

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
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC .....	.8617	4.0	5.0
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC .....	.6114	3.0	3.6
421	18	MED	VIRAL ILLNESS AGE >17 .....	.6646	3.2	3.9
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17 .....	.4800	2.6	3.2
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8405	6.7	9.0
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4350	10.7	15.6
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	.6799	3.2	4.2
426	19	MED	DEPRESSIVE NEUROSES .....	.5276	3.5	4.7
427	19	MED	NEUROSES EXCEPT DEPRESSIVE .....	.5438	3.6	5.0
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL .....	.7200	5.0	7.6
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION .....	.8357	5.2	6.8
430	19	MED	PSYCHOSES .....	.7653	6.7	8.9
431	19	MED	CHILDHOOD MENTAL DISORDERS .....	.6309	5.0	6.8
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES .....	.7068	3.4	5.1
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA .....	.2852	2.3	3.2
434	20	MED	NO LONGER VALID .....	.0000	.0	.0
435	20	MED	NO LONGER VALID .....	.0000	.0	.0
436	20	MED	NO LONGER VALID .....	.0000	.0	.0
437	20	MED	NO LONGER VALID .....	.0000	.0	.0
438	20	MED	NO LONGER VALID .....	.0000	.0	.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.9350	6.7	9.5
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.0732	7.1	10.3
441	21	SURG	HAND PROCEDURES FOR INJURIES .....	.9273	2.3	3.3
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5349	6.8	9.6
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC .....	.9896	2.7	3.6
444	21	MED	TRAUMATIC INJURY AGE >17 W CC .....	.7244	3.4	4.4
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC .....	.4713	2.4	3.0
446	21	MED	* TRAUMATIC INJURY AGE 0-17 .....	.2949	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17 .....	.4851	1.9	2.5
448	21	MED	* ALLERGIC REACTIONS AGE 0-17 .....	.0970	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC .....	.8306	2.8	3.9
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC .....	.4161	1.6	2.0
451	21	MED	* POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17 .....	.2618	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0125	3.8	5.2
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC .....	.4997	2.2	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC .....	.8713	3.4	4.9
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC .....	.4617	1.9	2.6
456	22	MED	NO LONGER VALID .....	.0000	.0	.0
457	22	MED	NO LONGER VALID .....	.0000	.0	.0
458	22	SURG	NO LONGER VALID .....	.0000	.0	.0
459	22	SURG	NO LONGER VALID .....	.0000	.0	.0
460	22	MED	NO LONGER VALID .....	.0000	.0	.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1994	2.5	4.6
462	23	MED	REHABILITATION	1.2033	10.4	12.3
463	23	MED	SIGNS & SYMPTOMS W CC .....	.6818	3.4	4.3
464	23	MED	SIGNS & SYMPTOMS W/O CC .....	.4630	2.5	3.1
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6065	2.5	3.6
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6630	2.5	4.2
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS .....	.5762	2.7	4.1
468	.....	.....	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.8458	11.3	14.5
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.	2.9929	5.0	5.7
472	22	SURG	NO LONGER VALID .....	.0000	.0	.0
473	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.9044	9.7	15.0
474	04	SURG	NO LONGER VALID .....	.0000	.0	.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.9155	10.0	12.7
476	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2902	10.0	12.3

* 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: 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 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
477 ....	.....	SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.9571	6.7	9.3
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4276	5.9	8.2
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4024	2.8	3.7
480	PRE	SURG	LIVER TRANSPLANT	10.6132	17.7	22.8
481	PRE	SURG	BONE MARROW TRANSPLANT	7.8889	23.4	25.6
482	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.8343	11.4	14.3
483	PRE	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	15.2827	34.0	41.0
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.1265	11.5	14.5
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.1094	8.5	10.3
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	5.2547	11.0	14.3
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9199	6.3	8.2
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	5.1474	15.0	19.8
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8802	7.0	9.4
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0475	4.3	5.8
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6364	3.0	3.5
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.8853	13.6	19.0
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8468	4.9	6.3
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC .....	.9800	1.9	2.5
495	PRE	SURG	LUNG TRANSPLANT	8.8879	13.8	16.2
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6865	8.5	10.3
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.1996	5.8	6.8
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.2996	3.9	4.3
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4471	3.8	5.0
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC .....	.9375	2.2	2.6
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.7466	9.8	12.0
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5591	5.9	6.9
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2336	3.3	4.2
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	13.8097	28.2	33.6
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	1.4893	2.0	3.4
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.9149	15.7	19.9
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8331	7.2	9.2
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.2966	6.0	8.3
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.7323	3.7	4.9
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.3509	5.8	8.0
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA .....	.7558	3.6	5.1
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	6.6413	13.4	16.5
513	PRE	SURG	PANCREAS TRANSPLANT	6.6497	10.3	13.4
514	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W CARDIAC CATH	6.4169	6.8	9.0
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.0652	4.3	6.8
516	05	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.7250	4.1	5.0
517	05	SURG	PERC CARDIO PROC W CORONARY ARTERY STENT W/O AMI	2.1497	1.9	2.7
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.6673	2.5	3.6
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.2654	3.4	5.1
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.5709	2.0	2.8
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC .....	.7354	4.2	5.4
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	.6631	9.0	10.7
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	.3983	3.5	4.3

* 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
256.31	Premature menopause	N	13	358, 359, 369
256.39	Other ovarian failure	N	13	358, 359, 369
277.7	Dysmetabolic Syndrome X	N	10	299
464.00	Acute laryngitis, without mention of obstruction	N	3	68, 69, 70
			pre	482
464.01	Acute laryngitis, with obstruction	N	3	68, 69, 70
			pre	482
464.50	Unspecified supraglottis, without mention of obstruction	N	3	68, 69, 70
			pre	482
464.51	Unspecified supraglottis, with obstruction	N	3	68, 69, 70
			pre	482
521.00	Unspecified dental caries	N	3	185, 186, 187
			pre	482
521.01	Dental caries limited to enamel	N	3	185, 186, 187
			pre	482
521.02	Dental caries extending into dentine	N	3	185, 186, 187
			pre	482
521.03	Dental caries extending into pulp	N	3	185, 186, 187
			pre	482
521.04	Arrested dental caries	N	3	185, 186, 187
			pre	482
521.05	Odontoclasia	N	3	185, 186, 187
			pre	482
521.09	Other dental caries	N	3	185, 186, 187
			pre	482
525.10	Unspecified acquired absence of teeth	N	3	185, 186, 187
			pre	482
525.11	Loss of teeth due to trauma	N	3	185, 186, 187
			pre	482
525.12	Loss of teeth due to periodontal disease	N	3	182, 183, 184
			pre	482
525.13	Loss of teeth due to caries	N	3	185, 186, 187
			pre	482
525.19	Other loss of teeth	N	3	185, 186, 187
			pre	482
530.12	Acute esophagitis	N	6	182, 183, 184
564.00	Unspecified constipation	N	6	182, 183, 184
564.01	Slow transit constipation	N	6	182, 183, 184
564.02	Outlet dysfunction constipation	N	6	182, 183, 184
564.09	Other constipation	N	6	182, 183, 184
602.3	Dysplasia of prostate	N	12	352
608.82	Hemospermia	N	12	352
608.87	Retrograde ejaculation	N	12	352
692.76	Sunburn of second degree	N	9	283, 284
692.77	Sunburn of third degree	N	9	283, 284
718.70	Developmental dislocation of joint, site unspecified	N	8	256
718.71	Developmental dislocation of joint, shoulder region	N	8	256
718.72	Developmental dislocation of joint, upper arm	N	8	256
718.73	Developmental dislocation of joint, forearm	N	8	256
718.74	Developmental dislocation of joint, hand	N	8	256
718.75	Developmental dislocation of joint, pelvic region and thigh	N	8	256
718.76	Developmental dislocation of joint, lower leg	N	8	256
718.77	Developmental dislocation of joint, ankle and foot	N	8	256
718.78	Developmental dislocation of joint, other specified sites	N	8	256
718.79	Developmental dislocation of joint, multiple sites	N	8	256
733.93	Stress fracture of tibia or fibula	Y	8	239
733.94	Stress fracture of the metatarsals	Y	8	239
733.95	Stress fracture of other bone	Y	8	239
772.10	Intraventricular hemorrhage, unspecified grade	Y	15	387, 389
772.11	Intraventricular hemorrhage, Grade I	Y	15	387, 389
772.12	Intraventricular hemorrhage, Grade II	Y	15	387, 389
772.13	Intraventricular hemorrhage, Grade III	Y	15	387, 389
772.14	Intraventricular hemorrhage, Grade IV	Y	15	387, 389
779.7	Periventricular leukomalacia	Y	15	387, 389
793.80	Unspecified abnormal mammogram	N	9	276
793.81	Mammographic microcalcification	N	9	276
793.89	Other abnormal findings on radiological examination breast	N	9	276
840.7	Superior glenoid labrum lesions (SLAP)	N	8	253, 254, 255
			24	487

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
997.71	Vascular complications of mesenteric artery	Y	6 15	188, 189, 190 387, ¹ 389 ¹
997.72	Vascular complications of renal artery	Y	11 15	331, 332, 333 387, ¹ 389 ¹
997.79	Vascular complications of other vessels	Y	5 15	130, 131 387, ¹ 389 ¹
V10.53	Personal history of malignant neoplasm, renal pelvis	N	17	411, 412
V45.84	Dental restoration status	N	23	467
V49.82	Dental sealant status	N	23	467
V83.01	Asymptomatic hemophilia A carrier	N	23	467
V83.02	Symptomatic hemophilia A carrier	N	23	467

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
37.28	Intracardiac echocardiography	N		
44.32	Percutaneous [endoscopic] gastrojejunostomy	Y	6 7 10 17	154–156 201 288 400, 406, 407
67.51	Transabdominal cerclage of cervix	Y	13 14 21 24	360 372, 373 442, 443 486
67.59	Other repair of internal cervical os	Y	13 14 21 24	360 372, 373 442, 443 486
75.38	Fetal pulse oximetry	N		
81.30	Refusion of spine, not otherwise specified	Y	1 8 21 24	4 497, 498 442, 443 486
81.31	Refusion of Atlas-axis spine	Y	1 8 21 24	4 497, 498 442, 443 486
81.32	Refusion of other cervical spine, anterior technique	Y	1 8 21 24	4 496, 519, 520 442, 443 486
81.33	Refusion of other cervical spine, posterior technique	Y	1 8 21 24	4 496, 519, 520 442, 443 486
81.34	Refusion of dorsal and dorsolumbar spine, anterior technique	Y	1 8 21 24	4 496, 497, 498 442, 443 486
81.35	Refusion of dorsal and dorsolumbar spine, posterior technique	Y	1 8 21 24	4 496, 497, 498 442, 443 486
81.36	Refusion of lumbar and lumbosacral spine, anterior technique	Y	1 8 21 24	4 496, 497, 498 442, 443 486
81.37	Refusion of lumbar and lumbosacral spine, lateral transverse process technique.	Y	1 8 21 24	4 496, 497, 498 442, 443 486
81.38	Refusion of lumbar and lumbosacral spine, posterior technique	Y	1 8 21 24	4 496, 497, 498 442, 443 486

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
81.39	Refusion of spine, not elsewhere classified	Y	1 8 21 24	4 497, 498 442, 443 486
97.44	Nonoperative removal of heart assist system	N		

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
256.3	Other ovarian failure	N	13	358, 359, 369
464.0	Acute laryngitis	N	3 pre	68, 69, 70 482
521.0	Dental caries	N	3 pre	185, 186, 187 482
525.1	Loss of teeth due to accident, extraction, or local periodontal disease	N	3 pre	185, 186, 187 482
564.0	Constipation	N	6	182, 183, 184
772.1	Intraventricular hemorrhage	Y	15	387,389
793.8	Nonspecific abnormal findings on radiological and other examinations of body structure, breast.	N	9	276

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
67.5	Repair of internal cervical os	Y	13 14 21 24	360 372, 373 442, 442 486
81.09	Refusion of spine, any level or technique	Y	1 8 21 24	4 497, 498 442, 443 486

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
411.81	Acute coronary occlusion without myocardial infarction	Y	5	124, 140
493.00	Extrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified.	N	4	96, 97, 98
493.10	Intrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified.	N	4	96, 97, 98
493.20	Chronic obstructive asthma without mention of status asthmaticus or acute exacerbation or unspecified.	Y	4	88
493.90	Asthma, unspecified without mention of status asthmaticus or acute exacerbation or unspecified.	N	4	96, 97, 98
V70.7	Examination of participant in clinical trial	N	23	467

TABLE 6F.—REVISED PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
75.34	Other fetal monitoring	N		

TABLE 6G.—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.

*25631	80600	82010	80637	80606	82021	77212	77210
2580	80601	82011	80638	80607	82022	77213	77211
2581	80602	82012	80639	80608	82030	77214	77212
2588	80603	82013	8064	80609	82031	7797	77213
2589	80604	82019	8065	80610	82032	*7729	77214
*25639	80605	82020	80660	80611	8208	77210	7797
2580	80606	82021	80661	80612	8209	77211	*7769
2581	80607	82022	80662	80613	82100	77212	77210
2588	80608	82030	80669	80614	82101	77213	77211
2589	80609	82031	80670	80615	82110	77214	77212
*6023	80610	82032	80671	80616	82111	7797	77213
5960	80611	8208	80672	80617	*7720	*7760	77214
5996	80612	8209	80679	80618	77210	77210	7797
6010	80613	82100	8068	80619	77211	77211	*7797
6012	80614	82101	8069	80620	77212	77212	7722
6013	80615	82110	8080	80621	77213	77213	7797
6021	80616	82111	8082	80622	77214	77214	*7798
78820	80617	*73394	8083	80623	7797	7797	77210
78829	80618	73310	80843	80624	*77210	*7761	77211
*60887	80619	73311	80849	80625	77210	77210	77212
5970	80620	73312	80851	80626	77211	77211	77213
5994	80621	73313	80852	80627	77212	77212	77214
*73310	80622	73314	80853	80628	77213	77213	7797
73393	80623	73315	80859	80629	77214	77214	*9972
73394	80624	73316	8088	80630	7722	7797	99771
73395	80625	73319	8089	80631	7797	*7762	99772
*73311	80626	73393	82000	80632	*77211	77210	99779
73393	80627	73394	82001	80633	77210	77211	*99771
73394	80628	73395	82002	80634	77211	77212	53640
73395	80629	8058	82003	80635	77212	77213	53641
*73312	80630	8059	82009	80636	77213	77214	53642
73393	80631	80600	82010	80637	77214	7797	53649
73394	80632	80601	82011	80638	7722	*7763	56962
73395	80633	80602	82012	80639	7797	77210	9974
*73313	80634	80603	82013	8064	*77212	77211	99771
73393	80635	80604	82019	8065	77210	77212	99772
73394	80636	80605	82020	80660	77211	77213	99779
73395	80637	80606	82021	80661	77212	77214	*99772
*73314	80638	80607	82022	80662	77213	7797	9975
73393	80639	80608	82030	80669	77214	*7764	99771
73394	8064	80609	82031	80670	7722	77210	99772
73395	8065	80610	82032	80671	7797	77211	99779
*73315	80660	80611	8208	80672	*77213	77212	*99779
73393	80661	80612	8209	80679	77210	77213	9972
73394	80662	80613	82100	8068	77211	77214	99771
73395	80669	80614	82101	8069	77212	7797	99772
*73316	80670	80615	82110	8080	77213	*7765	99779
73393	80671	80616	82111	8082	77214	77210	*99791
73394	80672	80617	*73395	8083	7722	77211	99771
73395	80679	80618	73310	80843	7797	77212	99772
*73319	8068	80619	73311	80849	*77214	77213	99779
73393	8069	80620	73312	80851	77210	77214	*99799
73394	8080	80621	73313	80852	77211	7797	99771
73395	8082	80622	73314	80853	77212	*7766	99772
*73393	8083	80623	73315	80859	77213	77210	99779
73310	80843	80624	73316	8088	77214	77211	*99881
73311	80849	80625	73319	8089	7722	77212	99771
73312	80851	80626	73393	82000	7797	77213	99772
73313	80852	80627	73394	82001	*7722	77214	99779
73314	80853	80628	73395	82002	77210	7797	*99883
73315	80859	80629	8058	82003	77211	*7767	99771
73316	8088	80630	8059	82009	77212	77210	99772
73319	8089	80631	80600	82010	77213	77211	99779
73393	82000	80632	80601	82011	77214	77212	*99889
73394	82001	80633	80602	82012	7797	77213	99771
73395	82002	80634	80603	82013	*7728	77214	99772
8058	82003	80635	80604	82019	77210	7797	99779
8059	82009	80636	80605	82020	77211	*7768	*9989
99771							
99772							
99779							

TABLE 6H.—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.

*2563
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TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY
[FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	33822	8.9935	2	3	6	12	19
2	6772	9.9778	3	5	8	13	20
3	2	43.5000	35	35	52	52	52
4	6035	7.1639	1	2	5	9	15
5	93311	3.1649	1	1	2	3	7
6	366	2.9672	1	1	2	4	6
7	12470	9.9739	2	4	7	12	20
8	4164	3.2759	1	1	2	4	7
9	1610	6.3491	1	3	5	8	13
10	17577	6.5503	2	3	5	8	13
11	3128	4.0767	1	2	3	5	8
12	46758	5.8962	2	3	4	7	11
13	6415	5.2011	2	3	4	6	9
14	319523	5.8762	2	3	5	7	11
15	145366	3.5498	1	2	3	4	7
16	11155	6.0293	2	3	5	7	12
17	3519	3.3231	1	2	3	4	6
18	25961	5.4162	2	3	4	7	10
19	8638	3.6972	1	2	3	5	7
20	5629	10.1482	3	5	8	13	20
21	1309	6.5516	2	3	5	8	13
22	2535	4.8174	1	2	4	6	9
23	9464	4.1855	1	2	3	5	8
24	52753	4.9830	1	2	4	6	10
25	25370	3.2236	1	2	3	4	6
26	31	2.7097	1	1	2	3	6
27	3441	5.0584	1	1	3	6	11
28	11316	6.2100	1	3	5	8	13
29	4486	3.6097	1	2	3	5	7
30	1	1.0000	1	1	1	1	1
31	3488	4.4903	1	2	3	5	8
32	1738	2.5621	1	1	2	3	5
33	1	1.0000	1	1	1	1	1
34	20249	5.0786	1	2	4	6	10
35	5728	3.3959	1	2	3	4	6
36	3190	1.4649	1	1	1	1	2
37	1452	4.0296	1	1	2	5	9
38	102	2.6569	1	1	2	3	5
39	912	1.9079	1	1	1	2	4
40	1545	3.4252	1	1	2	4	7
42	2223	2.2852	1	1	1	3	5
43	85	3.1882	1	2	3	4	6
44	1238	4.9548	2	3	4	6	9
45	2444	3.1678	1	2	3	4	6
46	3051	4.6834	1	2	4	6	9
47	1281	3.2560	1	1	3	4	6
49	2241	4.8104	1	2	3	6	9
50	2488	1.9425	1	1	1	2	3
51	203	2.6995	1	1	1	2	6
52	220	1.9318	1	1	1	2	3
53	2478	3.5557	1	1	2	4	8
54	2	1.5000	1	1	2	2	2
55	1505	2.7442	1	1	1	3	6
56	503	2.7256	1	1	2	3	5
57	708	3.9492	1	1	2	5	9
59	107	2.7850	1	1	2	3	5
60	2	3.5000	2	2	5	5	5
61	231	5.0996	1	1	2	6	12
62	3	1.3333	1	1	1	2	2
63	2934	4.3889	1	2	3	5	8
64	3033	6.1800	1	2	4	8	13
65	34466	2.8420	1	1	2	4	5
66	6978	3.1635	1	1	2	4	6
67	495	3.5960	1	2	3	4	7
68	16724	4.1158	1	2	3	5	7
69	5435	3.2736	1	2	3	4	6
70	24	2.9167	1	2	2	4	5
71	82	3.8049	1	2	3	4	7
72	883	3.5663	1	2	3	4	6
73	6630	4.4065	1	2	3	6	9

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	39010	9.9124	3	5	7	12	19
76	38998	11.2677	3	5	9	14	21
77	2352	4.9184	1	2	4	7	10
78	32087	6.7848	3	4	6	8	11
79	169783	8.4892	3	4	7	11	16
80	9018	5.6618	2	3	5	7	10
81	4	18.2500	3	3	4	8	58
82	61883	6.9447	2	3	5	9	14
83	6446	5.5496	2	3	4	7	10
84	1508	3.3455	1	2	3	4	6
85	20572	6.3122	2	3	5	8	12
86	2118	3.6643	1	2	3	5	7
87	60110	6.2840	1	3	5	8	12
88	389694	5.1207	2	3	4	6	9
89	525838	5.9470	2	3	5	7	11
90	53895	4.1549	2	3	4	5	7
91	54	4.5185	2	2	3	5	10
92	13774	6.3499	2	3	5	8	12
93	1672	4.0353	1	2	3	5	7
94	12030	6.2988	2	3	5	8	12
95	1595	3.7179	1	2	3	5	7
96	61986	4.6292	2	3	4	6	8
97	31444	3.6560	1	2	3	5	7
98	18	4.2222	1	2	2	4	6
99	18996	3.1991	1	1	2	4	6
100	7619	2.1869	1	1	2	3	4
101	19997	4.3938	1	2	3	5	9
102	5146	2.6570	1	1	2	3	5
103	475	46.6021	9	13	25	60	98
104	36578	11.3165	7	11	28	60	98
105	29726	9.2831	5	6	8	15	98
106	3401	11.4963	5	7	10	14	20
107	87868	10.3783	5	7	9	12	17
108	6048	10.2116	3	5	8	13	19
109	60265	7.6926	4	5	6	9	12
110	52595	9.2013	2	5	7	11	18
111	8545	4.7604	1	2	5	6	8
113	42250	12.1885	3	6	9	15	24
114	8712	8.3768	2	4	7	10	16
115	14329	8.1687	1	4	7	11	16
116	330888	3.6061	2	9	7	11	16
117	3717	4.1512	1	1	2	5	9
118	7667	2.6849	1	1	1	3	6
119	1307	4.8829	1	1	3	6	12
120	35929	8.1178	1	2	5	10	16
121	162112	6.3821	2	3	5	8	12
122	78969	3.7027	1	2	3	5	7
123	40659	4.5833	1	1	3	6	11
124	132801	4.3427	1	2	3	5	8
125	80169	2.7657	1	1	2	4	5
126	5150	11.6882	3	6	9	14	22
127	678903	5.2745	2	3	4	7	10
128	9424	5.6175	2	4	5	7	9
129	4140	2.7621	1	1	1	3	6
130	86009	5.6760	2	3	5	7	10
131	28236	4.2426	1	2	4	6	7
132	147648	3.0002	1	1	2	4	6
133	8321	2.3367	1	1	2	3	4
134	36118	3.2406	1	2	3	4	6
135	7266	4.5531	1	2	3	6	9
136	1221	2.7158	1	1	2	3	5
138	194087	3.9932	1	2	3	5	8
139	82604	2.5072	1	1	2	3	5
140	69724	2.6533	1	1	2	3	5
141	90403	3.6691	1	2	3	5	7
142	45776	2.6508	1	1	2	3	5
143	203918	2.1253	1	1	2	3	4
144	81577	5.3196	1	2	4	7	11
145	7224	2.7460	1	1	2	3	5
146	10683	10.2826	5	7	9	12	17

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
147	2629	6.4196	3	5	6	8	9
148	129247	12.1904	5	7	10	15	22
149	18462	6.5184	4	5	6	8	9
150	19795	11.2770	4	7	10	14	20
151	4814	5.8286	2	3	5	8	10
152	4381	8.1438	3	5	7	9	14
153	2083	5.3711	3	4	5	7	8
154	28660	13.1491	4	7	10	16	25
155	6596	4.2179	1	2	3	6	8
156	4	7.5000	1	1	5	6	18
157	7903	5.3790	1	2	4	7	11
158	4630	2.5395	1	1	2	3	5
159	16309	4.9926	1	2	4	6	10
160	11655	2.6619	1	1	2	3	5
161	11119	4.2027	1	1	3	5	9
162	7199	1.9267	1	1	1	2	4
163	5	4.4000	1	1	3	4	13
164	4824	8.4279	4	5	7	10	15
165	2066	4.8049	2	3	5	6	8
166	3532	5.0337	2	2	4	6	10
167	3269	2.5990	1	2	2	3	5
168	1327	4.7641	1	2	3	6	10
169	834	2.3405	1	1	2	3	5
170	10975	11.1690	2	5	8	14	22
171	1284	4.6597	1	2	4	6	9
172	30412	6.9363	2	3	5	9	14
173	2685	3.6648	1	1	3	5	7
174	240400	4.7974	2	3	4	6	9
175	32375	2.9414	1	2	3	4	5
176	15101	5.2286	2	3	4	6	10
177	9190	4.5348	2	2	4	6	8
178	3597	3.0703	1	2	3	4	6
179	12291	5.9729	2	3	5	7	11
180	85599	5.3567	2	3	4	7	10
181	26315	3.4185	1	2	3	4	6
182	243506	4.3356	1	2	3	5	8
183	83969	2.9155	1	1	2	4	5
184	79	2.9620	1	2	2	4	6
185	4760	4.5210	1	2	3	6	9
186	3	9.3333	1	1	9	18	18
187	646	3.9164	1	1	3	5	8
188	75558	5.5580	1	2	4	7	11
189	11984	3.1542	1	1	2	4	6
190	49	7.0204	2	3	4	5	8
191	8889	13.7967	4	6	10	17	28
192	1105	6.5122	2	4	6	8	11
193	5258	12.5369	5	7	10	16	22
194	718	6.7869	2	4	6	8	12
195	4327	10.1470	4	6	9	12	17
196	1162	5.7212	2	4	5	7	10
197	18754	8.9335	3	5	7	11	16
198	5751	4.5416	2	3	4	6	8
199	1704	9.5827	2	4	7	13	20
200	1063	10.3518	1	3	7	13	22
201	1398	13.7790	3	6	11	17	25
202	25975	6.4045	2	3	5	8	13
203	29017	6.6364	2	3	5	9	13
204	57319	5.7964	2	3	4	7	11
205	22900	6.1735	2	3	5	8	12
206	1948	3.9168	1	2	3	5	7
207	30817	5.0832	1	2	4	6	10
208	10061	2.8946	1	1	2	4	6
209	343375	5.0786	3	3	4	6	8
210	120891	6.8189	3	4	6	8	11
211	31665	4.9325	3	4	4	6	7
212	6	13.5000	1	4	4	29	29
213	9144	8.9604	2	4	7	11	18
216	5956	9.6949	2	4	8	12	20
217	16333	13.1971	3	5	9	16	28
218	21296	5.4123	2	3	4	7	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
[FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
219	19530	3.2240	1	2	3	4	6
220	6	4.0000	1	1	3	7	7
223	13251	2.8497	1	1	2	3	6
224	11112	1.9343	1	1	2	2	3
225	5734	4.8575	1	2	3	6	11
226	5148	6.5874	1	2	4	8	14
227	4695	2.7242	1	1	2	3	5
228	2340	3.7970	1	1	2	5	8
229	1108	2.4838	1	1	2	3	5
230	2365	5.2592	1	2	3	6	11
231	11343	4.9395	1	2	3	6	11
232	807	2.8872	1	1	1	3	7
233	5059	7.5181	2	3	6	10	15
234	3168	3.4419	1	1	3	4	7
235	5036	5.0473	1	2	4	6	9
236	38265	4.8164	1	3	4	6	9
237	1687	3.5033	1	2	3	4	6
238	7930	8.5212	3	4	6	10	16
239	49088	6.2151	2	3	5	8	12
240	11318	6.6744	2	3	5	8	13
241	3168	3.8570	1	2	3	5	7
242	2434	6.6348	2	3	5	8	13
243	87407	4.6676	1	2	4	6	9
244	12162	4.8047	1	2	4	6	9
245	5130	3.4458	1	2	3	4	6
246	1386	3.8117	1	2	3	5	7
247	16832	3.3990	1	1	3	4	7
248	10529	4.8161	1	2	4	6	9
249	11336	3.6591	1	1	2	4	8
250	3456	4.1062	1	2	3	5	7
251	2406	2.8579	1	1	2	4	5
253	19677	4.7732	1	3	4	6	9
254	10449	3.1906	1	2	3	4	6
255	1	3.0000	3	3	3	3	3
256	6054	5.0766	1	2	4	6	10
257	16333	2.7359	1	1	2	3	5
258	15978	1.9342	1	1	2	2	3
259	3773	2.6801	1	1	1	2	6
260	4896	1.4167	1	1	1	2	2
261	1844	2.2749	1	1	1	3	5
262	612	3.9477	1	1	3	5	8
263	18146	12.0208	3	5	8	14	24
264	3608	7.4088	2	4	6	9	14
265	3681	6.8036	1	2	4	8	14
266	2698	3.3039	1	1	2	4	7
267	233	4.2060	1	1	3	6	9
268	878	3.4989	1	1	2	4	7
269	7390	8.2441	1	3	6	10	17
270	2623	3.5783	1	1	2	5	8
271	9621	7.6144	2	4	6	9	14
272	5459	6.1597	2	3	5	8	12
273	1286	4.0420	1	2	3	5	8
274	2334	6.5900	1	3	5	8	13
275	246	4.3130	1	1	3	5	9
276	1177	4.6669	1	2	4	6	8
277	85183	5.7309	2	3	5	7	10
278	33396	4.4205	2	3	4	6	8
279	3	2.3333	1	1	2	4	4
280	15577	4.1954	1	2	3	5	8
281	7128	3.0464	1	1	3	4	6
282	3	1.6667	1	1	2	2	2
283	5629	4.5756	1	2	4	6	9
284	1868	3.1124	1	1	2	4	6
285	6195	10.3080	3	5	8	13	20
286	2070	6.4396	2	3	5	7	13
287	5676	10.5374	3	5	7	12	21
288	2639	5.7704	2	3	4	6	9
289	4765	3.0002	1	1	2	3	7
290	8753	2.3103	1	1	2	2	4
291	65	1.8462	1	1	1	2	3

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
292	4702	10.4872	2	4	8	14	22
293	624	5.5096	1	2	4	7	12
294	87857	4.6066	1	2	4	6	9
295	3277	3.7376	1	2	3	5	7
296	235003	5.1556	2	2	4	6	10
297	43573	3.4124	1	2	3	4	6
298	86	2.8256	1	1	2	3	5
299	1178	5.2199	1	2	4	7	10
300	15999	6.1363	2	3	5	8	12
301	3208	3.6234	1	2	3	4	7
302	8018	9.0636	4	5	7	11	19
303	19452	8.4231	4	5	7	10	15
304	11767	8.7339	2	4	6	11	18
305	2984	3.6384	1	2	3	5	7
306	7320	5.6291	1	2	3	8	13
307	2082	2.2517	1	1	2	3	4
308	7463	6.1733	1	2	4	8	14
309	4096	2.2954	1	1	2	3	4
310	23873	4.4002	1	1	3	6	10
311	7963	1.8339	1	1	1	2	3
312	1487	4.4654	1	1	3	6	10
313	591	2.3316	1	1	1	3	5
315	29749	6.9546	1	1	4	9	15
316	104601	6.6228	2	3	5	8	13
317	1507	2.8779	1	1	2	3	6
318	5584	5.9979	1	3	5	8	12
319	422	2.7725	1	1	2	3	6
320	186678	5.3171	2	3	4	6	10
321	30428	3.7951	1	2	3	5	7
322	61	4.1475	2	2	3	5	8
323	17241	3.2172	1	1	2	4	7
324	7479	1.8826	1	1	1	2	3
325	8160	3.8241	1	2	3	5	7
326	2676	2.6648	1	1	2	3	5
327	11	3.0909	1	1	3	4	5
328	663	3.6305	1	1	3	5	8
329	77	2.0130	1	1	1	2	4
331	46045	5.5426	1	3	4	7	11
332	4930	3.2917	1	1	2	4	7
333	281	5.0569	1	2	4	6	10
334	8654	4.4386	2	3	4	5	7
335	10721	3.1791	2	2	3	4	5
336	9563	3.7848	1	2	3	4	8
337	3041	2.1500	1	1	2	3	3
338	1226	5.1117	1	2	3	7	11
339	1344	4.9821	1	1	3	7	12
340	1	1.0000	1	1	1	1	1
341	2738	3.1088	1	1	1	3	6
342	298	3.4094	1	1	2	4	7
344	3502	2.3829	1	1	1	2	5
345	410	5.1244	1	2	3	6	10
346	4441	5.8726	1	3	4	7	12
347	365	2.9479	1	1	2	4	6
350	6270	4.3933	1	2	4	5	8
352	756	3.9577	1	2	3	5	8
353	2533	6.4212	2	3	5	7	12
354	7562	5.8375	3	3	4	7	11
355	5504	3.2862	2	3	3	4	5
356	25128	2.2924	1	1	2	3	4
357	5548	8.4874	3	4	7	10	16
358	20294	4.3121	2	3	3	5	7
359	29890	2.7295	2	2	3	3	4
360	15941	2.8557	1	2	2	3	5
361	378	2.9233	1	1	2	3	5
363	2862	3.4693	1	2	2	3	7
364	1644	3.8534	1	1	3	5	8
365	1722	7.2410	1	3	5	9	16
366	4410	6.7329	1	3	5	8	14
367	583	3.0617	1	1	2	4	6
368	3110	6.4810	2	3	5	8	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
369	3133	3.2515	1	1	2	4	7
370	1095	5.8429	3	3	4	5	10
371	1307	3.6526	2	3	3	4	5
372	927	3.2891	1	2	2	3	5
373	3734	2.2499	1	2	2	3	3
374	120	3.1583	1	2	2	3	4
375	10	2.3000	1	2	2	3	4
376	247	3.0931	1	2	2	4	6
377	48	5.0000	1	1	3	6	12
378	157	2.4140	1	1	2	3	4
379	337	3.4303	1	1	2	4	6
380	58	2.1207	1	1	1	2	5
381	152	2.5132	1	1	1	3	5
382	45	1.2889	1	1	1	1	2
383	1707	3.5817	1	1	2	4	7
384	114	2.1842	1	1	1	3	5
385	1	1.0000	1	1	1	1	1
389	15	11.7333	1	3	6	10	24
390	14	4.0000	1	2	3	6	7
391	1	4.0000	4	4	4	4	4
392	2323	9.6750	3	4	7	12	20
394	1870	7.1428	1	2	4	8	16
395	86911	4.4001	1	2	3	6	9
396	15	4.6667	1	2	4	6	7
397	17554	5.1878	1	2	4	7	10
398	17526	5.9417	2	3	5	7	11
399	1721	3.5758	1	2	3	5	7
400	6444	9.1189	1	3	6	12	20
401	5581	11.2575	2	5	9	15	23
402	1498	4.1128	1	1	3	6	9
403	31732	8.0627	2	3	6	10	17
404	4639	4.2720	1	2	3	6	9
406	2513	9.8607	3	4	7	12	20
407	720	4.4417	1	2	4	5	8
408	2178	8.0317	1	2	5	10	18
409	2822	5.9072	2	3	4	6	12
410	33412	3.9069	1	2	4	5	6
411	13	2.3077	1	1	2	2	5
412	29	2.4483	1	1	2	3	4
413	6419	7.0662	2	3	5	9	14
414	767	4.2529	1	2	3	5	9
415	38683	14.2779	4	6	11	18	28
416	183557	7.3848	2	4	6	9	14
417	16	5.0000	2	2	4	6	9
418	22822	6.1160	2	3	5	7	11
419	15294	4.7204	2	2	4	6	9
420	3109	3.5002	1	2	3	4	6
421	11464	3.7872	1	2	3	5	7
422	80	3.0625	1	2	3	4	6
423	7452	8.1162	2	3	6	10	16
424	1275	13.4204	2	5	9	16	26
425	15710	3.9945	1	2	3	5	8
426	4443	4.4510	1	2	3	5	9
427	1633	4.6418	1	2	3	6	9
428	835	6.8192	1	2	4	8	14
429	25967	6.3055	2	3	5	7	12
430	58669	8.0151	2	3	6	10	16
431	313	6.2045	1	3	5	7	11
432	469	4.7271	1	2	3	5	9
433	5418	3.0945	1	1	2	4	6
439	1343	8.4080	1	3	5	10	19
440	5131	9.0209	2	3	6	11	20
441	601	3.2313	1	1	2	4	7
442	15366	8.4839	1	3	6	10	18
443	3730	3.4399	1	1	3	4	7
444	5185	4.1338	1	2	3	5	8
445	2427	2.9250	1	1	2	4	5
447	5451	2.4748	1	1	2	3	5
449	28048	3.7457	1	1	3	5	8
450	6867	2.0051	1	1	1	2	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
451	3	1.3333	1	1	1	2	2
452	22666	4.8553	1	2	3	6	10
453	5068	2.8035	1	1	2	3	6
454	3940	4.5652	1	2	3	5	9
455	931	2.5994	1	1	2	3	5
461	3490	4.3739	1	1	2	5	11
462	12994	11.2271	4	6	9	14	21
463	21790	4.1239	1	2	3	5	8
464	6533	2.9963	1	1	2	4	6
465	154	3.4481	1	1	2	4	7
466	1470	3.9925	1	1	2	5	9
467	534	3.8390	1	1	2	4	8
468	58990	12.9159	3	6	10	17	30
471	11639	5.5322	3	4	4	6	9
473	7599	12.5038	1	3	7	18	32
475	107089	11.1800	2	5	9	15	22
476	4126	10.8924	2	5	9	14	21
477	24823	8.1004	1	3	6	11	17
478	106999	7.3166	1	3	5	9	15
479	24939	3.5376	1	1	3	5	7
480	541	20.4843	7	9	13	25	43
481	377	23.9310	10	18	22	27	38
482	5686	12.9474	4	7	10	15	25
483	42093	39.0315	14	22	33	49	70
484	313	12.6773	2	6	10	17	26
485	2880	9.5955	4	5	7	11	18
486	1856	12.4402	1	5	10	16	25
487	3339	7.3612	1	3	6	10	15
488	770	17.0078	3	7	13	22	36
489	14005	8.4383	2	3	6	10	17
490	5378	5.3405	1	2	4	6	10
491	12205	3.4483	2	2	3	4	6
492	2672	15.6662	3	5	8	25	34
493	54859	5.7621	1	3	5	7	11
494	29900	2.4482	1	1	2	3	5
495	153	15.0261	7	9	12	18	26
496	1444	9.5824	4	5	7	12	18
497	23721	6.1748	3	4	7	12	18
498	22152	3.3273	3	4	6	12	18
499	30284	4.6986	1	2	3	6	9
500	43962	2.6146	1	1	2	3	5
501	2180	10.9670	4	6	8	13	21
502	586	6.5648	3	4	5	8	11
503	5551	3.9996	1	2	3	5	7
504	114	29.5877	9	14	24	41	54
505	145	3.3517	1	1	1	3	7
506	915	17.4000	4	8	14	22	35
507	290	8.2621	2	4	7	11	18
508	657	7.4718	2	3	5	9	15
509	176	4.5455	1	2	4	6	9
510	1619	7.1779	2	3	5	9	15
511	602	4.7591	1	2	3	6	10
512	.....	.....	1	2	3	6	10
513	.....	.....	1	2	3	6	10
514	.....	.....	1	2	3	6	10
515	.....	.....	1	2	3	6	10
516	.....	.....	1	2	3	6	10
517	.....	.....	1	2	3	6	10
518	.....	.....	1	2	3	6	10
519	.....	.....	1	2	3	6	10
520	.....	.....	1	2	3	6	10
521	.....	.....	1	2	3	6	10
522	.....	.....	1	2	3	6	10
523	.....	.....	1	2	3	6	10
	10811358						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	33822	8.9935	2	3	6	12	19
2	6772	9.9778	3	5	8	13	20
3	2	43.5000	35	35	52	52	52
4	6035	7.1639	1	2	5	9	15
5	93311	3.1649	1	1	2	3	7
6	366	2.9672	1	1	2	4	6
7	12470	9.9739	2	4	7	12	20
8	4164	3.2759	1	1	2	4	7
9	1610	6.3491	1	3	5	8	13
10	17577	6.5503	2	3	5	8	13
11	3128	4.0767	1	2	3	5	8
12	46758	5.8962	2	3	4	7	11
13	6415	5.2011	2	3	4	6	9
14	319523	5.8762	2	3	5	7	11
15	145366	3.5498	1	2	3	4	7
16	11155	6.0293	2	3	5	7	12
17	3519	3.3231	1	2	3	4	6
18	25961	5.4162	2	3	4	7	10
19	8638	3.6972	1	2	3	5	7
20	5629	10.1482	3	5	8	13	20
21	1309	6.5516	2	3	5	8	13
22	2535	4.8174	1	2	4	6	9
23	9464	4.1855	1	2	3	5	8
24	52753	4.9830	1	2	4	6	10
25	25370	3.2236	1	2	3	4	6
26	31	2.7097	1	1	2	3	6
27	3441	5.0584	1	1	3	6	11
28	11316	6.2100	1	3	5	8	13
29	4486	3.6097	1	2	3	5	7
30	1	1.0000	1	1	1	1	1
31	3488	4.4903	1	2	3	5	8
32	1738	2.5621	1	1	2	3	5
33	1	1.0000	1	1	1	1	1
34	20249	5.0786	1	2	4	6	10
35	5728	3.3959	1	2	3	4	6
36	3190	1.4649	1	1	1	1	2
37	1452	4.0296	1	1	2	5	9
38	102	2.6569	1	1	2	3	5
39	912	1.9079	1	1	1	2	4
40	1545	3.4252	1	1	2	4	7
42	2223	2.2852	1	1	1	3	5
43	85	3.1882	1	2	3	4	6
44	1238	4.9548	2	3	4	6	9
45	2444	3.1678	1	2	3	4	6
46	3051	4.6834	1	2	4	6	9
47	1281	3.2560	1	1	3	4	6
49	2241	4.8104	1	2	3	6	9
50	2488	1.9425	1	1	1	2	3
51	203	2.6995	1	1	1	2	6
52	220	1.9318	1	1	1	2	3
53	2478	3.5557	1	1	2	4	8
54	2	1.5000	1	1	2	2	2
55	1505	2.7442	1	1	1	3	6
56	503	2.7256	1	1	2	3	5
57	708	3.9492	1	1	2	5	9
59	107	2.7850	1	1	2	3	5
60	2	3.5000	2	2	5	5	5
61	231	5.0996	1	1	2	6	12
62	3	1.3333	1	1	1	2	2
63	3003	4.4409	1	2	3	5	9
64	3033	6.1800	1	2	4	8	13
65	34466	2.8420	1	1	2	4	5
66	6978	3.1635	1	1	2	4	6
67	495	3.5960	1	2	3	4	7
68	16724	4.1158	1	2	3	5	7
69	5435	3.2736	1	2	3	4	6
70	24	2.9167	1	2	2	4	5
71	82	3.8049	1	2	3	4	7
72	883	3.5663	1	2	3	4	6
73	6630	4.4065	1	2	3	6	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	39010	9.9124	3	5	7	12	19
76	38998	11.2677	3	5	9	14	21
77	2352	4.9184	1	2	4	7	10
78	32087	6.7848	3	4	6	8	11
79	169783	8.4892	3	4	7	11	16
80	9018	5.6618	2	3	5	7	10
81	4	18.2500	3	3	4	8	58
82	61883	6.9447	2	3	5	9	14
83	6446	5.5496	2	3	4	7	10
84	1508	3.3455	1	2	3	4	6
85	20572	6.3122	2	3	5	8	12
86	2118	3.6643	1	2	3	5	7
87	60110	6.2840	1	3	5	8	12
88	389694	5.1207	2	3	4	6	9
89	525838	5.9470	2	3	5	7	11
90	53895	4.1549	2	3	4	5	7
91	54	4.5185	2	2	3	5	10
92	13774	6.3499	2	3	5	8	12
93	1672	4.0353	1	2	3	5	7
94	12030	6.2988	2	3	5	8	12
95	1595	3.7179	1	2	3	5	7
96	61986	4.6292	2	3	4	6	8
97	31444	3.6560	1	2	3	5	7
98	18	4.2222	1	2	2	4	6
99	18996	3.1991	1	1	2	4	6
100	7619	2.1869	1	1	2	3	4
101	19997	4.3938	1	2	3	5	9
102	5146	2.6570	1	1	2	3	5
103	475	46.6021	9	13	25	60	98
104	19650	14.1922	6	8	12	17	25
105	25952	9.7562	4	6	8	11	17
106	3401	11.4963	5	7	10	14	20
107	87868	10.3783	5	7	9	12	17
108	6047	10.2128	3	5	8	13	19
109	60265	7.6926	4	5	6	9	12
110	52587	9.2019	2	5	7	11	18
111	8545	4.7604	1	2	5	6	8
113	42250	12.1885	3	6	9	15	24
114	8712	8.3768	2	4	7	10	16
115	14329	8.1687	1	4	7	11	16
116	91838	4.4683	1	2	3	6	9
117	3717	4.1512	1	1	2	5	9
118	7667	2.6849	1	1	1	3	6
119	1307	4.8829	1	1	3	6	12
120	37500	8.5321	1	2	6	11	19
121	162112	6.3821	2	3	5	8	12
122	78969	3.7027	1	2	3	5	7
123	40659	4.5833	1	1	3	6	11
124	132801	4.3427	1	2	3	5	8
125	80169	2.7657	1	1	2	4	5
126	5150	11.6882	3	6	9	14	22
127	678903	5.2745	2	3	4	7	10
128	9424	5.6175	2	4	5	7	9
129	4140	2.7621	1	1	1	3	6
130	86009	5.6760	2	3	5	7	10
131	28236	4.2426	1	2	4	6	7
132	147648	3.0002	1	1	2	4	6
133	8321	2.3367	1	1	2	3	4
134	36118	3.2406	1	2	3	4	6
135	7266	4.5531	1	2	3	6	9
136	1221	2.7158	1	1	2	3	5
138	194087	3.9932	1	2	3	5	8
139	82604	2.5072	1	1	2	3	5
140	69724	2.6533	1	1	2	3	5
141	90403	3.6691	1	2	3	5	7
142	45776	2.6508	1	1	2	3	5
143	203918	2.1253	1	1	2	3	4
144	81577	5.3196	1	2	4	7	11
145	7224	2.7460	1	1	2	3	5
146	10683	10.2826	5	7	9	12	17

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
147	2629	6.4196	3	5	6	8	9
148	129247	12.1904	5	7	10	15	22
149	18462	6.5184	4	5	6	8	9
150	19795	11.2770	4	7	10	14	20
151	4814	5.8286	2	3	5	8	10
152	4381	8.1438	3	5	7	9	14
153	2083	5.3711	3	4	5	7	8
154	28660	13.1491	4	7	10	16	25
155	6596	4.2179	1	2	3	6	8
156	4	7.5000	1	1	5	6	18
157	7903	5.3790	1	2	4	7	11
158	4630	2.5395	1	1	2	3	5
159	16309	4.9926	1	2	4	6	10
160	11655	2.6619	1	1	2	3	5
161	11119	4.2027	1	1	3	5	9
162	7199	1.9267	1	1	1	2	4
163	5	4.4000	1	1	3	4	13
164	4824	8.4279	4	5	7	10	15
165	2066	4.8049	2	3	5	6	8
166	3532	5.0337	2	2	4	6	10
167	3269	2.5990	1	2	2	3	5
168	1327	4.7641	1	2	3	6	10
169	834	2.3405	1	1	2	3	5
170	10975	11.1690	2	5	8	14	22
171	1284	4.6597	1	2	4	6	9
172	30412	6.9363	2	3	5	9	14
173	2685	3.6648	1	1	3	5	7
174	240400	4.7974	2	3	4	6	9
175	32375	2.9414	1	2	3	4	5
176	15101	5.2286	2	3	4	6	10
177	9190	4.5348	2	2	4	6	8
178	3597	3.0703	1	2	3	4	6
179	12291	5.9729	2	3	5	7	11
180	85599	5.3567	2	3	4	7	10
181	26315	3.4185	1	2	3	4	6
182	243506	4.3356	1	2	3	5	8
183	83969	2.9155	1	1	2	4	5
184	79	2.9620	1	2	2	4	6
185	4760	4.5210	1	2	3	6	9
186	3	9.3333	1	1	9	18	18
187	646	3.9164	1	1	3	5	8
188	75558	5.5580	1	2	4	7	11
189	11984	3.1542	1	1	2	4	6
190	49	7.0204	2	3	4	5	8
191	8867	13.7982	4	6	10	17	27
192	1105	6.5122	2	4	6	8	11
193	5258	12.5369	5	7	10	16	22
194	718	6.7869	2	4	6	8	12
195	4327	10.1470	4	6	9	12	17
196	1162	5.7212	2	4	5	7	10
197	18754	8.9335	3	5	7	11	16
198	5751	4.5416	2	3	4	6	8
199	1704	9.5827	2	4	7	13	20
200	1063	10.3518	1	3	7	13	22
201	1430	13.8098	3	6	11	18	27
202	25975	6.4045	2	3	5	8	13
203	29017	6.6364	2	3	5	9	13
204	57319	5.7964	2	3	4	7	11
205	22900	6.1735	2	3	5	8	12
206	1948	3.9168	1	2	3	5	7
207	30817	5.0832	1	2	4	6	10
208	10061	2.8946	1	1	2	4	6
209	343375	5.0786	3	3	4	6	8
210	120891	6.8189	3	4	6	8	11
211	31665	4.9325	3	4	4	6	7
212	6	13.5000	1	4	4	29	29
213	9144	8.9604	2	4	7	11	18
216	5956	9.6949	2	4	8	12	20
217	16333	13.1971	3	5	9	16	28
218	21296	5.4123	2	3	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
219	19530	3.2240	1	2	3	4	6
220	6	4.0000	1	1	3	7	7
223	13251	2.8497	1	1	2	3	6
224	11112	1.9343	1	1	2	2	3
225	5734	4.8575	1	2	3	6	11
226	5148	6.5874	1	2	4	8	14
227	4695	2.7242	1	1	2	3	5
228	2340	3.7970	1	1	2	5	8
229	1108	2.4838	1	1	2	3	5
230	2365	5.2592	1	2	3	6	11
231	11343	4.9395	1	2	3	6	11
232	807	2.8872	1	1	1	3	7
233	5059	7.5181	2	3	6	10	15
234	3168	3.4419	1	1	3	4	7
235	5036	5.0473	1	2	4	6	9
236	38265	4.8164	1	3	4	6	9
237	1687	3.5033	1	2	3	4	6
238	7930	8.5212	3	4	6	10	16
239	49088	6.2151	2	3	5	8	12
240	11318	6.6744	2	3	5	8	13
241	3168	3.8570	1	2	3	5	7
242	2434	6.6348	2	3	5	8	13
243	87407	4.6676	1	2	4	6	9
244	12162	4.8047	1	2	4	6	9
245	5130	3.4458	1	2	3	4	6
246	1386	3.8117	1	2	3	5	7
247	16832	3.3990	1	1	3	4	7
248	10529	4.8161	1	2	4	6	9
249	11336	3.6591	1	1	2	4	8
250	3456	4.1062	1	2	3	5	7
251	2406	2.8579	1	1	2	4	5
253	19677	4.7732	1	3	4	6	9
254	10449	3.1906	1	2	3	4	6
255	1	3.0000	3	3	3	3	3
256	6054	5.0766	1	2	4	6	10
257	16333	2.7359	1	1	2	3	5
258	15978	1.9342	1	1	2	2	3
259	3773	2.6801	1	1	1	2	6
260	4896	1.4167	1	1	1	2	2
261	1844	2.2749	1	1	1	3	5
262	612	3.9477	1	1	3	5	8
263	18146	12.0208	3	5	8	14	24
264	3608	7.4088	2	4	6	9	14
265	3681	6.8036	1	2	4	8	14
266	2698	3.3039	1	1	2	4	7
267	233	4.2060	1	1	3	6	9
268	878	3.4989	1	1	2	4	7
269	7390	8.2441	1	3	6	10	17
270	2623	3.5783	1	1	2	5	8
271	9621	7.6144	2	4	6	9	14
272	5459	6.1597	2	3	5	8	12
273	1286	4.0420	1	2	3	5	8
274	2334	6.5900	1	3	5	8	13
275	246	4.3130	1	1	3	5	9
276	1177	4.6669	1	2	4	6	8
277	85183	5.7309	2	3	5	7	10
278	33396	4.4205	2	3	4	6	8
279	3	2.3333	1	1	2	4	4
280	15577	4.1954	1	2	3	5	8
281	7128	3.0464	1	1	3	4	6
282	3	1.6667	1	1	2	2	2
283	5629	4.5756	1	2	4	6	9
284	1868	3.1124	1	1	2	4	6
285	6195	10.3080	3	5	8	13	20
286	2070	6.4396	2	3	5	7	13
287	5676	10.5374	3	5	7	12	21
288	2639	5.7704	2	3	4	6	9
289	4765	3.0002	1	1	2	3	7
290	8753	2.3103	1	1	2	2	4
291	65	1.8462	1	1	1	2	3

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
292	4654	10.4850	2	4	8	13	21
293	624	5.5096	1	2	4	7	12
294	87857	4.6066	1	2	4	6	9
295	3277	3.7376	1	2	3	5	7
296	235003	5.1556	2	2	4	6	10
297	43573	3.4124	1	2	3	4	6
298	86	2.8256	1	1	2	3	5
299	1178	5.2199	1	2	4	7	10
300	15999	6.1363	2	3	5	8	12
301	3208	3.6234	1	2	3	4	7
302	7703	8.8384	4	5	7	10	15
303	19452	8.4231	4	5	7	10	15
304	11765	8.7340	2	4	6	11	18
305	2984	3.6384	1	2	3	5	7
306	7320	5.6291	1	2	3	8	13
307	2082	2.2517	1	1	2	3	4
308	7463	6.1733	1	2	4	8	14
309	4096	2.2954	1	1	2	3	4
310	23873	4.4002	1	1	3	6	10
311	7963	1.8339	1	1	1	2	3
312	1487	4.4654	1	1	3	6	10
313	591	2.3316	1	1	1	3	5
315	30147	7.0663	1	1	4	9	16
316	104601	6.6228	2	3	5	8	13
317	1507	2.8779	1	1	2	3	6
318	5584	5.9979	1	3	5	8	12
319	422	2.7725	1	1	2	3	6
320	186678	5.3171	2	3	4	6	10
321	30428	3.7951	1	2	3	5	7
322	61	4.1475	2	2	3	5	8
323	17241	3.2172	1	1	2	4	7
324	7479	1.8826	1	1	1	2	3
325	8160	3.8241	1	2	3	5	7
326	2676	2.6648	1	1	2	3	5
327	11	3.0909	1	1	3	4	5
328	663	3.6305	1	1	3	5	8
329	77	2.0130	1	1	1	2	4
331	46045	5.5426	1	3	4	7	11
332	4930	3.2917	1	1	2	4	7
333	281	5.0569	1	2	4	6	10
334	8654	4.4386	2	3	4	5	7
335	10721	3.1791	2	2	3	4	5
336	9563	3.7848	1	2	3	4	8
337	3041	2.1500	1	1	2	3	3
338	1226	5.1117	1	2	3	7	11
339	1344	4.9821	1	1	3	7	12
340	1	1.0000	1	1	1	1	1
341	2738	3.1088	1	1	1	3	6
342	298	3.4094	1	1	2	4	7
344	3502	2.3829	1	1	1	2	5
345	410	5.1244	1	2	3	6	10
346	4441	5.8726	1	3	4	7	12
347	365	2.9479	1	1	2	4	6
350	6270	4.3933	1	2	4	5	8
352	756	3.9577	1	2	3	5	8
353	2533	6.4212	2	3	5	7	12
354	7562	5.8375	3	3	4	7	11
355	5504	3.2862	2	3	3	4	5
356	25128	2.2924	1	1	2	3	4
357	5548	8.4874	3	4	7	10	16
358	20294	4.3121	2	3	3	5	7
359	29890	2.7295	2	2	3	3	4
360	15941	2.8557	1	2	2	3	5
361	378	2.9233	1	1	2	3	5
363	2862	3.4693	1	2	2	3	7
364	1644	3.8534	1	1	3	5	8
365	1722	7.2410	1	3	5	9	16
366	4410	6.7329	1	3	5	8	14
367	583	3.0617	1	1	2	4	6
368	3110	6.4810	2	3	5	8	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
369	3133	3.2515	1	1	2	4	7
370	1095	5.8429	3	3	4	5	10
371	1307	3.6526	2	3	3	4	5
372	927	3.2891	1	2	2	3	5
373	3734	2.2499	1	2	2	3	3
374	120	3.1583	1	2	2	3	4
375	10	2.3000	1	2	2	3	4
376	247	3.0931	1	2	2	4	6
377	48	5.0000	1	1	3	6	12
378	157	2.4140	1	1	2	3	4
379	337	3.4303	1	1	2	4	6
380	58	2.1207	1	1	1	2	5
381	152	2.5132	1	1	1	3	5
382	45	1.2889	1	1	1	1	2
383	1707	3.5817	1	1	2	4	7
384	114	2.1842	1	1	1	3	5
385	1	1.0000	1	1	1	1	1
389	15	11.7333	1	3	6	10	24
390	14	4.0000	1	2	3	6	7
391	1	4.0000	4	4	4	4	4
392	2323	9.6750	3	4	7	12	20
394	1870	7.1428	1	2	4	8	16
395	86911	4.4001	1	2	3	6	9
396	15	4.6667	1	2	4	6	7
397	17554	5.1878	1	2	4	7	10
398	17526	5.9417	2	3	5	7	11
399	1721	3.5758	1	2	3	5	7
400	6444	9.1189	1	3	6	12	20
401	5581	11.2575	2	5	9	15	23
402	1498	4.1128	1	1	3	6	9
403	31732	8.0627	2	3	6	10	17
404	4639	4.2720	1	2	3	6	9
406	2513	9.8607	3	4	7	12	20
407	720	4.4417	1	2	4	5	8
408	2178	8.0317	1	2	5	10	18
409	2822	5.9072	2	3	4	6	12
410	33412	3.9069	1	2	4	5	6
411	13	2.3077	1	1	2	2	5
412	29	2.4483	1	1	2	3	4
413	6419	7.0662	2	3	5	9	14
414	767	4.2529	1	2	3	5	9
415	38683	14.2779	4	6	11	18	28
416	183557	7.3848	2	4	6	9	14
417	16	5.0000	2	2	4	6	9
418	22822	6.1160	2	3	5	7	11
419	15294	4.7204	2	2	4	6	9
420	3109	3.5002	1	2	3	4	6
421	11464	3.7872	1	2	3	5	7
422	80	3.0625	1	2	3	4	6
423	7452	8.1162	2	3	6	10	16
424	1275	13.4204	2	5	9	16	26
425	15710	3.9945	1	2	3	5	8
426	4443	4.4510	1	2	3	5	9
427	1633	4.6418	1	2	3	6	9
428	835	6.8192	1	2	4	8	14
429	25967	6.3055	2	3	5	7	12
430	58669	8.0151	2	3	6	10	16
431	313	6.2045	1	3	5	7	11
432	469	4.7271	1	2	3	5	9
433	5418	3.0945	1	1	2	4	6
439	1343	8.4080	1	3	5	10	19
440	5131	9.0209	2	3	6	11	20
441	601	3.2313	1	1	2	4	7
442	15366	8.4839	1	3	6	10	18
443	3730	3.4399	1	1	3	4	7
444	5185	4.1338	1	2	3	5	8
445	2427	2.9250	1	1	2	4	5
447	5451	2.4748	1	1	2	3	5
449	28048	3.7457	1	1	3	5	8
450	6867	2.0051	1	1	1	2	4

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 12/00 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
451	3	1.3333	1	1	1	2	2
452	22666	4.8553	1	2	3	6	10
453	5068	2.8035	1	1	2	3	6
454	3940	4.5652	1	2	3	5	9
455	931	2.5994	1	1	2	3	5
461	3490	4.3739	1	1	2	5	11
462	12994	11.2271	4	6	9	14	21
463	21790	4.1239	1	2	3	5	8
464	6533	2.9963	1	1	2	4	6
465	154	3.4481	1	1	2	4	7
466	1470	3.9925	1	1	2	5	9
467	534	3.8390	1	1	2	4	8
468	56874	12.7662	3	6	10	16	25
471	11639	5.5322	3	4	4	6	9
473	7599	12.5038	1	3	7	18	32
475	107089	11.1800	2	5	9	15	22
476	4126	10.8924	2	5	9	14	21
477	24823	8.1004	1	3	6	11	17
478	106997	7.3166	1	3	5	9	15
479	24939	3.5376	1	1	3	5	7
480	540	20.1370	7	9	13	25	43
481	377	23.9310	10	18	22	27	38
482	5686	12.9474	4	7	10	15	25
483	42087	39.0295	14	22	33	49	70
484	313	12.6773	2	6	10	17	26
485	2880	9.5955	4	5	7	11	18
486	1856	12.4402	1	5	10	16	25
487	3339	7.3612	1	3	6	10	15
488	770	17.0078	3	7	13	22	36
489	14005	8.4383	2	3	6	10	17
490	5378	5.3405	1	2	4	6	10
491	12205	3.4483	2	2	3	4	6
492	2672	15.6662	3	5	8	25	34
493	54859	5.7621	1	3	5	7	11
494	29900	2.4482	1	1	2	3	5
495	153	15.0261	7	9	12	18	26
496	1468	9.5320	4	5	7	12	19
497	17184	6.5116	3	4	5	7	11
498	12708	4.1701	2	3	4	5	6
499	30284	4.6986	1	2	3	6	9
500	43962	2.6146	1	1	2	3	5
501	2180	10.9670	4	6	8	13	21
502	586	6.5648	3	4	5	8	11
503	5551	3.9996	1	2	3	5	7
504	114	29.5877	9	14	24	41	54
505	145	3.3517	1	1	1	3	7
506	915	17.4000	4	8	14	22	35
507	290	8.2621	2	4	7	11	18
508	657	7.4718	2	3	5	9	15
509	176	4.5455	1	2	4	6	9
510	1619	7.1779	2	3	5	9	15
511	602	4.7591	1	2	3	6	10
512	328	15.2439	7	8	11	17	28
513	112	12.6161	6	7	8	12	20
514	16927	7.9786	2	3	6	10	16
515	3774	6.0297	1	1	4	8	14
516	75742	4.7497	2	2	4	6	9
517	171198	2.7066	1	1	2	3	6
518	47731	3.4397	1	1	2	4	8
519	5448	4.7412	1	2	3	6	11
520	10509	2.7887	1	1	2	3	6
521	22732	5.0204	1	2	4	6	9
522	11649	9.7928	3	5	8	12	20
523	14818	4.1079	1	2	3	5	7
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2001

State	Urban	Rural
ALABAMA	0.344	0.410
ALASKA	0.417	0.696
ARIZONA	0.356	0.491
ARKANSAS	0.466	0.446
CALIFORNIA	0.339	0.436
COLORADO	0.422	0.577
CONNECTICUT	0.497	0.506
DELAWARE	0.511	0.450
DISTRICT OF COLUMBIA	0.508	0.369
FLORIDA	0.352	0.470
GEORGIA	0.459	0.554
HAWAII	0.413	0.561
IDAHO	0.545	0.502
ILLINOIS	0.406	0.533
INDIANA	0.524	0.612
IOWA	0.486	0.635
KANSAS	0.421	0.492
KENTUCKY	0.479	0.488
LOUISIANA	0.410	0.543
MAINE	0.615	0.819
MARYLAND	0.759	0.571
MASSACHUSETTS	0.512	0.563
MICHIGAN	0.460	0.589
MINNESOTA	0.494	0.447
MISSISSIPPI	0.452	0.479
MISSOURI	0.405	0.594
MONTANA	0.537	0.610
NEBRASKA	0.449	0.498
NEVADA	0.306	0.581
NEW HAMPSHIRE	0.549	0.491
NEW JERSEY	0.394	0.609
NEW MEXICO	0.466	0.464
NEW YORK	0.528	0.654
NORTH CAROLINA	0.516	0.570
NORTH DAKOTA	0.620	0.494
OHIO	0.501	0.595
OKLAHOMA	0.409	0.525
OREGON	0.613	0.583
PENNSYLVANIA	0.398	0.463
PUERTO RICO	0.486	0.638
RHODE ISLAND	0.520	0.453
SOUTH CAROLINA	0.440	0.494
SOUTH DAKOTA	0.440	0.638
TENNESSEE	0.529	0.453
TEXAS	0.438	0.494
UTAH	0.402	0.586
VERMONT	0.497	0.599
VIRGINIA	0.572	0.454
WASHINGTON	0.454	0.638
WEST VIRGINIA	0.583	0.527
WISCONSIN	0.568	0.611
WYOMING	0.525	0.717

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2001

State	Ratio
ALABAMA	0.044
ALASKA	0.058
ARIZONA	0.037
ARKANSAS	0.049
CALIFORNIA	0.034
COLORADO	0.045
CONNECTICUT	0.036

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2001—Continued

State	Ratio
DELAWARE	0.051
DISTRICT OF COLUMBIA	0.040
FLORIDA	0.043
GEORGIA	0.051
HAWAII	0.038
IDAHO	0.046
ILLINOIS	0.040
INDIANA	0.056
IOWA	0.050
KANSAS	0.050
KENTUCKY	0.046
LOUISIANA	0.048
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.053
MICHIGAN	0.044
MINNESOTA	0.047
MISSISSIPPI	0.044
MISSOURI	0.044
MONTANA	0.058
NEBRASKA	0.054
NEVADA	0.030
NEW HAMPSHIRE	0.061
NEW JERSEY	0.036
NEW MEXICO	0.045
NEW YORK	0.051
NORTH CAROLINA	0.046
NORTH DAKOTA	0.072
OHIO	0.048
OKLAHOMA	0.046
OREGON	0.046
PENNSYLVANIA	0.039
PUERTO RICO	0.045
RHODE ISLAND	0.029
SOUTH CAROLINA	0.046
SOUTH DAKOTA	0.059
TENNESSEE	0.049
TEXAS	0.046
UTAH	0.047
VERMONT	0.052
VIRGINIA	0.055
WASHINGTON	0.063
WEST VIRGINIA	0.045
WISCONSIN	0.051
WYOMING	0.065

Appendix A—Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities. We estimate the total impact of these changes for FY 2002 payments compared to FY 2001 payments to be approximately a \$1.7 billion increase. Therefore, we have prepared an impact analysis for this proposed rule.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an

analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

It is clear that the changes being proposed in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

We have reviewed this proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that the proposed rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

Section 202 of the Unfunded Mandate Reform Act of 1995 (Public Law 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule (or a final rule that has been preceded by a proposed 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 \$110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

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

II. Objectives

The primary objective of the hospital inpatient prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

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 proposed policy changes, as well as statutory changes

effective for FY 2002, 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. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 44 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 67 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 February 2001, we have included 4,583 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 February 2001, there were 1,058 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 517 psychiatric, 203 rehabilitation, 253 long-term care, 75 children's, and 10 cancer hospitals. In addition, there were 1,457 psychiatric units and 925 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 67 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 2002 would be between 0.5 and 3.0 percent, or 0 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

A. National Average Per Resident Amount (PRA)

As discussed in detail in section IV.G.2. of this proposed rule, we are proposing to implement section 511 of Public Law 106-554, which increases the floor of the locality-adjusted national average (PRA for the purposes of computing direct GME payments for cost reporting periods beginning during FY 2002. The national average PRA payment methodology, as provided in section 311 of Public Law 106-113, establishes a "floor" and "ceiling" based on a locality-adjusted, updated national average PRA for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2005. Section 511 of Public Law 106-554 increased the floor from 70 percent to equal 85 percent of a locality-adjusted national average PRA for FY 2002.

For this purpose rule, we have calculated an estimated impact of this proposed policy on teaching hospital's PRAs for FY 2002, making assumptions about update factors and geographic adjustment factors (GAF) for each hospital. Generally, using FY 1997 data, we calculated a floor based on 70 percent of the national average PRA and a floor based on 85 percent of the national average PRA. We then determined the amount of direct GME payments that would have been paid had the floor remained at 70 percent of the national average PRA. Next, we determined the amount of direct GME payments that would be paid with the floor increased to equal 85 percent of the national average PRA. We subtracted the difference between the two and inflated the difference to FY 2002 to determine the impact of this provision.

The figures we use in this impact, except for the FY 1997 weighted PRA of \$68,464, are estimations and are for demonstrative purposes only. Hospitals must use the methodology stated in section IV.G. of this proposed rule to revise (if appropriate) their individual PRAs.

In calculating this impact, we used 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 on a Medicare waiver outside of the prospective payment system, and those hospitals' PRAs do not determine their level of direct GME payments. For 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 the analysis.

Using the FY 1997 weighted average PRA of \$68,464, we determined an 85 percent floor of \$58,194 for FY 1997. We then determined that, for cost reporting periods ending in FY 1997, approximately 562 hospitals had PRAs that were below \$58,194 (336 hospitals of these hospitals had PRAs that were below the 70-percent floor, and 226 hospitals had PRAs that were above the 70-percent floor but below the 85-percent floor). The estimated total cost to the Medicare program in FY 2002 of replacing the PRAs of the 562 hospitals with the 85-percent floor is \$104.4 million.

B. Closed Training Programs or Hospitals That Close Their Training Programs

As discussed in IV.G.5, of this proposed rule, we are proposing to allow a hospital to receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's GME program if the hospital that closed its program agrees to temporarily reduce its FTE cap. We have calculated an estimated impact on the Medicare program for FY 2002 as a result of this proposal. We used the best available cost report data from the FY 1997 HCRIS in our analysis.

We estimate that approximately 5 to 10 programs, each with an average of 25 residents, close each year without advance warning, displacing the residents before they complete their training. Therefore, the number of residents displaced each year could be between 125 and 250. We estimated the impact of this proposed change based on direct GME and IME payment amounts in FY 1997 to determine a total GME amount and updated the total with the CPI-U for FY 2002. At most, the estimated impact for this proposed provision for FY 2002 is moving payments of between \$10 and \$20 million among different hospitals. This would result from redirecting these payments from the hospital that closed its program to the hospital(s) that takes on the residents.

VII. Quantitative Impact Analysis of the Proposed Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for

the prospective payment systems for operating and capital-related costs. We have prepared separate impact analyses of the proposed 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 2000 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 proposed policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 2000 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 proposed FY 2001 changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The proposed 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 wage data from hospitals' cost reporting periods beginning during FY 1998, compared to the FY 1997 wage data.

- The effects of our proposal to increase the accuracy of the wage index calculation by changing the overhead allocation method used so that the salaries and hours of lower-range, overhead employees and the overhead wage-related costs associated with the excluded areas of the hospital are more accurately removed when calculating the overhead costs attributable to wages.

- The effects of our proposal to include the contract labor costs of laboratories and pharmacies from Worksheet S-3 Part II Lines 9.01 and 9.02 in the wage index calculation.

- The combined effects of our proposed changes to the wage index data and calculations and the changes in the DRG recalibration.

- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2002 not including the effects of our proposed policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.

- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2002 including the effects of our proposed policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.

- The total change in payments based on FY 2002 policies relative to payments based on FY 2001 policies.

To illustrate the impacts of the FY 2002 proposed changes, our analysis begins with a FY 2002 baseline simulation model using: the FY 2001 DRG GROUPEL (version 18.0); the FY 2001 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2002 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 2001 to FY 2002. 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, as amended by section 301 of Public Law 106-554, we are proposing to update the large urban and the other areas average standardized amounts for FY 2002 using the most recently forecasted hospital market basket increase for FY 2002 of 3.1 percent minus 0.55 percentage points (for an update of 2.55 percent). Under section 1886(b)(3) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) is equal to the market basket increase of 3.1 percent minus 0.55 percentage points (for an update of 2.55 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2001 to FY 2002 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2001 that are no longer reclassified in FY 2002 may have a negative payment impact going from FY 2001 to FY 2002; conversely, hospitals not reclassified in FY 2001 that are reclassified in FY 2002 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. This effect may be alleviated somewhat by section 304(a) of Public Law 106-554, which provided that reclassifications for purposes of the wage index are for a 3 year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2001 will be 5.9 percent of actual total DRG payments. When the FY 2001 final rule was published, we projected FY 2001 outlier payments would be 5.1 percent of total DRG plus outlier payments; the standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2001 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2001 payments per case to estimated FY 2002 payments per case.

Fourth, section 213 of Public Law 106-554 provided that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2001, eligible SCHs that are rebased receive a hospital-specific rate comprised of the greater of 50-percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or 50-percent of the federal rate, and 50-percent of their FY 1996 hospital-specific rate.

Fifth, sections 302 and 303 of Public Law 106-554 affect payments for indirect medical education (IME) and disproportionate share hospitals (DSH), respectively. These sections increased IME and DSH payments during FY 2001 (effective with discharges on or after April 1, 2001). For FY 2002, section 302 established IME payments at the same level as FY 2001 (6.5 percent), and section 303 established DSH payments at the adjustment the hospital would otherwise receive minus 3 percent.

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 4,795 hospitals included in the analysis. This number is 93 fewer hospitals than were included in the impact analysis in the FY 2001 final rule (65 FR 47191).

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) and rural). There are 2,721 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,563 hospitals located in large urban areas (populations over 1 million), and 1,158 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,074 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 2002 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 2,766, 1,643, 1,123, and 2,029, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals

grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,674 non-teaching hospitals in our analysis, 881 teaching hospitals with fewer than 100 residents, and 240 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.) We note that section 211 of Public Law 106-554 reduced the qualifying DSH threshold to 15 percent for all hospitals (this threshold previously applied to urban hospitals with 100 or more beds and rural hospitals with 500 or more beds). Consequently, many more hospitals qualify for DSH. In the FY 2001

final rule, there were 3,070 hospitals that did not receive a DSH adjustment (65 FR 47192). In Table I, that number declines to 1,879. The number of urban hospitals with fewer than 100 beds receiving DSH increases from 72 prior to section 211 to 325 after its implementation. Among rural hospitals with fewer than 100 beds, 103 received DSH prior to section 211; for FY 2002 that number increases to 443.

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 proposed 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 (165), SCHs (667), MDHs (328), and SCH and RRCs that are not included in the SCH or the RRC categories (69) shown here were not reclassified for purposes of the standardized amount. There are 20 RRCs, 1 MDH, 5 SCHs and 2 SCH and

RRCs that will be reclassified as urban for the standardized amount in FY 2002 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 1999 Medicare cost report files, if available (otherwise FY 1998 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 46 and 78 hospitals, respectively. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2002. The next two groupings separate the hospitals in the first group by urban and rural status. 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 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM
[Percent changes in payments per case]

	Number of hosps. ¹ (0)	DRG re- calib. ² (1)	New wage data ³ (2)	New over- head alloc. ⁴ (3)	Include contract labor ⁵ (4)	DRG & WI changes ⁶ (5)	MGCRB reclassi- fication ⁷ (6)	Reclassi- fication hold-harm- less policy ⁸ (7)	All FY 2001 changes ⁹ (8)
By Geographic Location:									
All hospitals	4,795	0.5	0.2	0.0	0.0	0.0	-0.2	0.2	1.9
Urban hospitals ...	2,721	0.6	0.2	0.0	0.0	0.0	-0.7	0.2	1.7
Large urban areas (populations over 1 million) ..	1,563	0.7	-0.1	0.0	0.0	-0.1	-0.8	0.3	1.5
Other urban areas (populations of 1 million of fewer)	1,158	0.5	0.6	0.0	0.0	0.2	-0.5	0.1	2.0
Rural hospitals	2,074	-0.1	0.5	0.1	0.1	-0.2	2.7	0.1	3.2
Bed Size (Urban):									
0-99 beds	712	-0.1	0.3	0.0	0.0	-0.4	-0.8	0.2	2.1
100-199 beds	943	0.4	0.2	0.0	0.0	-0.2	-0.7	0.3	1.6
200-299 beds	530	0.6	0.3	0.0	0.1	0.1	-0.7	0.3	1.8
300-499 beds	391	0.7	0.1	0.0	0.0	0.0	-0.7	0.2	1.6
500 or more beds	145	1.0	0.0	0.0	0.0	0.2	-0.6	0.1	1.5
Bed Size (Rural):									
0-49 beds	1,209	-0.4	0.5	0.1	0.1	-0.5	0.4	0.0	3.0
50-99 beds	520	-0.2	0.5	0.1	0.1	-0.4	1.1	0.0	3.3
100-149 beds	204	-0.1	0.6	0.1	0.1	-0.1	3.2	0.2	3.0
150-199 beds	75	0.1	0.4	0.1	0.1	-0.1	5.2	0.2	3.4
200 or more beds	66	0.3	0.4	0.1	0.1	0.0	5.2	0.1	3.6
Urban by Region:									
New England	139	0.6	2.2	-0.1	0.0	1.3	-0.2	0.0	1.7
Middle Atlantic	417	0.7	-1.2	-0.1	0.0	-1.4	-0.8	0.6	0.2
South Atlantic	395	0.7	0.9	0.0	0.0	0.9	-0.8	0.3	2.8
East North Cen- tral	462	0.5	0.1	0.0	0.1	-0.2	-0.6	0.1	1.6
East South Cen- tral	160	0.6	1.1	0.1	0.0	1.1	-0.7	0.0	3.0
West North Cen- tral	189	0.6	0.5	0.1	0.1	0.3	-0.7	0.0	2.0
West South Cen- tral	342	0.7	-0.8	0.0	0.0	-0.9	-0.7	0.0	0.7
Mountain	137	0.6	0.9	0.0	0.0	0.7	-0.7	0.0	2.4
Pacific	434	0.7	0.4	0.1	0.0	0.4	-0.8	0.2	2.2
Puerto Rico	46	0.4	1.3	0.1	0.0	1.0	-0.5	-0.3	2.6
Rural by Region:									

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
 [Percent changes in payments per case]

	Number of hosps. ¹ (0)	DRG re- calib. ² (1)	New wage data ³ (2)	New over- head alloc. ⁴ (3)	Include contract labor ⁵ (4)	DRG & WI changes ⁶ (5)	MCGRB reclassi- fication ⁷ (6)	Reclassi- fication hold-harm- less policy ⁸ (7)	All FY 2001 changes ⁹ (8)
New England	49	0.0	0.6	0.1	0.0	-0.1	3.0	0.1	3.7
Middle Atlantic	74	0.0	-0.2	0.0	0.0	-1.0	2.5	0.0	2.2
South Atlantic	267	0.1	0.6	0.1	0.1	0.0	2.9	0.1	3.6
East North Cen- tral	273	-0.2	0.6	0.0	0.1	-0.3	2.2	0.2	2.8
East South Cen- tral	263	0.0	0.5	0.1	0.1	-0.2	3.3	0.0	3.6
West North Cen- tral	479	-0.3	0.8	0.2	0.1	-0.1	2.1	0.1	2.5
West South Cen- tral	331	-0.1	0.7	0.1	0.1	0.0	3.5	0.1	4.2
Mountain	194	-0.1	0.4	0.2	0.0	-0.4	1.9	0.0	2.9
Pacific	139	0.0	-0.2	0.1	0.1	-0.9	2.3	0.1	2.7
Puerto Rico	5	-0.3	3.9	0.1	0.0	2.9	1.9	-0.8	8.4
By Payment Classi- fication:									
Urban hospitals ...	2,766	0.6	0.2	0.0	0.0	0.0	-0.7	0.2	1.7
Large urban areas (populations over 1 million) ..	1,643	0.7	-0.1	0.0	0.0	-0.1	-0.7	0.3	1.5
Other urban areas (populations of 1 million of fewer)	1,123	0.5	0.6	0.0	0.0	0.2	-0.6	0.1	2.0
Rural areas	2,029	-0.1	0.5	0.1	0.1	-0.2	2.5	0.0	3.2
Teaching Status:									
Non-teaching	3,674	0.3	0.4	0.0	0.0	-0.1	0.2	0.2	2.2
Fewer than 100 Residents	881	0.6	0.3	0.0	0.0	0.1	-0.6	0.2	1.9
100 or more Resi- dents	240	1.0	-0.2	0.0	0.0	0.0	-0.5	0.1	1.3
Urban DSH:									
Non-DSH	1,879	0.4	0.2	0.0	0.0	-0.1	-0.2	0.3	1.7
100 or more beds Less than 100 beds	1,378	0.7	0.2	0.0	0.0	0.1	-0.7	0.2	1.7
325	0.0	0.4	0.1	0.0	-0.3	-0.8	0.3	3.3	
Rural DSH:									
Sole Community (SCH)	540	-0.2	0.4	0.1	0.0	-0.5	0.4	0.0	3.1
Referral Center (RRC)	157	0.2	0.5	0.1	0.1	0.0	5.3	0.1	3.7
Other Rural:									
100 or more beds	73	-0.1	0.7	0.1	0.1	-0.1	1.3	0.1	3.2
Less than 100 beds ..	443	-0.2	0.5	0.1	0.1	-0.4	0.6	0.0	4.3
Urban teaching and DSH:									
Both teaching and DSH	754	0.8	0.1	0.0	0.0	0.0	-0.7	0.2	1.6
Teaching and no DSH	295	0.7	0.2	0.0	0.1	0.0	-0.6	0.3	1.6
No teaching and DSH	949	0.4	0.4	0.0	0.0	0.1	-0.6	0.3	2.0
No teaching and no DSH	768	0.3	0.2	0.0	0.0	-0.2	-0.6	0.3	1.5
Rural Hospital Types:									
Non special status hos- pitals	800	-0.3	0.7	0.1	0.1	-0.2	0.9	0.0	3.6
RRC	165	0.2	0.5	0.1	0.1	0.0	6.3	0.1	3.6
SCH	667	-0.2	0.4	0.1	0.0	-0.5	0.4	0.0	2.5

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
 [Percent changes in payments per case]

	Number of hosps. ¹ (0)	DRG re- calib. ² (1)	New wage data ³ (2)	New over- head alloc. ⁴ (3)	Include contract labor ⁵ (4)	DRG & WI changes ⁶ (5)	MCGRB reclassi- fication ⁷ (6)	Reclassi- fication hold-harm- less policy ⁸ (7)	All FY 2001 changes ⁹ (8)
Medicare-de- pendent hospitals (MDH)	328	-0.3	0.5	0.1	0.1	-0.5	0.5	0.0	3.2
SCH and RRC	69	0.1	0.4	0.0	0.0	-0.3	2.5	0.0	2.7
Type of Ownership:									
Voluntary	2,785	0.6	0.2	0.0	0.0	-0.1	-0.3	0.2	1.8
Proprietary	777	0.6	0.2	0.1	0.0	0.1	-0.3	0.2	2.0
Government	1,187	0.5	0.6	0.1	0.0	0.3	0.1	0.1	2.5
Unknown	46	0.3	1.3	0.0	0.0	0.7	-1.7	1.0	2.6
Medicare Utiliza- tion as a Per- cent of Inpatient Days:									
0-25	396	0.9	0.2	0.0	0.0	0.4	-0.5	0.1	2.2
25-50	1,886	0.7	0.1	0.0	0.0	0.0	-0.6	0.2	1.7
50-65	1,843	0.4	0.4	0.0	0.0	0.0	0.1	0.2	2.2
Over 65	592	0.2	0.2	0.0	0.1	-0.2	0.2	0.3	1.9
Unknown	78	0.5	-2.1	-0.1	0.0	-2.4	-0.7	0.1	-1.1
Hospitals Reclassified by the Medicare Ge- ographic Classifica- tion Review Board: FY 2002									
Reclassifications:									
All Reclassified									
Hospitals	636	0.3	0.6	0.0	0.1	0.2	4.5	0.3	2.9
Standardized Amount Only	74	0.1	0.7	0.0	0.0	0.0	1.9	1.0	4.0
Wage Index Only	391	0.3	0.5	0.1	0.1	0.1	5.3	0.1	2.5
Both	58	0.4	0.7	0.0	0.1	0.4	4.1	0.6	0.0
Nonreclassified Hos- pitals	4,246	0.6	0.2	0.0	0.0	0.0	-0.8	0.2	1.9
All Reclassified Urban Hospitals	119	0.7	0.8	0.0	0.1	0.6	2.8	0.4	2.0
Urban Non- reclassified Hospitals	18	0.2	0.5	0.0	0.0	-0.2	-1.2	1.9	-0.6
Standardized Amount Only	81	0.8	0.7	0.0	0.1	0.6	3.3	0.1	2.2
Wage Index Only	20	0.5	1.4	0.0	0.1	1.1	1.9	2.1	2.5
Both	2,564	0.6	0.2	0.0	0.0	0.0	-0.9	0.2	1.6
All Reclassified Rural Hospitals	517	0.1	0.5	0.1	0.1	-0.1	5.6	0.2	3.6
Standardized Amount Only	19	-0.2	0.5	0.1	0.0	-0.5	3.9	1.5	2.0
Wage Index Only	475	0.1	0.5	0.1	0.1	-0.1	5.5	0.1	3.6
Both	23	0.1	0.8	0.1	0.1	0.2	7.7	1.5	4.2
Rural Nonreclassified Hospitals	1,554	-0.3	0.5	0.1	0.1	-0.4	-0.6	0.0	2.8
Other Reclassified Hospitals (Section 1886(D)(8)(B))	41	-0.1	-6.1	0.1	0.1	0.4	0.3	0.1	3.9

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 2000, and hospital cost report data are from reporting periods beginning in FY 1999 and FY 1998.

² This column displays the payment impact of the recalibration of the DRG weights based on FY 2000 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 1998 cost reports.

⁴ This column displays the impact of removing the salaries and hours of lower-range, overhead employees and the overhead wage-related costs associated with the excluded areas of the hospital from the wage index calculation.

⁵ This column displays the impact of including contract pharmacy and contract laboratory costs and hours in the wage index calculation.

⁶This 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, the revised overhead allocation, the laboratory and pharmacy contract labor costs, 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, 3, and 4, and the FY 2002 budget neutrality factor of .992394.

⁷Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2002 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2002. Reclassification for prior years has no bearing on the payment impacts shown here.

⁸Shown here are the effects of geographic reclassifications by the MGCRB including the effects of our proposed policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.

⁹This column shows changes in payments from FY 2001 to FY 2002. It incorporates all of the changes displayed in columns 5, 6, and 7 (the changes displayed in columns 1, 2, 3, and 4 are included in column 5). It also displays the impact of the FY 2002 update, changes in hospitals' reclassification status in FY 2002 compared to FY 2001, and the difference in outlier payments from FY 2001 to FY 2002. It also reflects section 213 of Public Law 106-554, which permitted all 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 Proposed 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 proposed 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 2001 DRG relative weights (GROUPEP version 18) to aggregate payments using the proposed FY 2002 DRG relative weights (GROUPEP version 19). Overall payments increase 0.5 percent due to the DRG reclassification and recalibration. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes is budget neutral. This budget neutrality factor of 0.992493 is applied to payments in Column 5.

The DRG changes we are proposing in this proposed rule would result in higher payments to urban hospitals (0.6 percent) and somewhat lower payments to rural hospitals (-0.1). The changes also would result in higher payments to larger hospitals than to smaller hospitals. This impact is consistent for both urban and rural bed size groups.

This distributional impact likely results from the changes we are proposing to major diagnostic category (MDC) 5 "Diseases and Disorders of the Circulatory System." As described in section II., we are proposing to remove cardiac defibrillator cases from DRGs 104 and 105, and create two new DRGs for these cases. In addition, we are proposing to revise the basis of the DRG assignment for cases involving percutaneous transluminal coronary angioplasty based on whether the patient experienced an acute myocardial infarction. Because MDC 5 is a high volume category, refining the categorizations of these cases has a noticeable impact.

C. Impact of Updating the Wage Data and the Proposed Changes to the Wage Index Calculation (Columns 2, 3 & 4)

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 proposed wage index for FY

2002 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1997 and before October 1, 1998. As with column 1, the impact of the new data on hospital payments is isolated in column 2 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 2001 wage index (based on FY 1997 wage data before geographic reclassifications to a model using the FY 2002 pre-reclassification wage index based on FY 1998 wage data).

The wage data collected on the FY 1998 cost reports are similar to the data used in the calculation of the FY 2001 wage index. For a thorough discussion of the data used to calculate the wage index, see section III.B of this proposed rule.

The results indicate that the new wage data are estimated to provide a 0.2 percent increase for hospital payments overall (prior to applying the budget neutrality factor, see column 5). Rural hospitals appear to experience the greatest benefit from the update to the 1998 wage data, with an increase of 0.5 percent. Rural hospitals in Nevada, Connecticut and Arizona experience wage index increases of more than 5 percent. Rural hospitals in Puerto Rico experience a 3.9 percent increase.

Urban hospitals as a group are not significantly affected by the updated wage data. While large urban hospitals appear to experience a 0.1 percent decline, estimated payments to urban hospitals overall showed an increase of 0.2 percent. Payments in other urban areas increase by 0.6 percent. Among urban census divisions, the New England division experiences a 2.2 percent increase, Middle Atlantic a 1.2 percent decrease, East South Central a 1.1 percent increase, and Puerto Rico a 1.3 percent increase.

Columns 3 and 4, respectively, show that the proposed change to the overhead calculation and the proposal to include contract labor costs in the wage index discussed in detail in Section III.C. of this proposed rule both appear to have negligible impacts on hospital payments overall. Urban hospitals as a group are not effected by these proposals as there is a 0.0 percent impact to their payments from each proposed change. Rural hospitals, however, do appear to benefit slightly from these changes, as evidenced by the estimated 0.1 percent increase in payments to this group.

We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 2001 and, therefore, do not reflect revision requests

received and processed by the fiscal intermediaries after that date. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions will be reflected in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The following chart compares the shifts in wage index values for labor market areas for FY 2001 relative to FY 2002. This chart demonstrates the impact of the proposed changes for the FY 2002 wage index relative to the FY 2001 wage index. The majority of labor market areas (318) experience less than a 5-percent change. A total of 36 labor market areas experience an increase of more than 5 percent with 4 having an increase greater than 10 percent. A total of 13 areas experience decreases of more than 5-percent. Of those, 4 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2001	FY 2002
Increase more than 10 percent	1	4
Increase more than 5 percent and less than 10 percent	20	36
Increase or decrease less than 5 percent	339	318
Decrease more than 5 percent and less than 10 percent	14	13
Decrease more than 10 percent	1	4

Among urban hospitals, 163 would experience an increase of between 5 and 10 percent and 16 more than 10 percent. A total of 33 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 121 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Five urban hospitals have decreases in their wage index values greater than 10 percent. There are no rural hospitals with decreases in their wage index values greater than 5 percent or with increases of more 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	16	0
Increase more than 5 percent and less than 10 percent	101	15
Increase or decrease less than 5 percent	2,395	2,135
Decrease more than 5 percent and less than 10 percent	121	0
Decrease more than 10 percent	5	0

D. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 5)

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 proposed rule, we compared simulated aggregate payments using the FY 2001 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2002 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.992493. 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 5. 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, 3 and 4, minus approximately 0.7 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

E. Impact of MGCRB Reclassifications (Columns 6 & 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2002. The changes in column 6 add in the post-reclassified wage index values resulting from the proposed change to include the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments.

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.

The proposed FY 2002 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2002. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of February 28, 2001. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2002.

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 0.991054 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.) This results in a larger budget neutrality offset than the FY 2001 factor of 0.993187. This larger offset is accounted for by the extension of wage index reclassifications for 3 years as a result of section 304 of Public Law 106-554, and our proposed policy to hold-harmless the calculation of urban areas' wage indexes for reclassifications out of the area (see Column 7). We have identified 162 hospitals that were reclassified for FY 2001 but not FY 2002, that will nonetheless continue to be reclassified due to section 304 of Public Law 106-554.

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.7 percent in Column 6. Payments to urban hospitals decline 0.7 percent. Hospitals in other urban areas see a decrease in payments of 0.5 percent, while large urban hospitals lose 0.8 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 smallest increase among the rural census divisions is 1.9 percent for Mountain and Puerto Rico regions. The largest increases are in rural West South Central and New England. These regions receive increases of 3.5 and 3.0 percent respectively.

Among all the hospitals that were reclassified for FY 2002, the MGCRB changes are estimated to provide a 4.5 percent increase in payments. Urban hospitals reclassified for FY 2002 are anticipated to receive an increase of 2.8 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 5.6 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 3.3 percent is expected, while those reclassified for purposes of the wage index only show a 1.9 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 1.2 for urban

hospitals and 0.6 for rural hospitals. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 0.3 percent.

Column 7 shows the impacts of our proposed policy to include the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located. This change affects overall payments by 0.2 percent, partially accounting for the larger budget neutrality factor compared to FY 2001. The payment impacts are generally largest in urban hospital groups, with the largest impact, 0.6 percent, experienced by urban hospitals in the Middle Atlantic census division.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by February 28, 2001. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome of these cases will be reflected in the analysis presented in the final rule.

F. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2002 (including statutory changes), to our estimate of payments per case in FY 2001. It includes the effects of the 2.55 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 0.8 percentage point difference between the projected outlier payments in FY 2001 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2001 (5.9 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

We also note that section 211 of Public Law 106-554 changed the criteria for hospitals to qualify for DSH payment status. Since more hospitals are now eligible to receive DSH payments for the full FY 2002, as opposed to for just the second 6 months of FY 2001, DSH payments to providers in FY 2002 would increase and this change is also captured in column 8.

Section 213 of Public Law 106-554 provided that all SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2002, eligible SCHs that rebase receive a hospital-specific rate comprised of 50 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or their Federal rate, and 50 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 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 7 may not equal the sum of the changes in columns 5 and 6, plus the other impacts that we are able to identify.

Hospitals in urban areas experience a 1.7 percent increase in payments per case compared to FY 2001. The 0.7 percent

negative impact due to reclassification is offset by a similar negative impact for FY 2001 of 0.4 percent (65 FR 47196). Hospitals in rural areas, meanwhile, experience a 3.2 percent payment increase. This is primarily due to the change in the DSH threshold to 15 percent for all hospitals enacted by section 211 of Public Law 106-554 and effective for discharges on or after April 1, 2001, and the positive effect of the reclassification changes (2.7 percent increase, plus an additional 0.1 percent increase from the proposal to include the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located).

The impact of lowering the DSH threshold is demonstrated in Column 8, although we would note that the estimated FY 2001 payments do reflect 6 months of payments to hospitals affected by this change. The impacts are seen in the rows displaying urban hospitals with fewer than 100 beds receiving DSH (3.3 percent increase), and all rural DSH categories.

Among urban census divisions, payments increased between 0.2 and 3.0 percent between FY 2001 and FY 2002. The rural census division experiencing the smallest increase in payments was the Mid-Atlantic region (2.2 percent). The largest increases by rural hospitals is in Puerto Rico, where payments appear to increase by 8.4 percent and West South Central, where payments appear to increase by 4.2 percent. Rural New England and South Atlantic regions also benefited with 3.7 and 3.6 percent respectively.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 3.1 percent, 3.7 percent, and 3.2 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 outlier payments from FY

2001 to FY 2002 (from 5.9 percent of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

Among hospitals that were reclassified for FY 2002, hospitals overall are estimated to receive a 2.9 percent increase in payments. Urban hospitals reclassified for FY 2002 are anticipated to receive an increase of 2.0 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 3.6 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, only a payment increase of 4.0 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 2.5 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 3.9 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2001 OPERATING PROSPECTIVE PAYMENT SYSTEM
[Payments per case]

	Number of hosps. (1)	Average FY 2001 payment per case ¹ (2)	Average FY 2001 payment per case ¹ (3)	All FY 2001 changes (4)
By Geographic Location:				
All hospitals	4,795	6,969	7,100	1.9
Urban hospitals	2,721	7,548	7,674	1.7
Large urban areas (populations over 1 million)	1,563	8,087	8,207	1.5
Other urban areas (populations of 1 million of fewer)	1,158	6,854	6,989	2.0
Rural hospitals	2,074	4,705	4,856	3.2
Bed Size (Urban):				
0-99 beds	712	5,114	5,220	2.1
100-199 beds	943	6,294	6,397	1.6
200-299 beds	530	7,192	7,320	1.8
300-499 beds	391	8,127	8,261	1.6
500 or more beds	145	9,946	10,099	1.5
Bed Size (Rural):				
0-49 beds	1,209	3,922	4,041	3.0
50-99 beds	520	4,410	4,554	3.3
100-149 beds	204	4,780	4,922	3.0
150-199 beds	75	5,291	5,470	3.4
200 or more beds	66	5,961	6,173	3.6
Urban by Region:				
New England	139	8,077	8,214	1.7
Middle Atlantic	417	8,561	8,579	0.2
South Atlantic	395	7,183	7,386	2.8
East North Central	462	7,210	7,323	1.6
East South Central	160	6,771	6,973	3.0
West North Central	189	7,287	7,430	2.0
West South Central	342	7,039	7,087	0.7
Mountain	137	7,282	7,454	2.4
Pacific	434	8,840	9,037	2.2
Puerto Rico	46	3,235	3,319	2.6
Rural by Region:				
New England	49	5,615	5,821	3.7
Middle Atlantic	74	5,052	5,165	2.2
South Atlantic	267	4,871	5,046	3.6
East North Central	273	4,743	4,875	2.8
East South Central	263	4,398	4,556	3.6
West North Central	479	4,506	4,620	2.5
West South Central	331	4,177	4,351	4.2
Mountain	194	5,020	5,166	2.9
Pacific	139	5,762	5,920	2.7
Puerto Rico	5	2,529	2,742	8.4
By Payment Classification:				
Urban hospitals	2,766	7,526	7,652	1.7

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2001 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
[Payments per case]

	Number of hosps. (1)	Average FY 2001 payment per case ¹ (2)	Average FY 2001 payment per case ¹ (3)	All FY 2001 changes (4)
Large urban areas (populations over 1 million)	1,643	8,002	8,121	1.5
Other urban areas (populations of 1 million of fewer)	1,123	6,870	7,008	2.0
Rural areas	2,029	4,687	4,838	3.2
Teaching Status:				
Non-teaching	3,674	5,605	5,728	2.2
Fewer than 100 Residents	881	7,309	7,445	1.9
100 or more Residents	240	11,258	11,410	1.3
Urban DSH:				
Non-DSH	1,879	6,354	6,461	1.7
100 or more beds	1,378	8,129	8,267	1.7
Less than 100 beds	325	4,925	5,089	3.3
Rural DSH:				
Sole Community (SCH)	540	4,295	4,427	3.1
Referral Center (RRC)	157	5,521	5,723	3.7
Other Rural:				
100 or more beds	73	4,304	4,441	3.2
Less than 100 beds	443	3,928	4,095	4.3
Urban teaching and DSH:				
Both teaching and DSH	754	9,091	9,238	1.6
Teaching and no DSH	295	7,562	7,683	1.6
No teaching and DSH	949	6,298	6,424	2.0
No teaching and no DSH	768	5,932	6,022	1.5
Rural Hospital Types:				
Non special status hospitals	800	4,042	4,186	3.6
RRC	165	5,434	5,630	3.6
SCH	667	4,562	4,676	2.5
Medicare-dependent hospitals (MDH)	328	3,844	3,966	3.2
SCH and RRC	69	5,649	5,803	2.7
Type of Ownership:				
Voluntary	2,785	7,136	7,261	1.8
Proprietary	777	6,580	6,712	2.0
Government	1,187	6,486	6,651	2.5
Unknown	46	6,283	6,449	2.6
Medicare Utilization as a Percent of Inpatient Days:				
0–25	396	9,504	9,713	2.2
25–50	1,886	8,030	8,164	1.7
50–65	1,843	6,012	6,142	2.2
Over 65	592	5,393	5,497	1.9
Unknown	78	10,244	10,132	–1.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:				
All Reclassified Hospitals	636	6,153	6,334	2.9
Standardized Amount Only	74	5,200	5,407	4.0
Wage Index Only	391	6,004	6,152	2.5
Both	58	6,818	6,816	0.0
All Nonreclassified Hospitals	4,246	7,105	7,236	1.9
All Urban Reclassified Hospitals	119	8,253	8,415	2.0
Urban Nonreclassified Hospitals	18	6,176	6,136	–0.6
Standardized Amount Only	81	8,946	9,141	2.2
Wage Index Only	20	6,193	6,346	2.5
Both	2,564	7,531	7,654	1.6
All Reclassified Rural Hospitals	517	5,277	5,466	3.6
Standardized Amount Only	19	4,658	4,750	2.0
Wage Index Only	475	5,283	5,472	3.6
Both	23	5,396	5,622	4.2
Rural Nonreclassified Hospitals	1,554	4,153	4,268	2.8
Other Reclassified Hospitals (Section 1886(D)(8)(B))	41	4,841	5,032	3.9

¹ These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2002 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 2001 with the average estimated per

case payments for FY 2002, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table

II equal the percentage changes in average payments from column 8 of Table I.

VIII. Impact for Critical Access Hospitals (CAHs)

There are approximately 365 facilities that qualify as CAHs. These CAHs are paid based on reasonable costs for their services to inpatients and outpatients. We examined several parts of the proposed rule, as discussed in detail in section VI.B. of the preamble, for their potential impact on CAHs.

A. Exclusion of CAHs From Payment Window Requirements

In this proposed rule, we are proposing to clarify the policy that CAHs are not subject to the payment window provisions of section 1886(a)(3) of the Act. Existing regulations do not require that these provisions be applied to CAHs, and we are not aware of specific situations in which they are now being applied. Consequently, we do not expect any increase or decrease in Medicare spending based on this clarification.

B. Availability of CRNA Pass-Through for CAHs

Under existing § 412.113(c), CRNA pass-through payment is available only to hospitals that either qualified for the pass-through of costs of anesthesia services furnished in calendar year 1989, or employed or contracted with a qualified nonphysician anesthetist as of January 1, 1988, to perform anesthesia services. We are proposing that certain CAHs that meet the pass-through criteria would qualify for pass-through payments. Under the existing criterion, the only facilities that could qualify for the pass-through as CAHs are those that would have qualified for the pass-through if they had elected to continue participating in Medicare as hospitals rather than converting to CAH status. We do not expect any increase or decrease in Medicare spending based on the proposed change in the regulations.

C. Payment for Emergency Room On-Call Physicians

In accordance with the amendments made by section 204 of Public Law 106-544, we are proposing to recognize as allowable costs, amounts for reasonable compensation and related costs for emergency room physicians who are on call but who are not present on the premises of a CAH. We expect that at least some CAHs will elect to compensate emergency room physicians for being on call, and that as a result, Medicare spending for CAH services will increase. However, we do not have information to develop a reliable estimate of how many CAHs will make this election, or how much physician compensation costs they will incur for on call time.

D. Treatment of Ambulance Services Furnished by Certain CAHs

In accordance with the provisions of section 205 of Public Law 106-554, we are proposing to amend the existing CAH regulations to provide for payment to CAHs for the reasonable costs of ambulance services furnished by a CAH or an entity owned or operated by the CAH if certain statutory requirements are met. We expect that at least some CAHs or entities owned or

operated by CAHs will be able to qualify for payment for their ambulance services. To the extent that CAHs or CAH owned or operated entities furnish these services under the conditions specified in the law, ambulance services will be paid for at higher rates than would otherwise apply. As a result, Medicare spending for ambulance services will increase. However, we do not have sufficient information or data to develop a reliable estimate of how many CAHs or entities will qualify or the dollar amount of ambulance service costs they will incur.

E. Qualified Practitioners for Preanesthesia and Postanesthesia Evaluations in CAHs

As discussed in section VI.B. of this proposed rule, in an effort to eliminate or minimize potential issues relating to beneficiary access to medical services in rural areas, we are proposing to allow CRNAs who administer the anesthesia to conduct the preanesthesia and postanesthesia evaluations in a CAH. As with any licensed independent health care provider, the proposed change would not permit CRNAs to practice beyond his or her licensed scope of practice.

We believe that this proposal would increase flexibility of providers in furnishing medical services in rural areas. However, we do not have information or data to develop a reliable estimate of how many CRNAs would be used to conduct preanesthesia and postanesthesia evaluations in CAHs or what the associated costs would be.

IX. Impact of Proposed Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 8th year of the capital prospective payment system (cost reports beginning in FY 1999) available through the December 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 2002 capital cost projections. In Appendix B of this proposed rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2002 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 2002. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 2002 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 2002 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 Proposed FY 2002 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 2001 to FY 2002 using a capital cost model. The FY 2002 model, as described in Appendix B of this proposed 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 1999 as reported on the December 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 January 1, 2001 in the provider-specific file. We used these data to determine the proposed FY 2002 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 1999, 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 1999. All Federal rate payment parameters are assigned to the applicable hospital. We will continue to pay regular exceptions during cost reporting periods beginning before October 1, 2001 but ending in FY 2002. However, in FY 2003 and later, payments will no longer be made under the regular exceptions provision, hence, we will no longer require the actuarial model described in Appendix B of this proposed rule.

For purposes of this impact analysis, the proposed FY 2002 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
2000	1.39
2001	1.37
2002	2.58

- We estimate that the Medicare case-mix index will increase by 0.0 percent in FY 2001 and will increase by 1.0 percent in FY 2002.
- The Federal capital rate and the hospital-specific rate were updated beginning 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 proposed FY 2002 update is 1.1 percent (see section IV. of the Addendum to this proposed rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 2001 to FY 2002. 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. We are no longer displaying a column for the hospital-specific payments in Table III since the FY 2001 transition blend percentage for fully prospective hospitals is 100 percent of the Federal rate and zero percent of the hospital-specific rate, and all hospitals (except those defined as "new" under § 412.300) are paid based on 100 percent of the Federal rate for FY 2002. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2002

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	62	57	61
High Cost Hospital	34	38	43	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(c) 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 2001 to FY 2002 using the above described

actuarial model. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 3.80 percent in FY 2002. This increase is somewhat lower than last year's (5.48 percent) due in part to the fact that because the transition period ends after FY 2001, there is no longer an increase in the Federal blend percentage, which increased from 90 to 100 percent from FY 2000 to FY 2001, for fully prospective hospitals.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2002 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 2001
FY 2001 Payments per Discharge								
Low Cost Hospitals	3,128	6,718,804	\$626.20	99.70	\$2.38	\$5.69	\$634.27	.....
Fully Prospective	2,945	6,231,764	627.54	100.00	.....	5.09	632.63	.....
100% Federal Rate	163	451,843	627.89	100.00	.....	7.75	635.64	.....
Hold Harmless	20	35,197	367.32	50.30	454.71	85.44	907.47	.....
High Cost Hospitals	1,577	4,110,246	636.96	97.69	19.34	10.64	666.93	.....
100% Federal Rate	1,386	3,744,619	648.86	100.00	.....	8.82	657.68	.....
Hold Harmless	191	365,627	515.12	75.29	217.38	29.23	761.73	.....
Total Hospitals	4,705	10,829,050	630.28	98.92	8.82	7.57	646.67	.....
FY 2002 Payments per Discharge								
Low Cost Hospitals	3,128	6,826,288	647.17	100.00	.....	3.19	650.36	2.54

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2002 ON PAYMENTS PER DISCHARGE—Continued

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 2001
Fully Prospective	2,945	6,331,437	646.59	100.00	.....	2.96	649.55	2.68
100% Federal Rate	183	494,852	654.56	100.00	.....	6.11	660.67	3.94
High Cost Hospitals	1,577	4,176,324	671.77	100.00	.....	5.72	677.49	1.58
100% Federal Rate	1,577	4,176,324	671.77	100.00	.....	5.72	677.49	3.01
Total Hospitals	4,705	11,002,612	656.51	100.00	.....	4.15	660.66	2.16

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 2.54 percent, and high capital cost hospitals will experience an average increase of 1.58 percent. These results are due to the fact that there is no longer an increase in the Federal blend percentage with the conclusion of the capital transition period in FY 2001 for fully prospective hospitals. Beginning FY 2002, all hospitals (except those defined as “new” under § 412.300) are paid based on 100 percent of the Federal rate for FY 2002.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage remains at 100 percent from FY 2001 (last year of the transition period) since they no longer receive payments based on the hospital-specific rate. The Federal rate payment percentage in FY 2001 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 in FY 2001 will increase from 75.29 percent to 100 percent since the transition period will have ended. All hold-harmless hospitals will be paid based on 100 percent of the Federal rate in FY 2002. We estimate that high cost hospitals (paid based on 100 percent of the Federal rate) will receive a decrease in exceptions payments from \$8.82 per discharge in FY 2001 to \$5.72 per discharge in FY 2002. This is primarily due to the expiration of the regular exceptions provision in FY 2002.

We are no longer presenting the average hospital-specific rate payment per discharge in Table III because the FY 2001 transition blend percentage for fully prospective hospitals is 100 percent of the Federal rate and zero percent of the hospital-specific rate, and all hospitals (except those defined as “new” under § 412.300) will be paid based on 100 percent of the Federal rate for FY 2002.

As stated previously, we will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001, but ending in FY 2002. However, in FY 2003 and later, regular exception payments will no longer be made under the regular exceptions provision, however, eligible hospitals could receive special exception payments under § 412.348(g).

We estimate that regular exceptions payments will decrease from 1.17 percent of total capital payments in FY 2001 to 0.63 percent of payments in FY 2002. These results are primarily due to the expiration of the regular exceptions after FY 2001 and the limited nature of the special exceptions policy in FY 2002. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2002 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	122	48
High Capital Cost	116	52
Total	238	100

In the past we presented a cross-sectional summary of hospital groupings by the capital prospective payment transition period methodology generated by our actuarial model (Appendix B). We are no longer including such a comparison since all hospitals (except those defined as “new” under § 412.300) will be paid based on 100 percent of the Federal rate in FY 2002 with the conclusion of the 10-year capital transition period.

C. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2002 actuarial model to estimate the potential impact of our proposed changes for FY 2002 on total capital payments per case, using a universe of 4,705 hospitals. The individual hospital payment parameters are taken from the best available data, including: The January 1, 2001 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table IV we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the proposed FY 2002 payment policies. As we explain in Appendix B of this proposed rule, we were not able to use 90 of the 4,795 hospitals in our database due to insufficient (missing or unusable) data. Consequently, the payment methodology distribution is based on 4,705

hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals. Columns 3 and 4 show estimates of payments per case under our model for FY 2001 and FY 2002. Column 5 shows the total percentage change in payments from FY 2001 to FY 2002. 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 1.85 percent increase in the Federal rate, a 1.0 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including the change for all hold-harmless hospitals being paid based on 100 percent of the Federal rate, and changes in exception payments. 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 2.2 percent in FY 2002. The results show that the effect of the Federal rate change alone is to increase payments by 3.0 percent. In addition to the increase attributable to the Federal rate change, a 0.8 percent decrease 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 (2.3 percent and 1.2 percent, respectively). This difference is due to the lower rate of decrease for urban hospitals relative to rural hospitals (0.7 percent and 1.7 percent, respectively) from the effect of all other changes. Urban hospitals will gain approximately the same as rural hospitals (3.0 percent versus 2.9 percent, respectively) from the effects of Federal rate changes alone.

Most regions are estimated to receive increases in total capital payments per case, partly due to the fact that payments to all hospitals (except those defined as “new” under § 412.300) will be based on 100 percent of the Federal rate in FY 2002. Changes by region vary from a minimum

maximum decrease of 0.6 percent (Mountain urban region) to a maximum increase of 3.0 percent (New England urban rural region).

By type of ownership, voluntary hospitals are projected to have the largest rate of increase of total payment changes (2.5 percent, a 3.0 percent increase due to the Federal rate changes, and a 0.5 percent decrease from the effects of all other changes). Similarly, payments to government hospitals will increase 2.2 percent (a 3.0 percent increase due to Federal rate changes, and a 0.8 percent decrease from the effects of all other changes), while payments to proprietary hospitals will increase 0.5 percent (a 2.9 percent increase due to Federal rate changes, and a 2.4 percent decrease from the effects of all other changes). This 2.4 percent decrease from all other changes is primarily due to the estimated decrease in exceptions payments and the change for all hold-harmless hospitals being paid based on 100 percent of the Federal rate.

Section 1886(d)(10) of the Act established the MGRB. 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 also 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 2.0 percent increase in payments (a 3.0 percent increase attributable to Federal rate changes and a 1.0 percent decrease attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly more (2.2 percent) than reclassified hospitals (2.0 percent) overall. Payments to nonreclassified hospitals will increase the same as reclassified hospitals from the Federal rate changes (3.0 percent), and they will lose less from the effects of all other changes (0.8 percent compared to 1.0 percent, respectively).

TABLE IV.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2001 Payments Compared to FY 2002 Payments]

	Number of hospitals	Average FY 2001 payments/case	Average FY 2002 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	4,705	647	661	2.2	3.0
Large urban areas (populations over 1 million)	1,519	749	766	2.3	3.0
Other urban areas (populations of 1 million or fewer)	1,125	635	650	2.4	3.0
Rural areas	2,061	439	444	1.2	2.9
Urban hospitals	2,644	699	716	2.3	3.0
0-99 beds	654	522	507	-2.8	2.8
100-199 beds	927	596	607	1.8	2.9
200-299 beds	528	667	684	2.6	3.0
300-499 beds	390	739	762	3.1	3.0
500 or more beds	145	902	925	2.6	2.9
Rural hospitals	2,061	439	444	1.2	2.9
0-49 beds	1,200	369	372	1.0	2.9
50-99 beds	516	412	416	1.0	2.9
100-149 beds	204	452	457	1.1	2.9
150-199 beds	75	485	495	2.2	2.9
200 or more beds	66	548	553	1.0	3.0
By Region:					
Urban by Region	2,644	699	716	2.3	3.0
New England	138	745	768	3.0	3.0
Middle Atlantic	407	782	800	2.4	2.9
South Atlantic	393	669	684	2.2	3.0
East North Central	448	672	690	2.7	3.0
East South Central	156	638	655	2.7	2.9
West North Central	181	688	708	2.9	3.0
West South Central	321	665	673	1.3	2.9
Mountain	127	702	698	-0.6	2.9
Pacific	427	787	808	2.7	3.0
Puerto Rico	46	295	304	3.1	3.1
Rural by Region	2,061	439	444	1.2	2.9
New England	49	522	534	2.3	3.0
Middle Atlantic	73	463	469	1.5	2.9
South Atlantic	267	457	458	0.1	2.9
East North Central	273	449	455	1.4	2.9
East South Central	260	410	415	1.2	2.9
West North Central	477	422	428	1.4	2.9
West South Central	325	390	398	2.1	2.9
Mountain	193	466	467	0.1	2.8
Pacific	139	520	530	2.0	3.0
By Payment Classification:					
All hospitals	4,705	647	661	2.2	3.0
Large urban areas (populations over 1 million)	1,599	742	759	2.3	3.0
Other urban areas (populations of 1 million or fewer)	1,090	636	651	2.4	3.0
Rural areas	2,016	437	442	1.2	2.9

TABLE IV.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued
 [FY 2001 Payments Compared to FY 2002 Payments]

	Number of hospitals	Average FY 2001 payments/case	Average FY 2002 payments/case	All changes	Portion attributable to Federal rate change
Teaching Status:					
Non-teaching	3,586	533	540	1.3	2.9
Fewer than 100 Residents	879	675	695	2.9	3.0
100 or more Residents	240	999	1,026	2.7	2.9
Urban DSH:					
100 or more beds	1,374	734	752	2.4	3.0
Less than 100 beds	317	489	491	0.4	2.8
Rural DSH:					
Sole Community (SCH/EACH)	540	395	390	-1.3	2.8
Referral Center (RRC/EACH)	157	504	511	1.4	2.9
Other Rural:					
100 or more beds	73	409	419	2.4	2.9
Less than 100 beds	439	369	380	2.8	3.0
Urban teaching and DSH:					
Both teaching and DSH	753	814	836	2.7	3.0
Teaching and no DSH	294	717	740	3.3	3.0
No teaching and DSH	938	585	595	1.7	2.9
No teaching and no DSH	704	590	595	0.9	2.9
Rural Hospital Types:					
Non special status hospitals	788	384	394	2.8	3.0
RRC/EACH	165	504	517	2.6	3.0
SCH/EACH	667	423	417	-1.5	2.8
Medicare-dependent hospitals (MDH)	327	363	365	0.7	2.9
SCH, RRC and EACH	69	510	508	-0.4	2.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY01 and FY02:					
Reclassified During FY02 Only	482	564	576	2.1	3.0
Reclassified During FY02 Only	153	571	580	1.6	2.9
FY02 Reclassifications:					
All Reclassified Hospitals	635	566	577	2.0	3.0
All Nonreclassified Hospitals	4,157	659	674	2.2	3.0
All Urban Reclassified Hospitals	119	741	763	2.9	3.0
Urban Nonreclassified Hospitals	2,487	699	715	2.3	3.0
All Reclassified Rural Hospitals	516	492	499	1.4	2.9
Rural Nonreclassified Hospitals	1,542	388	392	0.9	2.9
Other Reclassified Hospitals (Section 1886(D)(8)(B)).	41	461	455	-1.3	2.9
Type of Ownership:					
Voluntary	2,769	660	677	2.5	3.0
Proprietary	755	639	642	0.5	2.9
Government	1,179	581	594	2.2	3.0
Medicare Utilization as a Percent of Inpatient Days:					
0-25	389	825	846	2.5	3.0
25-50	1,872	736	755	2.5	3.0
50-65	1,832	568	580	2.2	3.0
Over 65	585	522	519	-0.7	2.9

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 will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001 but ending in FY 2002. In FY 2003 and later, no payments will be made under the regular exceptions policy, hence we will not compute a budget neutrality factor for regular exceptions in FY 2003 and later. As described in section V.D. of the preamble of this proposed rule, the budget neutrality adjustment for special exceptions will be based on historical costs. Consequently, there will be no need to estimate capital costs with the capital acquisition model. We will not publish this appendix after the final rule for the FY 2002 capital rates.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 8 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 proposed rule: the December 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),

PPS–XV (cost reporting periods beginning in FY 1998), and PPS–XVI (cost reporting periods beginning in FY 1999). In addition, to model payments, we use the January 1, 2001 update of the provider-specific file, and the March 1995 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 2001 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
No match	4
Audit file only	90
Provider-specific file only	185
Provider-specific and audit file	4,516
Total	4,795

One hundred eighteen of the 4,795 hospitals had unusable or missing data, or had no cost reports available. For 52 of the 118 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 52 hospitals in the analysis. We were able to estimate hospital-specific amounts from the cost reports as shown in the following table.

Cost report	Number of hospitals
PPS–9	1
PPS–12	1
PPS–13	1
PPS–14	1
PPS–15	2
PPS–16	8
Total	14

Hence we were able to use 66 (52 plus 14) of the 118 hospitals. The remaining 52 of the 118 hospitals could not be used in the analysis because we were not able to estimate their hospital-specific amount. An additional 38 hospitals could not be used in the analysis because we could not determine their capital costs, either because we had no cost reports for them or because there was insufficient

cost report data. Accordingly, we used 4,705 hospitals for the analysis. Ninety (52 plus 38) hospitals could not be used in the analysis because of insufficient (missing or unusable) information. These hospitals account for about 0.3 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 2000 (the MedPAR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals had considerably more discharges in FY 2000 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 2000 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 2000 MedPAR file using the FY 2002 DRG relative weights included in section VI. of the Addendum to this proposed rule. The case-mix index is increased each year after FY 2000 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 2001. We project that case-mix will increase 1.0 percent in FY 2002. (Since we are using FY 2000 cases for our analysis, the FY 2000 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 2001, the budget neutrality adjustment factors were 0.99933 for the national rate and 1.00508 for the Puerto Rico rate. In determining these factors, we used the factors from the first half of FY 2001 (October 2000 through March 2001) published in the August 1, 2000 final rule since section 547 of Public Law 106-554 specifies that the special increases and adjustments in effect between April and October 2001 do not apply for discharges occurring after FY 2001 and should not be included in determining the payment rates in subsequent years.

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 2002, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2002 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 2001 DRG relative weights and the FY 2001 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 2001 relative weights and the FY 2002 geographic adjustment factor. In making the comparison, we held the FY 2002 Federal rate portion constant and set the other budget neutrality adjustment factor and the regular and special exceptions reduction factors to 1.00. To achieve budget neutrality for the changes in the national geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99703 for FY 2002 to the previous cumulative FY 2001 adjustment of 0.99933, yielding a cumulative adjustment of 0.99637 through FY 2002. For the Puerto Rico geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99943 for FY 2002 to the previous cumulative FY 2001 adjustment of 1.00508, yielding a cumulative adjustment of 1.00450 through FY 2002. We then compared estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2002 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 0.99428 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 2002 would be 0.99067 nationally and 0.99876 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				Incremental adjustment			
	Geo-graphic adjustment factor	DRG re-classifications and recalibration	Combined	Cumulative	Geo-graphic adjustment factor	DRG re-classifications and recalibration	Combined	Cumulative
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 ¹	0.99846	1.00019	0.99865	0.99933	1.00365	1.00009	1.00374	1.00508
2001 ²	³ 0.99771	³ 1.00009	³ 0.99780	0.99922	³ 1.00365	³ 1.00009	³ 1.00374	1.00508
2002	⁴ 0.99703	⁴ 0.99428	⁴ 0.99133	0.99067	⁴ 0.99943	⁴ 0.99428	⁴ 0.99371	0.99876

¹ Factors effective for the first half of FY 2001 (October 2000 through March 2001).

² Factors effective for the second half of FY 2001 (April 2001 through September 2001).

³ Incremental factors are applied to FY 2000 cumulative factors.

⁴ Incremental factors are applied to the cumulative factors for the first half of FY 2001.

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. For FY 2002 additional payments for the "regular" exceptions are made only for cost reporting periods that begin before October 1, 2001. The adjustment for "special" exceptions payments (see § 412.348(g)) is described in section V.D. of the preamble of this proposed rule. 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. In modeling exceptions for FY 2002, we calculated exceptions only for qualifying cost reporting periods. 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. Since we will no longer use the model after the final notice for the FY 2002 rates, we propose to discontinue publishing this table after the final notice for the FY 2002 rates. The table below provides the actual factors for FYs 1992 through 2001, the proposed factors for FY 2002, and the estimated factors that would be applicable through FY 2006. 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 0.99067 (0.99876 for Puerto Rico) for FY 2002 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2002.

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	.....	0.9497	.....	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 ⁵	0.90	.9785	N/A	.9979	.9409	.....	382.03
2002	1.10	⁶ .9925	N/A	0.9913	.9426	.....	389.09
2003	0.60	.9975	N/A	⁷ 1.0000	⁷ .9426	⁴ 1.0255	403.44
2004	0.90	.9975	N/A	1.0000	.9426	.....	407.07
2005	1.10	.9975	N/A	1.0000	.9426	.....	411.55
2006	1.10	.9975	N/A	1.0000	.9426	.....	416.07

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: Rates are for the first half of FY 2001 (October 1, 2000 through March 31, 2001).

⁶ Note: Product of general exceptions factor (0.9937) and special exceptions factor (0.9988).

⁷ Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Appendix C—Report to Congress



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 2 2001

The Honorable Richard B. Cheney
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2002 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates, and the President's FY 2002 budget includes, an update for PPS hospitals equal to the market basket minus 0.55 percentage points. The President's FY 2002 budget estimated the PPS market basket rate of increase for FY 2002 to be 3.6 percent. Based on this estimate, we recommend an update for hospitals in both large urban and other areas of 3.05 percent.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection in order to maintain access to services for Medicare beneficiaries. Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection in order to maintain access to services for beneficiaries. SCHs and MDHs are PPS hospitals. However, SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate and MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. We recommend an update of 3.05 percent to the hospital-specific rate.

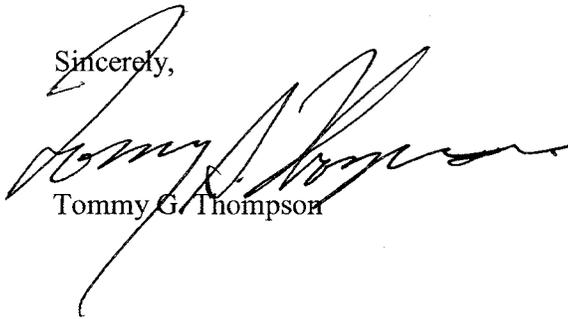
Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two thirds of the limit. The President's FY 2002 budget incorporates an increase to the TEFRA limit using 3.6 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase minus a percentage between 0 and 2.5 percentage points, or 0, resulting in an increase in the TEFRA limits of between 1.1 and 3.6 percent, or 0.

Page 2 – The Honorable Richard B. Cheney

My recommendation for the updates is based on cost projections used in the President's FY 2002 budget. A final recommendation on the appropriate percentage increases for FY 2002 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC). Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any across-the-board adjustment to the DRG weighting factors for FY 2002.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives. Please feel free to call me if you have any concerns or questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Tommy G. Thompson". The signature is fluid and cursive, with a long, sweeping underline that extends to the right and then loops back down.

Tommy G. Thompson



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 2 2001

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2002 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates, and the President's FY 2002 budget includes, an update for PPS hospitals equal to the market basket minus 0.55 percentage points. The President's FY 2002 budget estimated the PPS market basket rate of increase for FY 2002 to be 3.6 percent. Based on this estimate, we recommend an update for hospitals in both large urban and other areas of 3.05 percent.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection in order to maintain access to services for Medicare beneficiaries. Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection in order to maintain access to services for beneficiaries. SCHs and MDHs are PPS hospitals. However, SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate and MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. We recommend an update of 3.05 percent to the hospital-specific rate.

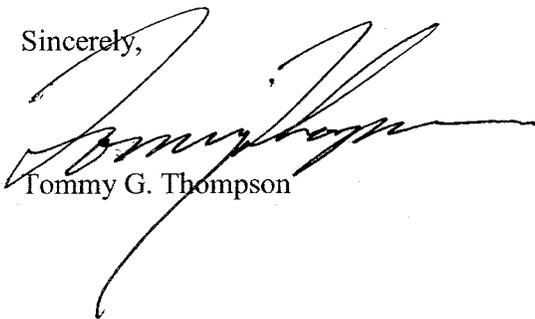
Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two thirds of the limit. The President's FY 2002 budget incorporates an increase to the TEFRA limit using 3.6 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase minus a percentage between 0 and 2.5 percentage points, or 0, resulting in an increase in the TEFRA limits of between 1.1 and 3.6 percent, or 0.

Page 2 – The Honorable J. Dennis Hastert

My recommendation for the updates is based on cost projections used in the President's FY 2002 budget. A final recommendation on the appropriate percentage increases for FY 2002 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC). Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any across-the-board adjustment to the DRG weighting factors for FY 2002.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate. Please feel free to call me if you have any concerns or questions.

Sincerely,



Tommy G. Thompson

Appendix D: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 2002 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)(XVII) of the Act, as amended by Section 301 of Public Law 106–554, sets the FY 2002 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.55 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2002 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 0.55 percentage points.

Under section 1886(b)(3)(B)(ii) of the Act, the FY 2002 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 proposing to update 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 first quarter 2001 forecast of the FY 2002 market basket increase of 3.1 percent for hospitals and units subject to the prospective payment system, the proposed update to the standardized amounts is 2.55 percent (that is, the market basket rate of increase minus 0.55 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 2.55 percent. The proposed update for hospitals and units excluded from the prospective payment system would range from the percentage increase in the excluded hospital market basket (currently estimated at 3.0 percent) minus a percentage between 0 and 2.5 percentage points, or 0 percentage points, resulting in an increase in the rate-of-increase limit between 0.5 and 3.0 percent, or 0 percent.

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, this Appendix provides the recommendations of appropriate update factors and the analysis underlying our recommendations and our response to MedPAC's recommendations concerning the update factors.

In its March 1, 2001 report, MedPAC stated that the legislated update of market basket minus 0.55 percentage points would provide a reasonable level of payments to hospitals. MedPAC did not make a separate recommendation for the hospital-specific rate applicable to SCHs and MDHs. We discuss MedPAC's recommendations concerning the update factors and our responses to these recommendations in section III. below.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is 2.55 percentage points for hospitals located in large urban and other areas. We are also recommending an update of 2.55 percentage points to the hospital-specific rate for SCHs and MDHs. As MedPAC states in its March 2001 report, there are signs of substantial improvement in hospitals' financial performance in FY 2000 as a result of the enactment of Public Law 106–113 and Public Law 106–554. In conjunction with the various "give-back" provisions in Public Law 106–113 and Public Law 106–554 and the continuation of positive (MedPAC estimates 12 percent for FY 1999 (page 64)) Medicare

hospital inpatient margins, we believe these recommended update factors for FY 2002 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.

We recommend that hospitals excluded from the prospective payment system receive an update of between 0.5 and 3.0 percentage points, or 0 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. The market basket rate of increase for excluded hospitals and units is currently forecast at 3.0 percent.

As required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of MedPAC in setting these recommended update factors. Our responses to the MedPAC recommendations concerning the update factors are discussed below.

III. MedPAC Recommendations for Updating the Prospective Payment System Operating Standardized Amounts

In its March 2001 Report to Congress, MedPAC recommended a combined operating and capital update for hospital inpatient prospective payment system payments for FY 2002. 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)(XVII) of the Act sets forth the FY 2002 percentage increase in the prospective payment system operating cost standardized amounts. The prospective payment system capital update is set at the discretion of the Secretary under the framework outlined in § 412.308(c)(1).

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 the capital input price index. 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 2002 is estimated to increase by 2.8 percent, based on HCFA's December 2000 forecasted operating market basket increase of 3.0 percent and HCFA's December 2000 forecasted capital market basket increase of 0.8 percent.

For FY 2002, MedPAC's update framework would support a combined operating and capital update for hospital inpatient prospective payment system payments of 1.5 percent to 3.0 percent (or between the

increase in the combined operating and capital market basket minus 1.3 percentage points and the increase in the combined operating and capital market basket plus 0.2 percentage points). In its update recommendation, MedPAC studied factors affecting the adequacy of payments in FY 2001 and factors expected to affect hospital costs in FY 2002. MedPAC concluded, "there is no compelling reason to change current law setting an operating update for fiscal year 2002 of 0.55 percent below the rate of increase in the operating market basket" (page 73). MedPAC also notes that while the number of hospitals with negative inpatient hospital margins have increased in FY 1999 (from 33.7 percent in 1998 to 36.7 percent in 1999) (page 71), overall high inpatient Medicare margins generally offset hospital losses on other lines of Medicare services (page 68). MedPAC continues to project substantially improved hospital total margins for FY 2000 based on performance in the first half of the fiscal year (page 72).

Response: Our long-term goal is to develop a single update framework for operating and capital prospective payments. However, the operating system update has been determined by Congress through FY 2003 (as amended by section 301 of Public Law 106-554). 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 agree with MedPAC's recommendation that the current law update for FY 2002 of the market basket minus 0.55 percentage points is appropriate for the operating system update. The following analyses measure changes in hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification on recalibration, and forecast error correction.

A. Productivity

Service level labor 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 the portion of productivity attributed to direct labor 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 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.

Since it is not possible at this time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 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 direct labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected 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 FY 2002 hospital output growth is simply the sum of the expected change in intensity (0.3 percent), projected admissions change (1.6 percent for FY 2002), and projected real case-mix growth (1.0 percent), or 2.9 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 (2.9 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 -0.6 to -0.5 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 its framework to reflect expected improvements in hospital productivity. In its FY 2002 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 2002. Our productivity adjustment of -0.6 to -0.5 percent is consistent with the range of MedPAC's fixed standard of expected productivity growth of 0.5 percent for FY 2002.

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 2002, we recommend an adjustment of 0.2 to 0.3 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" (pages 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 other uses. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies.

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 1996 through 2000 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 Consumer Price Index (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.

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. Without reliable estimates of the proportions of the overall annual intensity increases due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume that one-half of the annual increase is due to each of these factors.

For FY 2002, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1996 through 2000 data. In determining case-mix constant intensity, 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 1.4 percent per year. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1996 through FY 2000.

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 average percentage change in charge per discharge was 4.7 percent and the average annual change in the CPI for hospital and related services was 4.2 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 -0.9 percent. Assuming the technology/fixed cost ratio still holds (.33), technology would account for a -0.3 percent annual decline while fixed costs would account for a -0.6 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, has increased during the period.

For FYs 1995 through 1999, observed case-mix index change ranged from a low of -0.7 percent to a high of 1.6 percent, with a 5-year average change of 0.2 percent. If we assume that the upper bound of real case-mix was 1.0 percent, we estimate that case-mix constant intensity increased by an average 0.3 percent during FYs 1996 through 2000, for a cumulative increase of 1.4 percent. If we assume that the upper bound of real case-mix increase was 1.4 percent, we estimate that case-mix constant intensity increased by an average 0.2 percent during FYs 1996 through 2000, for a cumulative increase of 1.2 percent. Thus, we are recommending an intensity adjustment for FY 2002 between 0.2 and 0.3 percent.

MedPAC does not make an adjustment for intensity per se, but its combined update recommendation for FY 2002 includes two categories that we consider to be comparable with our intensity recommendation. MedPAC is recommending a 0.0 to 0.5 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. MedPAC recognized an allowance for science and technological advances of 0.5 percent to 1.0 percent. It believes that the costs associated with scientific and technological advances should be financed at least in part through improvements in hospital productivity. Hence, MedPAC offsets its allowance for science and technology by 0.5 percent for

productivity. In addition, MedPAC includes, when appropriate, an adjustment for one-time factors expected to affect costs in FY 2002 and the removal of the adjustment for FY 2002 one-time factors in its science and technology adjustment. MedPAC concluded that a one-time adjustment of 0.5 percent for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulatory requirements should be reflected in the FY 2002 payment update. Additionally, since MedPAC believes that the costs associated with one-time factors should not be built permanently into the rates, it recommended that the FY 2002 payment rates be reduced by 0.5 percent to offset the increase it recommended in the FY 2000 update for the costs associated with year 2000 (Y2K) computer improvements. Thus, MedPAC's combined FY 2002 adjustment for science and technological advances is 0.0 percent to 0.5 percent.

MedPAC's recommendation also takes into account the trend of some acute care providers to shift care to a postacute 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 an inappropriate distribution of payments and reduces the resources available for acute care providers to pay for services to other Medicare beneficiaries. We agree with MedPAC that the site-of-care substitution effect is real and believe that it is factored into 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 2002 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs, but do not reflect greater resource requirements. Unlike in past years, where we differentiated between "real" case-mix increase and increases attributable to changes in coding behavior, we do not believe changes in coding behavior will impact the overall case-mix in FY 2002. As such, for FY 2002, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 percent 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 (upcoding) and has recommended a positive adjustment when DRG coding changes have led to a decline in case-mix (downcoding). In light of evidence that coding had no significant effect on case-mix change, MedPAC recommended an adjustment of 0.0 percent for FY 2002.

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. MedPAC recognizes

that as the DRG system matures, it should account for more of the variation in costs by DRG assignment, leaving less within-DRG variation in case complexity and costliness (page 76). Therefore, MedPAC recommended an adjustment of 0.0 percent for FY 2002.

D. Effect of FY 2000 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2000 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. The estimated market basket percentage increase used to update the FY 2000 payment rates was 2.9 percent. Our most recent data indicates the actual FY 2000 increase was 3.6 percent. The resulting

forecast error in the FY 2000 market basket rate of increase is 0.7 percentage points. This forecast error is a result of prices for wages, benefits, and chemicals increasing more rapidly than expected. Market conditions enabled hospitals to be less restrictive with pay increases than initially projected. Prices for chemicals were underestimated due to the unanticipated surge in oil prices in FY 2000.

MedPAC also made a recommendation in its FY 2002 combined update framework to adjust for any error in the market basket forecasts used to set FY 2000 payment rates. It recommended a combined adjustment for FY 2000 forecast error correction of 0.7 percent. MedPAC determined this forecast error adjustment by weighting the difference between the actual and forecasted operating (92 percent) and capital (8 percent) market basket increases for FY 2000. The forecasted FY 2000 operating market basket was 2.9 percent and the actual FY 2000 operating market basket increase was 3.6 percent. The FY 2000 capital market basket was forecasted to increase by 0.6 percent and the actual market basket increase was 0.9 percent. This implies that MedPAC's combined operating and capital market basket was forecasted at

2.7 percent and the combined actual operating and capital market basket was 3.4 percent. Accordingly, MedPAC recommended a 0.7 percent forecast error correction for its FY 2002 combined update recommendation.

F. Medicare Policy Change

In developing its update recommendation for FY 2002, MedPAC includes an adjustment for Medicare policy changes affecting financial status in its section of factors affecting current level of payments. While MedPAC's update framework has not considered such costs in the past, MedPAC believes that it is appropriate to account for significant costs incurred as a result of new Medicare policy. For FY 2002, MedPAC believes that legislated updates will match cost growth and that the overall the net affects of legislative changes (from Public Law 105-33, Public Law 106-113, and Public Law 106-554) will be small. Thus, it did not recommend any additional allowance for these costs for FY 2002. Accordingly, MedPAC recommended a 0.0 percent adjustment for Medicare policy changes in its update framework for FY 2002.

COMPARISON OF FY 2002 UPDATE RECOMMENDATIONS

Market basket	HHS	MedPAC ¹
	MB	MB ¹
Policy Adjustment Factors:		
Productivity	-0.6 to -0.5	(2)
Site-of-Service Substitution	(3)	-2.0 to -1.0.
Intensity	0.2 to 0.3	
Science & Technology .....	.....	0.0 to 0.5.
Real Within DRG Change .....	.....	(4)
One-Time Factors .....	.....	0.0
Medicare Policy Changes .....	.....	0.0
Subtotal	-0.4 to -0.2	-2.0 to -0.5
Case-Mix Adjustment Factors:		
Projected Case-Mix Change	1.0	
Real Across DRG Change	1.0	0.0
Subtotal	0.0	0.0
Effect of FY 2000 DRG Reclass/Recalibration	0.0	
Forecast Error Correction	0.7	0.7
Total Recommendation Update	MB + 0.3 to MB + 0.5	MB¹ - 1.3 to MB¹ + 0.2.

¹ Used HCFA's December 2000 operating and capital 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 Case-Mix Adjustment.

While the above analysis would suggest an update between operating market basket plus 0.3 percentage points and the operating market basket plus 0.5 percentage points, consistent with current law, we are recommending an update of market basket increase minus 0.55 percentage points (or 2.55 percent). Just as MedPAC believes that market basket minus 0.55 percentage points will provide a reasonable level of payments for FY 2002, we believe that a 2.55 update factor for FY 2002 will appropriately reflect current trends in health care delivery,

including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services.

Also consistent with current law, we are recommending that the hospital-specific rates applicable to SCHs and MDHs be increased by the same update, 2.55 percentage points. As MedPAC states in its March 2001 report, there are signs of substantial improvement in hospital financial performance in FY 2000. In conjunction with the various "give-back" provisions in Public Law 106-113 and Public

Law 106-554 and the continuation of positive (12 percent for FY 1999) Medicare hospital inpatient margins, we believe these recommended update factors for FY 2002 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.

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