for urban hospitals relative to rural hospitals (0.1 percent and 1.4 percent, respectively) from the Federal rate changes alone. Urban hospitals are actually projected to gain slightly more than rural hospitals (3.5 percent versus 3.2 percent, respectively) from the effects of all other changes.

All regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 90 to 100 percent). Changes by region vary from a minimum of 2.6 percent increase (West South Central urban region) to a maximum of 7.4 percent increase (Pacific rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (4.5 percent, a 0.6 percent increase due to the Federal rate changes, and a 3.9 percent increase from the effects of all other changes). Payments to voluntary hospitals will increase 3.7 percent (a 0.3 percent increase due to Federal rate changes, and a 3.4 percent increase from the effects of all other changes) and payments to proprietary hospitals will increase 2.6 percent (a 0.1 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, and for purposes of DSH for FYs 1999 through 2001. 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 2001 compared to the effects of reclassification for FY 2000, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2001 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 2001 as a whole are projected to experience a 5.2 percent increase in payments (a 2.0 percent increase attributable to Federal rate changes and a 3.2 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (3.8 percent) than reclassified hospitals (5.2 percent) overall. Payments to nonreclassified hospitals will increase less than reclassified hospitals due to the Federal rate changes (0.3 percent compared to 2.0 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2000 payments compared to FY 2001 payments]

	Number of hospitals	Average FY 2000 payments/case	Average FY 2001 payments/case	All changes	Portion attributable to federal rate change
By Geographic Location:					
All hospitals	4,792	641	665	3.8	0.3
Large urban areas (populations over 1 million)	1,524	745	772	3.6	0.0
Other urban areas (populations of 1 million or fewer)	1,149	629	653	3.7	0.4
Rural areas	2,119	429	449	4.6	1.4
Urban hospitals	2,673	695	720	3.6	0.1
0–99 beds	658	499	518	3.8	0.6
100–199 beds	929	610	630	3.4	0.3
200–299 beds	543	662	684	3.4	0.3
300–499 beds	400	726	754	3.8	−0.1
500 or more beds	143	889	923	3.8	0.0
Rural hospitals	2,119	429	449	4.6	1.4
0–49 beds	1,220	358	378	5.8	2.0
50–99 beds	531	409	429	4.9	1.4
100–149 beds	219	444	461	3.8	1.0
150–199 beds	81	467	489	4.7	1.8
200 or more beds	68	526	547	3.9	1.0
By Region:					
Urban by Region	2,673	695	720	3.6	0.1
New England	145	723	751	3.9	−0.1
Middle Atlantic	408	769	797	3.7	−0.1
South Atlantic	398	674	693	2.9	−0.2
East North Central	454	660	692	4.9	0.8
East South Central	154	638	660	3.4	−0.3
West North Central	182	691	715	3.4	0.1
West South Central	328	661	678	2.6	0.8
Mountain	124	687	723	5.3	0.3
Pacific	435	780	804	3.1	−0.5
Puerto Rico	45	293	311	6.1	2.3
Rural by Region	2,119	429	449	4.6	1.4
New England	52	525	544	3.6	0.2
Middle Atlantic	78	450	469	4.1	0.8
South Atlantic	276	443	462	4.4	1.8
East North Central	279	432	459	6.2	1.6
East South Central	265	395	411	4.2	1.5
West North Central	491	420	440	4.6	1.5
West South Central	334	391	404	3.4	1.0
Mountain	200	461	478	3.7	1.1

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2000 payments compared to FY 2001 payments]

	Number of hospitals	Average FY 2000 payments/case	Average FY 2001 payments/case	All changes	Portion attributable to federal rate change
Pacific	139	506	543	7.4	1.4
By Payment Classification:					
All hospitals	4,792	641	665	3.8	0.3
Large urban areas (populations over 1 million)	1,618	736	763	3.6	0.1
Other urban areas (populations of 1 million or fewer)	1,136	628	650	3.5	0.2
Rural areas	2,038	425	446	4.8	1.5
Teaching Status:					
Non-teaching	3,682	530	549	3.5	0.6
Fewer than 100 Residents	871	669	694	3.7	0.3
100 or more Residents	239	979	1,022	4.4	−0.2
Urban DSH:					
100 or more beds	1,379	733	759	3.6	0.1
Less than 100 beds	70	570	604	5.9	0.5
Rural DSH:					
Sole Community (SCH/EACH)	149	382	399	4.5	2.1
Referral Center (RRC/EACH)	56	490	506	3.2	1.0
Other Rural:					
100 or more beds	48	383	401	4.9	2.3
Less than 100 beds	102	343	360	5.0	1.9
Urban teaching and DSH:					
Both teaching and DSH	720	807	838	3.8	0.1
Teaching and no DSH	325	699	728	4.1	0.2
No teaching and DSH	729	603	621	3.1	0.2
No teaching and no DSH	980	570	588	3.0	0.2
Rural Hospital Types:					
Non special status hospitals	819	376	394	5.0	1.7
RRC/EACH	150	493	515	4.3	1.4
SCH/EACH	661	425	448	5.5	1.5
Medicare-dependent hospitals (MDH)	351	356	377	5.7	1.9
SCH, RRC and EACH	57	499	516	3.5	0.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY00 and FY01:					
Reclassified During Both FY00 and FY01	377	546	569	4.1	0.9
Reclassified During FY01 Only	149	531	579	9.1	6.0
Reclassified During FY00 Only	131	553	546	−1.2	−3.1
FY01 Reclassifications:					
All Reclassified Hospitals	526	543	571	5.2	2.0
All Nonreclassified Hospitals	4,268	654	679	3.8	0.3
All Urban Reclassified Hospitals	88	701	746	6.3	2.3
Urban Nonreclassified Hospitals	2,559	696	720	3.5	0.0
All Reclassified Rural Hospitals	438	488	510	4.7	1.9
Rural Nonreclassified Hospitals	1,681	386	404	4.6	1.0
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	463	473	2.1	0.7
Type of Ownership:					
Voluntary	2,520	655	680	3.7	0.3
Proprietary	655	626	643	2.6	−0.1
Government	1,093	576	602	4.5	0.6
Medicare Utilization as a Percent of Inpatient Days:					
0–25	369	801	838	4.7	0.1
25–50	1,820	736	763	3.7	0.0
50–65	1,882	568	590	3.8	0.6
Over 65	688	512	528	3.2	0.7

Appendix B: Technical Appendix on the 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 used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 7 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised 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 March 31, 2000 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), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), PPS–XIV (cost reporting periods beginning in FY 1997), and PPS–XV (cost reporting periods beginning in FY 1998). In addition, to model payments, we use the April 1, 2000 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 2000 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	173
Provider-Specific and Audit File	4,715
Total	4,888

One hundred forty-three of the 4,888 hospitals had unusable or missing data, or had no cost reports available. For 42 of the 143 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 42 hospitals in the analysis. We were able to estimate hospital-specific amounts for five additional hospitals from the cost reports as shown in the following table:

Cost report	Number of hospitals
PPS–9	1
PPS–12	2
PPS–14	1
PPS–15	1
Total	5

Hence we were able to use 47 of the 143 hospitals. We used 4,792 hospitals for the analysis. Ninety-six hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 0.5 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

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 changes in bed-size (greater than ±20 percent). 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 to 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 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 the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(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 1999 (the MedPAR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals had considerably more discharges in FY 1999 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 more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address 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 all of the FY 1999 discharges, and we have removed some discharges 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 is 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 1999 MedPAR file using the FY 2001 DRG relative weights included in section VI. of the Addendum to this final rule. The case-mix index is increased each year after FY 1999 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 0.0 percent in FY 2000. We project that case-mix will increase 0.0 percent in FY 2001. (Since we are using FY 1999 cases for our analysis, the FY 1999 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 2000, the budget neutrality adjustment factors were 1.00142 for the national rate and 1.00134 for the Puerto Rico rate.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

To determine the factors for FY 2001, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2001 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 2000 relative weights and the FY 2001 geographic adjustment factor. In making the comparison, we held the FY 2001 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99782 for FY 2001 to the previous cumulative FY 2000 adjustment of 1.00142, yielding a cumulative adjustment of 0.99924 through FY 2001. For the Puerto Rico geographic adjustment factor, we applied an incremental budget neutrality adjustment of 1.00365 for FY 2001 to the previous cumulative FY 2000 adjustment of 1.00134, yielding a cumulative adjustment of 1.00499 through FY 2001. We then compared estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2001 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2001 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00009 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2001 would be 0.99933 nationally and 1.00508 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
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	.....	.....	.....	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508

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 (the national rate and the Puerto Rico rate are determined separately) 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 FYs 1992 through 2000, the final factors for FY 2001, and the estimated factors that would be applicable through FY 2005. We caution that these are estimates for FYs 2002 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 0.99933 (1.00508 for Puerto Rico) for FY 2001 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2001.

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	0.10	.9783	N/A	1.0028	.9392	.....	378.10
2000	0.30	.9730	N/A	.9985	.9402	.....	377.03
2001	0.90	.9785	N/A	.9979	.9409	.....	382.03
2002	0.90	[6] 1.0000	N/A	[5] 1.0000	[5] .9409	.....	393.94
2003	0.90	[6] 1.0000	N/A	1.0000	.9409	[4] 1.0255	407.64
2004	0.80	[6] 1.0000	N/A	1.0000	.9409	.....	410.90
2005	0.90	[6] 1.0000	N/A	1.0000	.9409	.....	414.60

[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: 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 2001 by hospitals subject to the prospective payment system and by hospitals or units excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XVI) of the Act sets the FY 2001 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.1 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2001 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. For Medicare-dependent, small rural hospitals, the percentage increase is the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.1 percentage points. Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i) of the Act to provide that, for sole community hospitals, the rate of increase for FY 2001 is equal to the market basket percentage increase.

Under section 1886(b)(3)(B)(ii) of the Act, the FY 2001 percentage increase in the rate-of-increase limits for hospitals and units excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available, or 0 percentage point if costs do not exceed two-thirds of the limit.

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 and units excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 2000 forecast of the FY 2001 market basket increase of 3.4 percent for hospitals and units subject to the prospective payment system, the update to the standardized amounts is 2.3 percent (that is, the market basket rate of increase minus 1.1 percent percentage points) for hospitals in both large urban and other areas. The update to the hospital-specific rate applicable to Medicare-dependent, small rural hospitals is also 2.3 percent. The update to the hospital-specific rate applicable to sole community hospitals is 3.4 percent. The update for hospitals and units excluded from the prospective payment system can range from the percentage increase in the excluded hospital market basket (currently estimated at 3.4 percent) minus a percentage between 0 and 2.5 percentage points, or 0 percentage point, resulting in an increase in the rate-of-increase limit between 0.9 and 3.4 percent, or zero percent (see section V of the Addendum of this final rule).

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), 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. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, we published the FY 2001 update factors recommended by the Secretary in Appendix D of the May 5, 2000 proposed rule (65 FR 26434). In its March 1, 2000 report, MedPAC did not make a specific update recommendation for FY 2001 payments for Medicare acute inpatient hospitals. However, in its June 1, 2000 report, which was issued after the May 5, 2000 proposed rule, MedPAC recommended a combined operating and capital update for hospital inpatient prospective payment system payments for FY 2001. We describe the basis of our FY 2001 update recommendation in Appendix D of the May 5, 2000 proposed rule at 65 FR 26434. Our responses to the MedPAC recommendations concerning the update factors for FY 2001 are discussed below in section II of this Appendix.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, in the May 5, 2000 proposed rule, we recommended that an appropriate update factor for the standardized amounts was 2.0 percentage points for hospitals located in large urban and other areas. We also recommended an update of 2.0 percentage points to the hospital-specific rate for Medicare-dependent, small rural hospitals. In addition, we recommended an update of 3.1 percentage points to the hospital-specific rate for sole community hospitals. We believed these recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

Also in the proposed rule, we recommended that hospitals excluded from the prospective payment system receive an update of between 0.6 and 3.1 percentage

points, or zero percentage points. The update for excluded hospitals and units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its rate-of-increase limit for the most recent cost reporting period for which information is available. For the proposed rule, the market basket rate of increase for excluded hospitals and units was forecast at 3.1 percent.

III. MedPAC Recommendations for Updating the Prospective Payment System Operating Standardized Amounts

In its June 2000 Report to Congress, MedPAC presented a combined operating and capital update for hospital inpatient prospective payment system payments for FY 2001 and recommended that Congress implement a single combined (operating and capital) prospective payment system rate. With the end of the transition to fully prospective capital payments ending with FY 2001, both operating and capital prospective system payments will be made using standard Federal rates adjusted by hospital specific payment variables. Currently, section 1886(b)(3)(B)(i)(XVI) of the Act sets forth the FY 2001 percentage increase in the prospective payment system operating cost standardized amounts. The prospective payment system capital update is set under the framework established by the Secretary outlined in § 412.308(c)(1).

For FY 2001, MedPAC's update framework supports a combined operating and capital update for hospital inpatient prospective payment system payments of 3.5 percent to 4.0 percent (or between the increase in the combined operating and capital market basket plus 0.6 percentage points and the increase in the combined operating and capital market basket plus 1.1 percentage points). MedPAC also notes that while the number of hospitals with negative inpatient hospital margins have increased in FY 1998 (most likely as the result of the implementation of Public Law 105–33), overall high inpatient Medicare margins generally offset hospital losses on other lines of Medicare services. MedPAC continues to project positive (greater than 11 percentage points) Medicare inpatient hospital margins through FY 2002.

MedPAC's FY 2001 combined operating and capital update framework uses a weighted average of HCFA's forecasts of the operating (prospective payment system input price index) and capital (CIPI) market baskets. This combined market basket was used to develop an estimate of the change in overall operating and capital prices. MedPAC calculated a combined market basket forecast by weighting the operating market basket forecast by 0.92 and the capital market basket forecast by 0.08, since operating costs are estimated to represent 92 percent of total hospital costs (capital costs are estimated to represent the remaining 8 percent of total hospital costs). MedPAC's combined market basket for FY 2001 is estimated to increase by 2.9 percent, based on HCFA's March 2000 forecasted operating market basket increase of 3.1 percent and HCFA's March 2000 forecasted capital market basket increase of 0.9 percent.

Response: As we stated in the May 5, 2000 proposed rule (65 FR 26317), we responded to a similar comment in the July 30, 1999 final rule (64 FR 41552), the July 31, 1998 final rule (63 FR 41013), and the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments. However, we have not yet developed such a single framework as the actual operating system update has been determined by Congress through FY 2002. In the meantime, we intend to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We maintain our goal of combining the update frameworks at the end of the 10-year capital transition period (the end of FY 2001) and may examine combining the payment systems post-transition. Because of the similarity of the update frameworks, we believe that they could be combined with little difficulty.

The update framework analysis is a largely empirical process carried out by HCFA that quantifies changes in the hospital productivity, scientific and technological advances, practice pattern changes, hospital case mix, the effects of reclassification on recalibration, and forecast error correction. The update framework suggests an update for the prospective payment system operating standardized amounts ranging from of 2.4 percent (market basket minus 1 percent) to 2.9 percent (market basket minus 0.5 percent) is supported by the analyses outlined below.

A. Productivity

Service level productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use a labor productivity measure since this update framework applies to operating payment. To recognize that we are apportioning the short-run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure for operating costs by the share of direct labor services in the market basket to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989, or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

As stated in the proposed rule, since it was not possible at that time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.3 to 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low and larger in years that output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply the sum of the expected change in intensity (0.0 percent), projected admissions change (1.6 percent for FY 2001), and projected real case-mix growth (0.5 percent), or 2.1 percent. The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.4 percent.

Multiplying the expected change in total hospital service output (2.1 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.4, provides our productivity standard of -0.5 to -0.4 percent. In past years, MedPAC made an adjustment for productivity improvement to reflect the level of improvement in the production of health care services, without affecting the quality of those services. Typically, MedPAC made a downward adjustment in their framework to reflect expected improvements in hospital productivity. In their FY 2001 combined update framework, MedPAC did not make an adjustment for productivity. Instead, MedPAC believes that the costs associated with scientific and technological advances should be financed partially through improvements in hospital productivity. As a result, MedPAC offset its adjustment for scientific and technological advances by a fixed standard of expected productivity

growth of 0.5 percent for FY 2001. Our productivity adjustment of -0.5 to -0.4 percent is within the range of MedPAC's fixed standard of expected productivity growth of 0.5 percent used to offset its scientific and technological advances adjustment for FY 2001.

B. Intensity

We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2001, we recommended an adjustment of 0.0 percent. The basis of this recommendation is discussed below. We have no empirical evidence that accurately gauges the level of quality-enhancing technology changes. A study published in the Winter 1992 issue of the *Health Care Financing Review,* ''Contributions of case mix and intensity change to hospital cost increases'' (pp. 151–163), suggests that one-third of the intensity change is attributable to high-cost technology. The balance was unexplained but the authors speculated that it is attributable to fixed costs in service delivery.

Typically, a specific new technology increases cost in some uses and decreases cost in others. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies and new technologies.

Other things being equal, per-discharge fixed costs tend to fluctuate in inverse proportion to changes in volume. Fixed costs exist whether patients are treated or not. If volume is declining, per-discharge fixed costs will rise, but the reverse is true if volume is increasing.

Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1995 through 1999 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the CPI for hospital and related services and changes in real case-mix. Thus, in order to measure changes in intensity, one must measure changes in real case-mix.

For FYs 1995 through 1999, observed case-mix index change ranged from a low of −0.3 percent to a high of 1.7 percent, with a 5-year average change of 0.6 percent. Based on evidence from past studies of case-mix change, we estimate that real case-mix change fluctuates between 1.0 and 1.4 percent and the observed values generally fall in this range, although some years the figures fall outside this range. The average percentage change in charge per discharge was 3.6 percent and the average annual change in the CPI for hospital and related services was 4.1 percent. Dividing the change in charge per discharge by the quantity of the real case-mix index change and the CPI for hospital and related services yields an average annual change in intensity of −1.9 percent. Assuming the technology/fixed cost ratio still holds (.33), technology would account for a −0.6 percent annual decline while fixed costs would account for a −1.3 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, has increased during the period. In the past, we have not recommended a negative intensity adjustment. Although we did not recommend a negative adjustment for FY 2001, we reflected the possible range that such a negative adjustment could span, based on our analysis. Accordingly, for FY 2001, we recommended an intensity adjustment between 0 percent and −0.6 percent.

MedPAC does not make an adjustment for intensity per se, but its combined update recommendation for FY 2001 includes two categories that we consider to be comparable with our intensity recommendation. MedPAC is recommending a 0.0 to 0.5 percent update for scientific and technological advances to account for anticipated uses of emerging technologies that enhance the quality of hospital services, but increase costs of hospital care. The Commission recognized an allowance for science and technological advances of 0.5 percent to 1.0 percent. However, with their productivity offset of 0.5 percent, MedPAC's combined FY 2001 adjustment for science and technological advances is 0.0 percent to 0.5 percent.

MedPAC's recommendation also takes into account the increasingly apparent trend of some acute care providers to shift care to a post acute care facility. While this can occur for many reasons and the shifting of costs may maintain or improve quality of care for Medicare beneficiaries, it leads to a redistribution of payments and reduces the resources available for acute care providers to pay for services to other Medicare beneficiaries. In the past two years, MedPAC recommended a negative adjustment for site-of-care substitution or unbundling of the payment unit. However, in light of the financial pressures in the hospital industry during FYs 1998–1999 since the implementation of Public Law 105–33, MedPAC recommends a 0.0 percent adjustment for site-of-care substitution for FY 2001. We agree with MedPAC that the site-of-care substitution effect is real and that it is accounted for by our intensity recommendation.

C. Change in Case-Mix

Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2001 update recommendation, we projected a 0.5 percent increase in the case-mix index. We defined real case-mix as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that results in assignment of cases to higher weighted DRGs, but do not reflect greater resource requirements. Unlike in past years, where we differentiated between ''real'' case-mix increase and increases attributable to changes in coding behavior, we do not feel changes in coding behavior will impact the overall case-mix in FY 2001. As such, for FY 2001, we estimate that real case-mix is equal to projected change in case-mix. Thus, we recommended a 0.0 adjustment for case-mix.

MedPAC's analysis indicates that coding change has reduced case-mix index growth. In the past, MedPAC has recommended a negative adjustment when DRG coding changes has led to case-mix index growth. However, MedPAC now believes that it is appropriate to include a positive adjustment for DRG coding change in the FY 2001 update and recommends a combined adjustment of 0.5 percent.

MedPAC also makes an adjustment for within DRG severity. In past years, MedPAC has included an adjustment for increased case complexity not captured by the DRG classification system. The Commission recognizes that as the DRG system adjusts, it should account for more of the variation in costs by DRG assignment, leaving less within-DRG variation in case complexity and costliness. Therefore, MedPAC recommended a combined adjustment of 0.0 for FY 2001. As a result, for FY 2001, MedPAC recommends a total combined case-mix adjustment of 0.5 percent.

D. Effect of FY 1999 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 1999 resulted in a 0.0 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. Our proposed update framework for FY 2001 did not reflect a forecast error correction because, for FY 1999, there was less than a 0.25 percentage point difference between the actual market basket and the forecasted market basket.

MedPAC also made a recommendation in its FY 2001 combined update framework to adjust for any error in the market basket forecasts used to set FY 1999 payment rates.

MedPAC recommended a combined adjustment for FY 1999 forecast error correction of 0.1 percent. However, they noted that this forecast error adjustment is a result of the difference between the forecasted FY 1999 operating market basket of 2.4 percent and the actual FY 1999 operating market basket increase of 2.5 percent. The FY 1999 capital market basket forecast was equal to the actual observed increase of 0.7 percent for capital costs. Therefore, we have included MedPAC's entire 0.1 percent adjustment for FY 1999 forecast error correction in the comparison of MedPAC and HCFA's update recommendations for FY 2001 shown below in Table 1.

F. One Time Factors

MedPAC includes an adjustment for one-time factors in its update framework to

account for significant costs incurred by hospitals for unusual nonrecurring events. While MedPAC's update framework has not explicitly considered such costs in the past, the Commission believes Medicare should aid hospitals when incurring systematic and substantial one-time costs will improve care for Medicare beneficiaries. For its FY 2001 update recommendation, MedPAC considered the costs of year 2000 improvements and the costs of major new regulatory requirements. The Commission did not recommend any additional allowance for these costs for FY 2001. Accordingly, MedPAC recommended a 0.0 percent combined adjustment for one-time factors in their update framework for FY 2001.

HCFA's update framework does not include an adjustment for one-time factors. As we mentioned in last year's proposed rule, higher input prices that hospitals incur to convert computer systems to be compliant on January 1, 2000, were accounted for through the market basket percentage increase.

TABLE 1.—COMPARISON OF FY 2001 UPDATE RECOMMENDATIONS

	HCFA	MedPAC
Market basket	MB	MB[1]
Policy Adjustment Factors		
Productivity	−0.5 to −0.4	([2])
Site-Of-Service Substitution	([3])	0.0
Intensity	0.0 to −0.6	
Science & Technology		0.0 to 0.5
Practice Patterns		([4])
Real Within DRG Change		([5])
Subtotal	−0.5 to −1.0	0.0 to 0.5
Case-Mix Adjustment Factors		
Projected Case-Mix Change	−0.5	
Real Across DRG Change	0.5	0.5
Real Within DRG Change	([3])	0.0
Subtotal	0.0	0.5
Effect of FY 1999 Reclassification and Recalibration	0.0	
Forecast Error Correction	0.0	0.1
Total Recommendation Update	MB −0.5 to MB −1.0	MB[1] + 0.6 to MB[1] +1.1

[1] Used HCFA's March 2000 operating market basket forecast in its combined update recommendation.
[2] Included in MedPAC's Science and Technology Adjustment.
[3] Included in HHS' Intensity Factor.
[4] Included in MedPAC's Productivity Measure in its Science and Technology Adjustment.
[5] Included in MedPAC's Case-Mix Adjustment.

MedPAC's combined update recommendation of between 3.5 percent and 4.0 percent for FY 2001 operating and capital payments is higher than the current law amount as set forth by Public Law 105–33 and the amount in the proposed rule. While the above analysis would support a recommendation that the update be between than the operating market basket minus 0.5 percentage points and the operating market basket minus 1.0 percentage points, consistent with current law we recommended an update of market basket increase minus 1.1 percentage points (or 2.3 percent). We note that this approximates the lower bound of the range suggested by our framework when accounting for a negative intensity change.

IV. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

In recommending an update, the Secretary takes into account the factors in the update framework, as well as other factors such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high-quality care to Medicare beneficiaries through adequate reimbursement to health care providers.

To ensure that beneficiaries continue to have access to high-quality care and to allow more time to assess the full impact of Public Law 105–33 and Public Law 106–113, the Secretary recommends an update of 3.4 percent (full market basket) for FY 2001. We note that this recommendation requires a change in law. The FY 2001 President's Budget Mid-Session Review, released on June 26, 2000, included a proposal to provide for the full market basket update for FY 2001. We will continue to evaluate our current framework to ensure that the recommended update appropriately reflects current trends in health care delivery and that Medicare acts as a prudent purchaser providing incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

We received one comment concerning our proposed update recommendation.

Comment: One commenter stated that the continual update and routine replacement of procedures with more sophisticated, higher cost procedures is not picked up within the HCFA pricing system, particularly the use of pharmaceuticals and other scientific and technological advances. The commenter argued that the market basket minus 1.1 percent update for FY 2001 does not recognize the true impact of these factors on hospital-based payments, noting that from FYs 1998 through 2000 the cumulative market basket rose significantly higher than the Medicare operating prospective payment system updates, which were mandated by Public Law 105–33.

Response: By design, the market basket captures only the pure price change of inputs such as labor, materials, and capital that are used to produce a constant quantity and quality of care. This is done using price proxies that reflect the prices of the major inputs hospitals utilize in providing care. For pharmaceuticals, the price proxy used is the Producer Price Index (PPI) for pharmaceutical preparations produced by Bureau of Labor Statistics. This price proxy captures the price change of 'new' pharmaceuticals after they are introduced and the price changes between new drugs that replace existing drugs or generic drugs that replace brand-name drugs.

The market basket appropriately does not recognize the introduction or the increased

utilization of 'new' scientific and technological advances. Instead, these factors, including the increased use of 'new' pharmaceutical drugs, would be reflected in the intensity adjustment of the update framework. Our intensity standard is partly based on changes in the use of quality enhancing services or technology changes (along with changes in case-mix). HCFA's update recommendation uses this adjustment to account for the additional costs of adopting and utilizing new advances that an efficient provider would face in providing a high quality of patient care.

[FR Doc. 00–19108 Filed 7–31–00; 8:45 am]

BILLING CODE 4120–01–P