DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, and 485

[HCFA–1118–P]

RIN 0938–AK09

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

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment system for operating costs to: implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Public Law 106–113); and implement changes arising from our continuing experience with the system. In addition, in the Addendum to this proposed rule, we are describing proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 2000. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the prospective payment systems.

We are proposing changes to the policies governing payments to hospitals for the direct costs of graduate medical education and payments to disproportionate share hospitals, sole community hospitals, and critical access hospitals to implement changes made by Public Law 106–113.

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

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

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1118–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

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

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

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

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1118–P.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1118–P; and

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

FOR FURTHER INFORMATION CONTACT:

Steve Phillips, (410) 786–4531, Operating Prospective Payment, DRG, Wage Index, Reclassifications, and Sole Community Hospital Issues.

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

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

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I. Background

A. Summary

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

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

Under sections 1820 and 1834(g) of the Act, payments are made to critical

access hospitals (CAHs) (that is, rural nonprofit hospitals or facilities that meet certain statutory requirements) for outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under parts 413 and 415.

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

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

On July 30, 1999, we published a final rule in the **Federal Register** (64 FR 41490) that implemented both statutory requirements and other changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, as well as changes addressing payment for excluded hospitals and payments for GME costs. Generally, these changes were effective for discharges occurring on or after October 1, 1999. Correction notices for the July 30, 1999 final rule relating to the wage index and geographic adjustment factor were issued in the **Federal Register** on January 12, 2000 (65 FR 1817) and February 7, 2000 (65 FR 5933).

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

Other provisions of Public Law 106–113 that relate to Medicare payments to hospitals effective prior to October 1, 2000, will be addressed in a separate interim final rule with comment period. The provisions that will be included in the interim final rule are summarized in section I.C. of this preamble.

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

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment system for operating costs. We are not proposing any policy changes relating to payments for capital-related costs under the hospital inpatient prospective payment system in FY 2001. Our proposed changes relating to capital-related costs include only changes to the amounts and factors for determining the rates for capital-related costs for FY 2001. We also are proposing changes relating to payments for GME costs and payments to excluded hospitals and units, DSHs, SCHs, and CAHs. This proposed rule would be effective for discharges occurring on or after October 1, 2000.

The following is a summary of the major changes that we are proposing to make:

1. Proposed Changes to the DRG Reclassifications and Recalibrations of Relative Weights

As required by section 1886(d)(4)(C) of the Act, we adjust the DRG classifications and relative weights annually. Our proposed changes for FY 2001 are set forth in section II. of this preamble.

2. Proposed Changes to the Hospital Wage Index

In section III. of this preamble, we discuss proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section include the following:

- The FY 2001 wage index update, using FY 1997 wage data.
- The transition to excluding from the wage index Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.
- Revisions to the wage index based on hospital redesignations and reclassifications.

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

In section IV. of this preamble, we discuss several provisions of the regulations in 42 CFR Parts 412 and 413 and set forth certain proposed changes concerning the following:

- Postacute care transfers.
- Sole community hospitals.
- Rural referral centers.
- Changes relating to the indirect medical education adjustment.
- Changes relating to the DSH adjustment and collection of data on uncompensated costs for services furnished in hospitals under the prospective payment system.
- Medicare Geographic Classification Review Board (MGCRB) classifications.
- Payment for the direct costs of GME.

4. Last Year of Transition Period for the Prospective Payment System for Capital-Related Costs

In section V. of this preamble, we discuss FY 2001 as the last year of a 10-year transition period established to phase-in the prospective payment system for capital-related costs for inpatient hospital services.

5. Proposed Changes for Hospitals and Hospital Units Excluded from the Prospective Payment Systems

In section VI. of this preamble, we discuss the following proposals concerning excluded hospital and hospital units and CAHs:

- Limits on and adjustments to the proposed target amounts for FY 2001.
- Development of prospective payment system for inpatient rehabilitation hospitals and units.
- Continuous improvement bonus payments.
- Clarification that the 5-percent threshold used in calculating an excluded hospital's cost per discharge is based only on Medicare inpatients discharged from the hospital-within-a-hospital.
- All-inclusive payment rate option for CAHs.
- Condition of participation for CAHs relating to organ, tissue, and eye procurement.

6. Determining Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2001 prospective payment rates for operating costs and capital-related costs. We also address update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2001 for hospitals and hospital units excluded from the prospective payment system.

7. Impact Analysis

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

8. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 2001 capital cost model.

9. Report to Congress on the Update Factor for Hospitals under the Prospective Payment System and Hospitals and Units Excluded from the Prospective Payment System

Section 1886(e)(3) of the Act requires the Secretary to report to Congress on our initial estimate of a recommended update factor for FY 2001 for payments to hospitals included in the prospective payment systems, and hospitals excluded from the prospective payment systems. This report is included as Appendix C to this proposed rule.

10. Proposed Recommendation of Update Factor for Hospital Inpatient Operating Costs

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix D provides our recommendation of the appropriate percentage change for FY 2001 for the following:

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

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. This annual report makes recommendations concerning hospital inpatient payment policies. In section VII. of this preamble, we discuss the MedPAC recommendations and any actions we are proposing to take with regard to them (when an action is recommended). For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220.

C. Provisions of Public Law 106–113 To Be Included in Interim Final Rule With Comment Period

As we have indicated under section I.A. of this preamble, we are planning to publish an interim final rule with comment period to address provisions of Public Law 106–113 that are effective prior to October 1, 2000. This interim final rule with comment period will be issued prior to the publication of the hospital inpatient prospective payment system final rule by August 1. A summary of the provisions of Public Law 106–113 that will be addressed in the interim final rule with comment period follows:

- Section 111(b), which provides for an additional payment to teaching hospitals equal to the additional amount the hospital would have been paid for FY 2000 if the IME adjustment formula under section 1886(d)(5)(B) of the Act (which reflects the higher indirect operating costs associated with GME) for FY 2000 had remained the same as for FY 1999. (Section 111(a) also changed the IME adjustment formula for discharges occurring during FY 2001 and for discharges occurring on or after October 1, 2001, which is addressed in section IV.D. of this preamble.)
- Section 121, which amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to the cap on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. We will address the wage adjustment to the FY 2000 caps in the interim final rule. (The wage adjustment to the FY 2001 caps is discussed in section VI. of this preamble.)
- Section 312, which amended section 1886(h)(5) of the Act to provide that, effective July 1, 2000, in determining the cap on the number of residents for GME and IME costs, the period of board eligibility and the initial residency period for child neurology is the period of board eligibility for pediatrics plus 2 years. This provision applies on and after July 1, 2000, to residency programs that began before, on, or after November 29, 1999.
- Section 401(a), which amended section 1886(d)(8) of the Act to direct the Secretary to treat certain hospitals located in urban areas as being located in rural areas of their State if the hospital meets statutory criteria and files an application with HCFA. This provision is effective on January 1, 2000.
- Section 401(b), which contains conforming changes to incorporate the reclassifications under the amendments made by section 401(a) of Public Law 106–113 to outpatient hospital services (section 1833(t) of the Act) and the CAH statute (section 1820(c)(2)(B)(i) of the Act). This provision is effective on January 1, 2000.
- Section 403(a), which amended section 1820(c)(2)(B)(iii) of the Act to delete the 96-hour length of stay restriction on inpatient care in a CAH and to authorize a period of stay that does not exceed, on an annual basis, 96 hours per patient. This provision is effective on November 29, 1999.
- Section 403(b), which amended section 1820(c)(2)(B)(i) of the Act to allow for-profit hospitals to qualify for CAH status. This provision is effective on November 29, 1999.
- Section 403(c), which amended section 1820(c) of the Act to allow hospitals that have closed within 10 years prior to November 29, 1999, or hospitals that downsized to a health clinic or health center, to be designated as CAHs if they meet the established criteria for designation.
- Section 403(e), which amended sections 1833(a)(1)(D)(i) and 1833(a)(2)(D)(i) the Act to eliminate the Medicare Part B deductible and coinsurance for clinical diagnostic laboratory tests furnished by a CAH on an outpatient basis. This provision is effective with respect to services furnished on or after November 29, 1999.
- Section 403(f), which amended section 1883 of the Act to reinstate the right of CAHs that meet applicable requirements to enter into ''swing-bed'' agreements.
- Section 404, which amended section 1886(d)(5)(G) of the Act to extend the Medicare-dependent, small rural hospital program for 5 years, from FY 2001 through FY 2005. Section 404 also amended section 1886(b)(3)(D) of the Act as a conforming change to make the 5-year extension applicable to the

target amounts for Medicare-dependent, small rural hospitals.

• Section 407(a)(1), which amended section 1886(h)(4)(F) of the Act to direct the Secretary, for purposes of determining a hospital's FTE cap for direct GME payments, to count an individual to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. Section 407(a)(2) made a corresponding amendment to section 1886(d)(5)(B)(v) of the Act relating to the IME adjustment. The provision relating to direct GME is effective with cost reporting periods beginning on or after November 29, 1999. The provision relating to the IME adjustment applies to discharges occurring in cost reporting periods beginning on or after November 29, 1999.

• Section 407(b)(1), which amended section 1886(h)(4)(F)(i) of the Act to provide that a rural hospital's direct FTE count for direct GME may not exceed 130 percent of the number of unweighted residents that the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996. Section 407(b)(2) made a similar change to section 1886(d)(5)(B)(v) of the Act relating to the IME adjustment. The provision relating to direct GME applies to cost reporting periods beginning on or after April 1, 2000. The provision relating to the IME adjustment applies to discharges occurring on or after April 1, 2000.

• Section 407(c), which amended sections 1886(h)(4)(H) and 1886(d)(5)(B)(v) of the Act to allow a non-rural hospital that establishes separately accredited approved medical residency training programs (or rural training tracks) in a rural area or has an accredited training program with an integrated rural track, to receive an FTE cap adjustment for purposes of direct GME and IME. The provision is effective with cost reporting periods beginning on or after April 1, 2000 for direct GME, and with discharges occurring on or after April 1, 2000 for IME.

• Section 407(d) addresses the situation where residents were training in a residency training program at a Veterans Affairs hospital and then were transferred on or after January 1, 1997 and on or before July 30, 1998, to a non-Veterans Affairs hospital because the program in which the residents were training would lose its accreditation by the Accreditation Council on Graduate Medical Education (ACGME) if the residents continued to train at the facility. In this scenario, the non-Veterans Affairs hospital may receive a temporary adjustment to its 1996 FTE cap to include in its FTE count those residents who were transferred from the Veterans Affairs hospital. This provision applies as if it was included in the enactment of Public Law 105–33, that is, for GME with cost reporting periods beginning on or after October 1, 1997, and for IME, discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

• Section 541, which amended section 1886 of the Act to provide an additional payment to hospitals that receive payments under section 1861(v) of the Act for approved nursing and allied health education programs to reflect utilization of Medicare+Choice enrollees. This provision is effective for portions of cost reporting periods in a year beginning with calendar year 2000.

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

Under the prospective payment system, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system, and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 2000, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). Medicare fiscal intermediaries enter the information into their claims processing systems and subject it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.

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

Currently, cases are assigned to one of 501 DRGs (including one DRG for a diagnosis that is invalid as a discharge diagnosis and one DRG for ungroupable diagnoses) in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6 (Diseases and Disorders of the Digestive System)); however, some MDCs are not constructed on this basis since they

involve multiple organ systems (for example, MDC 22 (Burns)).

In general, cases are assigned to an MDC based on the principal diagnosis, before assignment to a DRG. However, there are five DRGs to which cases are directly assigned on the basis of procedure codes. These are the DRGs for liver, bone marrow, and lung transplants (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (CC).

Generally, the GROUPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

The changes we are proposing to make to the DRG classification system for FY 2001 and other issues concerning DRGs are set forth below. Unless otherwise noted, our DRG analysis is based on the full (100 percent) FY 1999 MedPAR file (bills received through December 31, 1999 for discharges in FY 1999).

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

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

a. Heart Transplant (DRG 103)

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

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

We reviewed the FY 1999 MedPAR file containing bills through December 31, 1999 and found no cases in which a bone marrow transplant and a heart transplant were performed in the same admission. However, to ensure appropriate DRG assignment of these cases, we are proposing that the heart transplant DRG, which encompasses combined heart-lung transplantation (ICD–9–CM procedure code 33.6) and heart transplantation (ICD–9–CM procedure code 37.5) be assigned to pre-MDC. In this way, cases involving a bone marrow transplant and a heart transplant would be assigned to DRG 103 (DRG 103 would be reordered higher in the pre-MDC surgical hierarchy, as discussed in section II.B.5. of this preamble).

b. Heart Assist Devices

We continue to review data in MDC 5 (Diseases and Disorders of the Circulatory System) to determine if cases are being assigned to the most appropriate DRG based on clinical coherence and similar resource consumption. At the December 1, 1994 ICD–9–CM Coordination and Maintenance Committee meeting, we recommended creation of new codes to capture single and bi-ventricular heart assist systems. These codes, 37.65 (Implant of an external, pulsatile heart assist system) and 37.66 (Implant of an implantable, pulsatile heart assist system), were adopted for use for discharges occurring on or after October 1, 1995. However, code 37.66 was deemed investigational and was not considered a covered procedure. Effective May 5, 1997, we revised Medicare coverage of heart assist devices to allow coverage of a ventricular assist device (code 37.66) used for support of blood circulation postcardiotomy if certain conditions were met.

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

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

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

[1] A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second DRG is for cases without CC. If a third number is included, it represents cases with patients who are age 0–17. Occasionally, a pair of DRGs is split between age ≥17 and age 0–17.

analysis, and all of these cases are subject to payment as cost outliers.

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

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

c. Platelet Inhibitors

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

For the past 2 years, a manufacturer of platelet inhibitors has submitted data to support its position that cases involving platelet inhibitor therapy receiving angioplasty should be reclassified from DRG 112 (Percutaneous Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant). In the July 30, 1999 final rule (64 FR 41503), we noted that we had received a new set of data from the platelet inhibitor manufacturer containing 27,673 cases from 164 hospitals in which Medicare patients underwent an angioplasty.

Included with the data were tables summarizing the results of the commenter's analysis of the data, showing that angioplasty cases receiving platelet inhibitor therapy are more expensive than those not receiving platelet inhibitors. According to the commenter, the approximate average standardized charges for the different classes of patients are as follows:

- No drug, no stent: $19,877.
- No drug, with stent: $22,968.
- Drug, no stent: $26,389.
- Drug, stent: $30,139.

Using the 100 percent FY 1999 MedPAR file that contains discharges through September 30, 1999, we performed analysis of the cases for which procedure code 99.20 was reported. There were a total of 37,222 cases spread across 123 DRGs.

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

We also noted that there are several procedures assigned to DRG 112 that have average standardized charges lower than the average charges for all cases in the DRG. For example, average charges for cases with procedure code 37.34 (Catheter ablation of lesion or tissues of heart) were $18,429. The following chart illustrates the variation among the average charges for DRG 112. This chart shows that the average charges for cases with procedure code 99.20 are well within the normal variation of other procedures.

DRG 112	Cases	Average standardized charges
Catheter ablation of lesion or tissues of heart (code 37.34)	6,972	$18,429
All cases within DRG 112	60,842	20,224
Injection or infusion of platelet inhibitor (code 99.20)	4,310	22,786
Multiple vessel PTCA or coronary atherectomy with or without mention of thrombolytic agent (code 36.05)	4,951	23,608
Single vessel PTCA or coronary atherectomy with mention of thrombolytic agent (code 36.02)	1,560	25,181

These examples indicate that there is always some variation in charges within a DRG. This difference in variations of charges is within the normal range of charge variations.

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

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

weights, are adequate to finance appropriate care of Medicare patients.

We also received a comment from another manufacturer of platelet inhibitors whose therapy is targeted on acute coronary syndrome patients without coronary intervention. These cases are assigned to DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction with Cardiac Catheterization and Complex Diagnosis) or DRG 140 (Angina Pectoris). The manufacturer's concern is that both types of cases, those performed in conjunction with coronary intervention and those without, be given an equal focus in this evaluation.

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

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

In summary, currently 75 percent of cases where code 99.20 is present are assigned to DRG 116. The next most common DRG where these cases are assigned is DRG 112 (12 percent). Cases assigned to DRG 116 generally involve implantation of a pacemaker or artery stent, while cases assigned to DRG 112 involve percutaneous cardiovascular procedures. Our analysis found a $3,897 difference between cases involving platelet inhibitor therapy that were assigned to DRG 116 and cases assigned to DRG 112, indicating a clinical distinction between the cases grouping to the two DRGs. Finally, among platelet inhibitor therapy cases that are assigned to DRG 112, our analysis found that the average charges are well within the normal variation around the overall average charges within the DRG. Based on these findings, we do not believe it would be appropriate to assign all cases where procedure code 99.20 is present to DRG 116. Therefore, we are not proposing to change to our current policy which specifies that assignment of cases to this code does not affect the DRG assignment.

d. Extracorporeal Membrane Oxygenation

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

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

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

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

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

a. V05.8 (Vaccination for Disease, NEC)

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

Based on inquiries we have received, we reviewed the appropriateness of including diagnosis code V05.8 on the list of acceptable secondary diagnoses under DRG 390. It was pointed out that by including V05.8 on the acceptable secondary diagnosis list for DRG 390, newborns who receive vaccinations are classified as having significant health problems. The inquirers believed this incorrectly labels an otherwise healthy newborn as having a significant medical condition. Providing a vaccination to a newborn is performed to prevent the infant from contracting a disease.

We agree with the inquirers that, absent any evidence of disease, a newborn should not be considered as having a significant problem simply because a preventative vaccination was provided. Therefore, we are proposing that V05.8 be removed from the list of acceptable secondary diagnoses under DRG 390 and assigned as a secondary diagnosis under DRG 39l. In doing so, these cases would no longer be classified to DRG 390.

b. Diagnosis Code 666.02 (Third-stage Postpartum Hemorrhage, Delivered With Postpartum Complication)

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

We believe a third-stage postpartum hemorrhage should be considered a complicating diagnosis and, in order to more appropriately categorize these cases, we are proposing that diagnosis code 666.02 be removed from DRG 373 and assigned as a complicating diagnosis under DRG 372.

c. Diagnosis Code 759.89 (Specified Congenital Anomalies, NEC) (Alport's Syndrome)

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

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

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

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

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

There are several options for resolving this issue:

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

Since a change in sequencing of congenital anomaly codes and their manifestations and complications would require a change of coding policy, this issue was brought to the Editorial Advisory Board, which is currently evaluating it. A final decision on any proposed policy change would not be finalized and published in time for either this proposed rule or the final rule. Therefore, this option would not assist in immediately addressing the issue at hand.

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

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

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

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

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

We are recommending that diagnosis code 759.89 remain in MDC 15, since it encompasses such a wide variety of conditions. In addition, we are not proposing a change in the DRG assignment because the payment impact would be minimal and the cases few. We will continue to pursue the possibility of modifying the ICD–9–CM code as well as evaluating the coding rules.

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

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

We have received an inquiry on the appropriateness of including diagnosis code 273.8 in DRGs 403 and 404. The inquirer pointed out that disorders of

plasma protein metabolism are not lymphomas or leukemia. We agree that diagnosis code 273.8 is not a lymphoma or leukemia and is more closely related to DRG 413 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses with CC) and DRG 414 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses without CC).

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

DRGs 403/404 all cases in 10-percent sample			DRGs 413/414 all cases in 10-percent sample		
DRG	Count	Average charge	DRG	Count	Average charge
403	2,107	$17,617	413	387	$12,278
404	296	8,063	414	47	5,906

Code	DRG	Count	Average charge	Code	DRG	Count	Average charge
273.8	403	17	$8,573	273.8	404	3	$6,644

Therefore, we are proposing to move diagnosis code 273.8 from DRGs 403 and 404 to DRGs 413 and 414.

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

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

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

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

5. Surgical Hierarchies

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

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

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other OR procedures'' as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for the procedure in the most resource-intensive surgical class, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small.

We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we are proposing to modify the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of the revised GROUPER software at the time the proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule. Further, as discussed in section II.C of this preamble, we anticipate that the final recalibrated weights will be somewhat different from those proposed, since they will be based on more complete data. Consequently, further revision of the hierarchy, using the above principles, may be necessary in the final rule.

At this time, we are proposing to revise the surgical hierarchy for the pre-MDC DRGs, MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), and MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders) as follows:

- In the pre-MDC DRGs, as we stated previously, we are proposing to move DRG 103 (Heart Transplant) from MDC 5 to pre-MDC. We are proposing to reorder DRG 103 (Heart Transplant) above DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses).
- In the pre-MDC DRGs, we are proposing to reorder DRG 481 (Bone Marrow Transplant) above DRG 495 (Lung Transplant).
- In MDC 8, we are proposing to reorder DRG 230 (Local Excision and Removal of Internal Fixation Devices of Hip and Femur) above DRG 226 (Soft Tissue Procedures with CC) and DRG 227 (Soft Tissue Procedures without CC).
- In MDC 10, we are proposing to reorder DRG 288 (OR Procedures for Obesity) above DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders).

6. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative coding or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this standard list of diagnoses using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we do not propose to delete any of the diagnosis codes on the CC list.

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- The same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; and the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions. In the July 30, 1999 final rule (64 FR 41490) we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2000. (See section II.B.8. below, for a discussion of ICD–9–CM changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6F and 6G in section V. of the Addendum to this proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 2000. Each table shows the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6G—Deletions from the CC

Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $92.00 plus $6.00 shipping and handling and on microfiche for $20.50, plus $4.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161; or by calling (703) 487–4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, and 1999) and those in Tables 6F and 6G of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2000. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 17.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 18.0 of this manual, which includes the final FY 2001 DRG changes, will be available in October 2000 for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

7. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the OR procedures performed is related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.21 Transurethral prostatectomy
60.29 Other transurethral prostatectomy
60.61 Local excision of lesion of prostate
60.69 Prostatectomy NEC
60.81 Incision of periprostatic tissue
60.82 Excision of periprostatic tissue
60.93 Repair of prostate
60.94 Control of (postoperative) hemorrhage of prostate
60.95 Transurethral balloon dilation of the prostatic urethra
60.99 Other operations on prostate

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962), or in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496).

a. Moving Procedure Codes From DRGs 468 or 477 to MDCs

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

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

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

Our medical consultants then identified those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under either DRG 468 or 477 and, therefore, are not proposing to move any procedures from either DRG 468 or DRG 477 to one of the surgical DRGs.

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

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be moved from one of these DRGs to another of these DRGs based on average charges and length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If our medical consultants were to find these shifts, we

would propose moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are not proposing to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis Codes to MDCs

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

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

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

As described in section II.B.1 of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and HCFA, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while HCFA has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

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

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

Copies of the Coordination and Maintenance Committee minutes of the 1999 meetings can be obtained from the HCFA Home Page by typing http://www.hcfa.gov/medicare/icd9cm.htm. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Center for Health Plans and Providers, Purchasing Policy Group, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 2000. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in section VI. of the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classification of these new codes.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or other codes, or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2000. For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A (New Diagnosis Codes). There were no procedure codes that were replaced by expanded codes or other codes, or were deleted. Revisions to diagnosis code titles are in Table 6D (Revised Diagnosis Code Titles), which also include the proposed DRG assignments

for these revised codes. Revisions to procedure code titles are in Table 6E (Revised Procedure Codes Titles).

9. Other Issues

a. Immunotherapy

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

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

Based on the commenter's request, we examined cases only for hospitals that use the particular drug manufactured by the commenter. We concluded that due to the variation of charges across the cases and the limited number of cases distributed across 19 different DRGs, it would be inappropriate to classify these cases to a single DRG. For example, it would be inappropriate to classify these cases into DRG 403 because only a few cases were coded with a principal diagnosis assigned to MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasm), the MDC that includes DRG 403. We stated in the July 30, 1999 final rule (64 FR 41497) that we would perform a full analysis of immunotherapy cases using the FY 1999 MedPAR data to determine if changes are needed.

Using 100 percent of the data in the FY 1999 MedPAR file, we performed an analysis of all cases for which procedure code 99.28 was reported. We identified 1,179 cases in 136 DRGs in 22 MDCs. No more than 141 cases were assigned to any one particular DRG.

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

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

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

Although there were 141 cases assigned to DRG 403, it would be inappropriate to place all immunotherapy cases, regardless of diagnosis, into a DRG that is designated for lymphoma and nonacute leukemia. We establish DRGs based on clinical coherence and resource utilization. Each DRG encompasses a variety of cases, reflecting a range of services and a range of resources. Generally, then, each DRG reflects some higher cost cases and some lower cost cases. To the extent a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, that is, additional payments over and above the standard prospective payment rate. We have not received any comments from hospitals regarding payment for immunotherapy cases.

b. Pancreas Transplant

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

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

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

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

Using 100 percent of the data in the FY 1999 MedPAR file (which contains hospital bills through December 31, 1999), we performed an analysis of the cases for which procedure codes 52.80 and 52.83 were reported. We identified a total of 79 cases in 8 DRGs, in 3 MDCs, and in 1 pre-MDC. Of the 79 cases identified, 49 cases were assigned to DRG 302, 14 cases were assigned to DRG 468, and 8 cases were assigned to DRG 191 (Pancreas, Liver and Shunt

Procedures with CC). The additional 8 cases were distributed over 5 other assorted DRGs, and due to their disparity, were not considered in our evaluation.

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

C. Recalibration of DRG Weights.

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

The proposed recalibrated DRG relative weights are constructed from FY 1999 MedPAR data (discharges occurring between October 1, 1998 and September 30, 1999), based on bills received by HCFA through December 31, 1999, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1999 MedPAR file includes data for approximately 11,059,625 Medicare discharges.

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

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed in section II.B of this preamble. As noted in section II.B.5, due to the unavailability of the revised GROUPER software, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification. However, there are some changes that cannot be modeled.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG are eliminated.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1999 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We propose to use that same case threshold in recalibrating the DRG weights for FY 2001. Using the FY 1999 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. We computed the weights for these 40 low-volume DRGs by adjusting the FY 2000 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The weights developed according to the methodology described above, using the proposed DRG classification changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor (1.45431) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

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

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan

Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

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

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. As discussed below in section III.F of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

B. FY 2001 Wage Index Update

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

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

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

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

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

C. FY 2001 Wage Index Proposal

Because it is used to adjust payments to hospitals under the prospective payment system, the hospital wage index should, to the extent possible, reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. In response to concerns within the hospital community related to the removal from the wage index calculation costs related to graduate medical education (GME) (teaching physicians and residents), and certified registered nurse anesthetists (CRNAs), which are paid by Medicare separately from the prospective payment system, the American Hospital Association (AHA) convened a workgroup to develop a consensus recommendation on this issue. The workgroup recommended that costs related to GME and CRNAs be phased out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we specified in the July 30, 1999 final rule (64 FR 41505) that we would phase-out these costs from the calculation of the wage index over a 5-year period, beginning in FY 2000. In keeping with the decision to phase-out costs related to GME and CRNAs, the proposed FY 2001 wage index is based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs.

1. Teaching Physician Costs and Hours Survey

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

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

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

When we notified the hospitals, through our fiscal intermediaries, that they could review the survey data on the Internet, we also notified hospitals that requests for changes to the teaching survey data must be submitted by March 6, 2000. We instructed fiscal intermediaries to review the requests for changes received from hospitals and submit necessary data revisions to HCFA by April 3, 2000.

We removed from the wage data the physician Part A teaching costs and hours reported on the survey form for every hospital that completed the survey. These data had been verified by the fiscal intermediary before submission to HCFA. We have identified 42 teaching hospitals in our database that reported physician Part A costs on Line 4 of their Worksheet S–3 and teaching-related costs on Line 23 of Worksheet A, Column 1, but for which we do not have teaching physician costs from the survey because the hospitals failed to complete the survey. As we did in the case of such hospitals in calculating the FY 2000 wage index, for purposes of calculating the FY 2001 wage index, we propose to subtract the costs reported on Line 23 of the Worksheet A, Column 1 (GME Other Program Costs) from Line 1 of the Worksheet S–3. These costs (from Line 23, Column 1 of Worksheet A) are included in Line 1 of the Worksheet S–3, which is the sum of Column 1, Worksheet A. They also represent costs for which the hospital is paid through the per resident amount under the direct GME payment. To determine the hours to be removed, the costs reported on Line 23 of the Worksheet A, Column 1 would be divided by the national average hourly wage for teaching physicians based upon the survey of $65.62.

For the FY 2000 wage index, the AHA workgroup recommended that, if reliable teaching physician data were not available for removing teaching costs from hospitals' total physician Part A costs, HCFA should remove 80 percent of the costs and hours reported by hospitals attributable to physicians' Part A services. In calculating the FY 2000 wage index, if we did not receive survey data for a teaching hospital, we removed 80 percent of the hospital's reported total physician Part A costs and hours from the calculation. For the FY 2001 wage index, we are proposing a different approach. In some instances, fiscal intermediaries have verified that teaching hospitals do not have teaching physician costs; for these hospitals, it is not necessary to adjust the hospitals' physician Part A costs. We are actively conferring with the fiscal intermediaries to distinguish teaching hospitals that do not have teaching physician costs from teaching hospitals that have not identified the portion of their physician Part A costs associated with teaching physicians (that is, hospitals that did not complete the teaching survey and did not report teaching-related costs on Worksheet A, Line 23). We propose to remove 100 percent of the physician Part A costs and hours (reported on Worksheet S–3, Lines 4, 10, 12, and 18) in the FY 2001 wage index calculation for those hospitals where the fiscal intermediary verifies that the hospital has otherwise unidentified teaching physician costs included in physician Part A costs and hours.

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

Thus, for the proposed wage index, we are either using the data submitted on the teaching physician survey or, in the absence of such data, removing the amount reported on Line 23 of Worksheet A, Column 1 or removing 100 percent of physician Part A costs reported on Worksheet S–3.

2. Nurse Practitioner and Clinical Nurse Specialist Costs

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

3. Severance and Bonus Pay Costs

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

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

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

Severance pay costs are included in the proposed FY 2001 wage index as a salary cost to the extent that associated hours are also reported. However, we are soliciting public comments on this issue.

4. Health Insurance and Health-Related Costs

In the September 1, 1994 final rule (59 FR 45356), we stated that health insurance, purchased or self-insurance, is a core wage-related cost. Over the past year, we have received several inquiries from hospitals and hospital associations requesting that we define ''purchased health insurance costs.'' In response, in

this proposed rule, we are clarifying that, for wage index purposes, we define ''purchased health insurance costs'' as the premiums and administrative costs a hospital pays on behalf of its employees for health insurance coverage. ''Self-insurance'' includes the hospital's costs (not charges) for covered services delivered to its employees, less any amounts paid by the employees, and less the personnel costs for hospital staff who delivered the services (these costs are already included in the wage index). For purchased health insurance and self-health insurance, the included costs must be for services covered in a health insurance plan.

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

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

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

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

D. Verification of Wage Data From the Medicare Cost Report

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

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2001 wage index pending their resolution before calculation of the final FY 2001 wage index. We have instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data (through HCRIS) no later than April 3, 2000. We expect that all unresolved data elements will be resolved by that date. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed data for 19 hospitals that failed edits. For two of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. Four hospitals had negative average hourly wages after allocating overhead to their excluded areas and, therefore, were removed from the calculation. The data from the remaining 13 hospitals also failed the edits and were removed. The data for these hospitals will be included in the final wage index if we receive corrected data that pass our edits. As a result, the proposed FY 2001 wage index is calculated based on FY 1997 wage data for 4,926 hospitals.

E. Computation of the Proposed FY 2001 Wage Index

The method used to compute the proposed FY 2001 wage index is as follows:

Step 1—As noted above, we are proposing to base the FY 2001 wage index on wage data reported on the FY 1997 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1996 and before October 1, 1997. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1996 and reported a cost reporting period exceeding 52 weeks. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1997 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1997 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997), we included wage data from only one of the cost reporting periods, the longest, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the latest period in the wage index calculation.

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

In calculating a hospital's average salaries plus wage-related costs,

including all GME and CRNA costs, we subtracted from Line 1 (total salaries) the Part B salaries reported on Lines 3 and 5, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Lines 2, 4, and 6. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, and physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, 16, 18, and 20).

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

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

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

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

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1996 through April 15, 1998 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/96	11/15/96	1.02848
11/14/96	12/15/96	1.02748
12/14/96	01/15/97	1.02641
01/14/97	02/15/97	1.02521
02/14/97	03/15/97	1.02387
03/14/97	04/15/97	1.02236
04/14/97	05/15/97	1.02068
05/14/97	06/15/97	1.01883
06/14/97	07/15/97	1.01695
07/14/97	08/15/97	1.01520
08/14/97	09/15/97	1.01357
09/14/97	10/15/97	1.01182
10/14/97	11/15/97	1.00966
11/14/97	12/15/97	1.00712
12/14/97	01/15/98	1.00451
01/14/98	02/15/98	1.00213
02/14/98	03/15/98	1.00000
03/14/98	04/15/98	0.99798

For example, the midpoint of a cost reporting period beginning January 1, 1997 and ending December 31, 1997 is June 30, 1997. An adjustment factor of 1.01695 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1997 and covers a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 (with and without GME and CRNA costs) for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

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

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

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage (using the same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $21.6988.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.9667 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate

prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2001, this change affects 241 hospitals in 41 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system.

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

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

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

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

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

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

Section 1886(d)(8)(B) of the Act established that a hospital located in a rural county adjacent to one or more urban areas is treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an MSA (or NECMAs), if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. Through FY 2000, hospitals are required to use standards published in the **Federal Register** on January 3, 1980, by the Office of Management and Budget. For FY 2000, there were 26 hospitals affected by this provision.

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

We are in the process of working with the Office of Management and Budget to identify the hospitals that would be affected by this amendment. We refer the reader to the September 30, 1988 final rule (53 FR 38499) for a complete discussion of our approach to identify the outlying counties using the standards published in the January 3, 1980 **Federal Register**.

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

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

their wage index values calculated exclusive of the wage data of the redesignated hospitals.

• The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, geographic reclassification may not reduce the wage index value for an urban area below the statewide rural wage index value.

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

The proposed wage index values for FY 2001 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value; that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

Tables 4D and 4E list the average hourly wage for each labor market area, before the redesignation of hospitals, based on the FY 1997 wage data. In addition, Table 3C in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital based on the preliminary FY 1997 data as of February 25, 2000 (reflecting the phase-out of GME and CRNA wages as described at section III.C of this preamble). The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification for FY 2002 (unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2)). We note that in adjudicating these wage index reclassifications the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2001 wage index.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2001 reclassification requests. The proposed FY 2001 wage index values incorporate all 586 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act, and section 152 Public Law 106–113) for FY 2001. The final number of reclassifications may vary because some MGCRB decisions are still under review by the Administrator and because some hospitals may withdraw their requests for reclassification.

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

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the **Federal Register**. The request for withdrawal of an application for reclassification that would be effective in FY 2001 must be received by the MGCRB by June 19, 2000. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Requests for Wage Data Corrections

To allow hospitals time to evaluate the wage data used to construct the proposed FY 2001 hospital wage index, we made available to the public a data file containing the FY 1997 hospital wage data. As stated in section II.D of this preamble, the data file used to construct the proposed wage index includes FY 1997 data submitted to HCFA as of mid-February 2000. In a memorandum dated January 28, 2000, we instructed all Medicare intermediaries to inform the prospective payment hospitals that they service of the availability of the wage data file and the process and timeframe for requesting revisions. The wage data file was made available on February 7, 2000 through the Internet at HCFA's home page (http://www.hcfa.gov). We also instructed the intermediaries to advise hospitals of the availability of these data either through their representative hospital organizations or directly from HCFA. Additional details on ordering this data file are discussed in section IX.A of this preamble, ''Requests for Data from the Public.''

In addition, Table 3C in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the proposed wage index values. It should be noted that the hospital average hourly wages shown in Table 3C may not reflect any changes made to a hospital's data after February 7, 2000. Changes approved by a hospital's fiscal intermediary and forwarded to HCFA by April 3, 2000 will be reflected on the final public use wage data file scheduled to be made available on May 5, 2000.

We believe hospitals have sufficient time to ensure the accuracy of their FY 1997 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. However, if, after review of the wage data file released February 4, 2000, a hospital believed that its FY 1997 wage data were incorrectly reported, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by March 6, 2000. Hospitals were notified of this deadline, and of all other possible deadlines and requirements, through written communications from their fiscal intermediaries in late January 2000.

After reviewing requested changes submitted by hospitals, intermediaries transmitted any revised cost reports to HCFA and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted. This procedure ensures that hospitals have every opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, if a

hospital disagrees with the intermediary's resolution of a requested change, the hospital may contact HCFA in an effort to resolve policy disputes. We note that the April 3, 2000 deadline also applies to these requested changes. We will not consider factual determinations at this time, as these should have been resolved earlier in the process.

Any wage data corrections to be reflected in the final wage index must have been reviewed and verified by the intermediary and transmitted to HCFA on or before April 3, 2000. (The deadline for hospitals to request changes from their fiscal intermediaries was March 6, 2000.) These deadlines are necessary to allow sufficient time to review and process the data so that the final wage index calculation can be completed for development of the final prospective payment rates to be published by August 1, 2000.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2001 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes.

The final wage data public use file will be released by May 5, 2000. Hospitals should examine both Table 3C of this proposed rule and the May 5 final public use wage data file (which reflects revisions to the data used to calculate the values in Table 3C) to verify the data HCFA is using to calculate the wage index. Hospitals will have until June 5, 2000, to submit requests to correct errors in the final wage data due to data entry or tabulation errors by the intermediary or HCFA. The correction requests that will be considered at that time will be limited to errors in the entry or tabulation of the final wage data that the hospital could not have known about before the release of the final wage data public use file.

As noted above in section III.C of this preamble, the final wage data file released on May 5, 2000 will include hospitals' teaching survey data as well as cost report data. As with the file made available in February 2000, HCFA will make the final wage data file released in May 2000 available to hospital associations and the public on the Internet. However, this file is being made available solely for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that result from the correction process described above (with the March 6 deadline). Hospitals are encouraged to review their hospital wage data promptly after the release of the final file because data presented at this time cannot be used by hospitals to initiate new wage data correction requests.

If, after reviewing the final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and HCFA. The letters should outline why the hospital believes an error exists and provide all supporting information, including dates. These requests must be *received* by HCFA and the intermediaries no later than June 5, 2000. Requests mailed to HCFA should be sent to: Health Care Financing Administration; Center for Health Plans and Providers; Attention: Wage Index Team, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, MD 21244–1850. Each request must also be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact HCFA immediately to discuss its findings.

At this point in the process, changes to the hospital wage data will only be made in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor HCFA will accept the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCFA on or before April 3, 2000.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 2000 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 5, 2000) will be incorporated into the final wage index to be published by August 1, 2000 and effective October 1, 2000.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals will have access to the final wage data by early May 2000, they will have the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2001 wage index by August 1, 2000 and the implementation of the FY 2001 wage index on October 1, 2000. If hospitals avail themselves of this opportunity, the wage index implemented on October 1, should be virtually error free. Nevertheless, in the unlikely event that errors should occur after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2001 (that is, by the June 5, 2000 deadline). As indicated earlier, since a hospital will have the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be necessary. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

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

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

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

Effective with discharges on or after October 1, 1998, section 1886(d)(5)(J) of the Act required the Secretary to define

and pay as transfers all cases assigned to one of 10 DRGs (identified below) selected by the Secretary if the individuals are discharged to one of the following settings:

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

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

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

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

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

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

Section 1886(d)(5)(J)(iv)(I) authorizes the Secretary to include in the proposed rule for FY 2001 a description of other post-discharge services that should be added to this postacute care transfer provision. Since FY 1999 was the first year this policy was effective and because of pending changes to payment policies for other postacute care settings such as hospital outpatient departments, we have limited data to assess whether additional postacute care settings should be included. We will continue to closely monitor this issue as more data become available.

In its analysis, HER relied on HCFA's Standard Analytic Files containing claims submission data through September 1999. However, the second and third quarter submissions for calendar year 1999 were not complete. It was decided that transfer cases would be identified by linking acute hospital discharges with postacute records based on Medicare beneficiary numbers and dates of discharge from the acute hospital with dates of admission or provision of service by the postacute provider. This method was used rather than selecting cases based on the discharge status code on the claim even though this code is being used for payment to these cases because we wanted to also assess how accurately hospitals are coding this status. However, the need to link acute and postacute episodes further limited the analytic data, due to the greater time lag for collecting postacute records. Therefore, much of HER's analysis focused on only the first two quarters of FY 1998. The two preceding fiscal years served as a baseline for purposes of comparison.

HER looked at the 10 DRGs included under the transfer payment policy and identified a slight decrease in the percentage of short-stay postacute transfers. Short-stay transfers were defined as those with a length of stay at least one day below the geometric mean length of stay for the DRG. Comparing the share of short-stay postacute transfers to total discharges shows that during the first two quarters of FY 1998, the resulting percentage was 34 percent. The same comparison during the first two quarters of FY 1999 yielded 33 percent. When HER examined the share of short-stay postacute transfers relative to all short-stay cases, it found that the percentage fell from 59 percent in FY 1998 to 58 percent in FY 1999. According to HER, ''[t]hese figures suggest that the policy change resulted in a moderate decline in the number of postacute care transfers paid for under the lower per diem methodology.''

Evidence also suggests that hospitals are keeping patients in these 10 DRGs longer prior to transfer. The mean length of stay of short-stay postacute transfers remained fairly constant prior to the change and after the change, declining less than one-half percent. On the other hand, the mean length of stay of nontransfer short-stay patients fell by

1.8 percent. By comparison, the mean length of stay of long-stay postacute transfers fell by 3.4 percent, while it fell only 2.1 percent for long-stay nontransfers. The report suggests ''[t]he relative decline in the length of stay of transfers among all long-stay cases suggests that (prospective payment system) hospitals may have responded to the policy change by holding such patients until they exceeded the geometric mean minus one day threshold prior to post-discharge referral.''

We believe these marginal reactions by hospitals to the postacute transfer policy suggest that the increase in the rate of postacute transfers over the past several years has been due to a number of factors, of which Medicare payment policy has been only one. As indicated in the Conference report accompanying Public Law 105–33 (H.R. Conf. Rept. No. 105–217, 105th Cong., 1st Sess., at 740 (1997)), Congress' intent was to ''continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' The preliminary results of HER's report suggest that the policy resulting from Public Law 105–33 has not had a disruptive impact on existing clinical practices.

To assess the adequacy of payments under the new policy, HER examined average profits per case prior to and after the policy change. Prior to the policy change, HER found average profits for short-stay transfers in the 10 DRGs to be $2,454 per case. Across the 10 DRGs the average profits ranged from $32,007 per case for DRG 483 to minus $26 per case for DRG 211 (the only one of the 10 DRGs with a negative profit margin prior to implementing the policy). After the policy change, the average profit per case was $1,180 per case. However, 3 of the 10 DRGs had negative average profits after implementation of the policy. The average margin for DRG 483 declined to $16,672 per case.

The study also attempted to ascertain whether there was any concerted effort to circumvent the policy by delaying transfers to avoid having a case defined as a transfer, or by not coding the case correctly on the discharge status indicator on the bill. To assess whether postacute care was being delayed, HER considered, for the periods preceding and subsequent to the policy change, the number and percent of cases admitted to either a hospital or distinct-part unit of a hospital excluded from the prospective payment system or to a skilled nursing facility 2 or 3 days following the discharge, and the number and percent of patients who received services from a home health agency 4 or 5 days after discharge from an acute care hospital. The percentages are based on the share of transferred patients falling into the time windows described above relative to all such transfers.

The analysis identified 699 patients transferred to an excluded hospital or unit 2 or 3 days following discharge from an acute care hospital during the first two quarters of FY 1998, and 660 such cases during the first two quarters of FY 1999. Similarly, there were 2,219 transfers to skilled nursing facilities 2 or 3 days after discharge during the first two quarters of FY 1998, and 1,759 during the first two quarters of FY 1999. The percentage of such transfers was constant for both excluded hospitals and units and for skilled nursing facilities. The analysis found that home health referral on the 4th or 5th day following discharge fell from 17.5 percent to 16.5 percent between the two study periods, from 12,667 cases to 9,745 cases. On the basis of these findings, HER believes ''[t]hese results do not support the contention that (prospective payment system) hospitals (would) circumvent the lower per diem payments by delaying the date of postacute care admission or visit.''

The study also examined the discharge destination codes as reported on the acute care hospital claims against postacute care transfers identified on the basis of a postacute care claim indicating the patient qualifies as a transfer. This analysis found that in 1998, only 74 percent of transfer cases had discharge destination codes on the acute care hospital claim that were consistent with whether there was a postacute care claim for the case matching the date of discharge. In FY 1999, the year the postacute care transfer policy went into effect, this rate rose to 79 percent. This indicates that hospitals are improving the accuracy of coding transfer cases.

Transfers to hospitals or units excluded from the prospective payment system must have a discharge destination code (Patient Status) of 05. Transfers to a skilled nursing facility must have a discharge destination code of 03. Transfers to a home health agency must have a discharge destination code of 06. If the hospital's continuing care plan for the patient is not related to the purpose of the inpatient hospital admission, a condition code 42 must be entered on the claim. If the continuing care plan is related to the purpose of the inpatient hospital admission, but care did not start within 3 days after the date of discharge, a condition code 43 must be entered on the claim. The presence of either of these condition codes in conjunction with discharge destination code 06 will result in full payment rather than the transfer payment amount. We intend to closely monitor the accuracy of hospitals' discharge destination coding in this regard and take whatever steps are necessary to ensure that accurate payment is made under this policy.

Section 1886(d)(5)(J)(iv)(II) of the Act authorized but did not require the Secretary to include as part of this proposed rule additional DRGs to include under the postacute care transfer provision. As part of ''The President's Plan to Modernize and Strengthen Medicare for the 21st Century'' (July 2, 1999), the Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, we are not proposing any change to the postacute care settings or the 10 DRGs.

HER did undertake an analysis of how additional DRGs might be considered for inclusion under the policy. The analysis supports the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent choices based on the other criteria as well. Most have fairly high short-stay PAC rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

Extending the policy beyond these initial DRGs, however, may well require more extensive analysis and grouping of like-DRGs. One concern raised in the analysis relates to single DRGs including multiple procedures with varying lengths of stay. Because the transfer payment methodology only considers the DRG overall geometric mean length of stay for a DRG, certain procedures with short lengths of stay relative to other procedures in the same DRG may be more likely to be treated as transfers. The analysis also considers pairs of DRGs, such as DRGs 263 and 264, as well as larger bundles of DRGs (grouped by common elements such as trauma, infections, and major organ procedures). According to HER, ''[i]n extending the PAC transfer policy, it is necessary to go beyond the flawed concept of a single DRG to discover multiple DRGs with a common link that

exhibit similar PAC statistics. Aggregation of this sort provides a logical bridge in expanding the PAC transfer policy that is easily justified to Congress and that avoids unintended inequities in the way DRGs—and potentially hospitals—are treated under this policy. Hospitals can be inadvertently penalized or not under the current implementation criteria due to systematic differences in the DRG mix.''

Finally, the HER report concludes with a discussion of the issues related to potentially expanding the postacute care transfer policy to all DRGs. On the positive side, HER points to the benefits of expanding the policy to include all DRGs:

- A simple, uniform formula-driven policy;
- Same policy rationale exists for all DRGs—the statutory provision requiring the Secretary to select only 10 DRGs was a political compromise;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive short-stay postacute care transfer policy for other DRGs.

According to HER, the negative implications of expanding the policy to all DRGs include:

- The postacute care transfer policy is irrelevant for many DRGs;
- Added burden for the fiscal intermediaries to verify discharge destination codes;
- Diluted program savings beyond the initial 10 DRGs;
- Difficult to identify ongoing postacute care that resumes after discharge; and
- Heterogeneous procedures within single DRGs having varying lengths of stay.

At the time we developed this proposed rule, HER's report was not yet in final format. We anticipate that, by the time the final FY 2001 rule is published, this report will be available in final format. We will announce in that rule how to attain copies of the complete report.

B. Sole Community Hospitals (SCHs) (412.63, 412.73, and 413.75, Proposed New § 412.77, and § 412.92)

Under the hospital inpatient prospective payment system, special payment protections are provided to sole community hospitals (SCHs). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as, among other things, a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria a hospital must meet to be classified as an SCH are located at § 412.92(a).

Currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: the Federal national rate applicable to the hospital; or the hospital's ''target amount'';—that is, either the updated hospital-specific rate based on FY 1982 costs per discharge, or the updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113, which amended section 1886(b)(3) of the Act, provides that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 target amount (the hospital-specific rate as opposed to the Federal rate) may elect to receive payment under a methodology using a third hospital-specific rate based on the hospital's FY 1996 costs per discharge. This amendment to the statute means that, for discharges occurring in FY 2001, eligible SCHs can elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

We are aware that language in the Conference Report accompanying Public Law 106–113 indicates that the House bill (H.R. 3075) would have permitted SCHs that were being paid the Federal rate to rebase, not SCHs that were paid on the basis of either their FY 1982 or FY 1987 target amount (H.R. Conf. Rep. No. 106–479, 106th Cong., 1st Sess. at 890 (1999)). The language of the section 405 amendment to section 1886(b)(3) (which added new subparagraph (I)(ii)) clearly limits the option to substitute the FY 1996 base year to SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of the target amount applicable to the hospital under section 1886(b)(3)(C).

When calculating an eligible SCH's FY 1996 hospital-specific rate, we propose to utilize the same basic methodology used to calculate FY 1982 and FY 1987 bases. That methodology is set forth in §§ 412.71 through 412.75 of the regulations and discussed in detail in several prospective payment system documents published in the **Federal Register** on September 1, 1983 (48 FR 3977); January 3, 1984 (49 FR 256); June 1, 1984 (49 FR 23010); and April 20, 1990 (55 FR 15150).

Since we anticipate that eligible hospitals will elect the option to rebase using their FY 1996 cost reporting periods, we are instructing our fiscal intermediaries to identify those SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of their target amounts. For these hospitals, fiscal intermediaries will calculate the FY 1996 hospital-specific rate as described below in this section IV.B. If this rate exceeds a hospital's current target amount based on the greater of the FY 1982 or FY 1987 hospital-specific rate, the hospital will receive payment based on the FY 1996 hospital-specific rate (based on the blended amounts described at section 1886(b)(3)(I)(i) of the Act) unless the hospital notifies its fiscal intermediary in writing prior to the end of the cost reporting period that it does not wish to be paid on the basis of the FY 1996 hospital-specific rate. Thus, if a hospital does not notify its fiscal intermediary before the end of the cost reporting period that it declines the rebasing option, we will deem the lack of such notification as an election to have section 1886(b)(3)(I) of the Act apply to the hospital.

An SCH's decision to decline this option for a cost reporting period will remain in effect for subsequent periods until such time as the hospital notifies its fiscal intermediary otherwise.

The FY 1996 hospital-specific rate will be based on FY 1996 cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996, that are 12 months or longer. If the hospital's last cost reporting period ending on or before September 30, 1996 is less than 12 months, the hospital's most recent 12-month or longer cost reporting period ending before the short period report would be utilized in the computations. If a hospital has no cost reporting period beginning in FY 1996, it would not have a hospital-specific rate based on FY 1996.

For each hospital eligible for FY 1996 rebasing, the fiscal intermediary would calculate a hospital-specific rate based on the hospital's FY 1996 cost report as follows:

- Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the FY 1996 cost report.
- Divide the total Medicare operating cost by the number of Medicare discharges in the cost reporting period to determine the FY 1996 base period cost per case. For this purpose, transfers are considered to be discharges.

• In order to take into consideration the hospital's individual case-mix, divide the base year cost per case by the hospital's case-mix index applicable to the FY 1996 cost reporting period. This step is necessary to standardize the hospital's base period cost for case-mix and is consistent with our treatment of both FY 1982 and FY 1987 base-period costs per case. A hospital's case-mix is computed based on its Medicare patient discharges subject to DRG-based payment.

The fiscal intermediary will notify eligible hospitals of their FY 1996 hospital-specific rate prior to October 1, 2000. Consistent with our policies relating to FY 1982 and FY 1987 hospital-specific rates, we propose to permit hospitals to appeal a fiscal intermediary's determination of the FY 1996 hospital-specific rate under the procedures set forth in 42 CFR part 405, subpart R, which concern provider payment determinations and appeals. In the event of a modification of base period costs for FY 1996 rebasing due to a final nonappealable court judgment or certain administrative actions (as defined in § 412.72(a)(3)(i)), the adjustment would be retroactive to the time of the intermediary's initial calculation of the base period costs, consistent with the policy for rates based on FY 1982 and FY 1987 costs.

Section 405 prescribes the following formula to determine the payment for SCHs that elect rebasing:

For discharges during FY 2001:

• 75 percent of the updated FY 1982 or FY 1987 former target (identified in the statute as the ''subparagraph (C) target amount''), plus

• 25 percent of the updated FY 1996 amount (identified in the statute as the ''''rebased target amount'').

For discharges during FY 2002:

• 50 percent of the updated FY 1982 or FY 1987 former target, plus

• 50 percent of the updated FY 1996 amount.

For discharges during FY 2003:

• 25 percent of the updated FY 1982 or FY 1987 former target, plus

• 75 percent of the updated FY 1996 amount.

For discharges during FY 2004 or any subsequent fiscal year, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 amount.

We are proposing to add a new § 412.77 and amend § 412.92(d) to incorporate the provisions of section 1886(b)(3)(I) of the Act, as added by section 405 of Public Law 106–113.

Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i)(XVI) of the Act to provide, for fiscal year 2001, for full market basket updates to both the Federal and hospital-specific payment rates applicable to sole community hospitals. We are proposing to amend § § 412.63, 412.73, and 412.75 to incorporate the amendment made by section 406 of Public Law 106–113.

C. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts were the same for discharges beginning with that date, rural referral centers would continue to receive special treatment under both the disproportionate share hospital (DSH) payment adjustment and the criteria for geographic reclassification.

As discussed in 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be classified as a rural referral center for FY 1998 and later years so long as that hospital continued to be located in a rural area and did not voluntarily terminate its rural referral center status. Otherwise, a hospital seeking rural referral center status must satisfy applicable criteria. One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (specifying a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if its—

• Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and

• Number of discharges is at least 5,000 per year, or if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value includes all urban hospitals nationwide, and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These values are based on discharges occurring during FY 1999 (October 1, 1998 through September 30, 1999) and include bills posted to HCFA's records through December 1999.

We are proposing that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2000, must have a case-mix index value for FY 1999 that is at least—

• 1.3401; or

• The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

The median case-mix values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2291
2. Middle Atlantic (PA, NJ, NY)	1.2387
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3116
4. East North Central (IL, IN, MI, OH, WI)	1.2602
5. East South Central (AL, KY, MS, TN)	1.2692
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1881
7. West South Central (AR, LA, OK, TX)	1.2800
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3302
9. Pacific (AK, CA, HI, OR, WA)	1.3076

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 1999 MedPAR file, which will contain data

from additional bills received through March 31, 2000.

For the benefit of hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1999 case-mix index value in Table 3C in section VI. of the Addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 1998 (that is, October 1, 1997 through September 30, 1998). That is the latest year for which we have complete discharge data available.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2000, must have as the number of discharges for its cost reporting period that began during FY 1999 a figure that is at least—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,733
2. Middle Atlantic (PA, NJ, NY)	8,681
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,845
4. East North Central (IL, IN, MI, OH, WI)	7,526
5. East South Central (AL, KY, MS, TN)	6,852
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,346
7. West South Central (AR, LA, OK, TX)	5,380
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,026
9. Pacific (AK, CA, HI, OR, WA)	6,160

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals. These numbers will be revised in the final rule based on the latest FY 1998 cost report data.

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2000, must have at least 3,000 discharges for its cost reporting period that began during FY 1999.

D. Indirect Medical Education (IME) Adjustment (§ 412.105)

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

Section 111 of Public Law 106–113 modified the transition for the IME adjustment that was established by Public Law 105–33. We will publish these changes in a separate interim final rule with comment period. However, for discharges occurring during FY 2001, the adjustment formula equation used to calculate the IME adjustment factor is $1.54 \times [(1 + r)^{.405} - 1]$. (The variable r represents the hospital's resident-to-bed ratio.)

In the July 30, 1999 final rule (64 FR 41517), we set forth certain policies that affected payment for both direct and indirect GME. These policies related to adjustments to full-time equivalent (FTE) resident caps for new medical residency programs affecting both direct and indirect GME programs; the adjustment to GME caps for certain hospitals under construction prior to August 5, 1997 (the enactment date of Public Law 105–33) to account for residents in new medical residency training programs; and the temporary adjustment to FTE caps to reflect residents affected by hospital closures. When we amended the regulations under § 413.86 for direct GME, we inadvertently did not make the corresponding changes in § 412.105 for IME. We are proposing to make the following conforming changes:

- To amend § 412.105(f)(1)(vii) to provide for an adjustment to the FTE caps for new medical residency programs as specified under § 413.86(g)(6).
- To add a new § 412.105(f)(1)(viii) related to the adjustment to the FTE caps for newly constructed hospitals that sponsor new residency programs in effect on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, to conform to the provisions of § 413.86(g)(7).
- To add a new § 412.105(f)(1)(ix) to specify that a hospital may receive a temporary adjustment to its FTE cap to take into account residents added because of another hospital's closure if the hospital meets the criteria listed under § 413.86(g)(8).

In addition, we are proposing to add a cross-reference to ''§ 413.86(d)(3)(i) through (v)'' in § 412.105(g), and to correct the applicable period in both §§ 412.105(g) and 413.86(d)(3) by revising the phrase ''For portions of cost reporting periods beginning on or after January 1, 1998'' to read ''For portions of cost reporting periods occurring on or after January 1, 1998''.

E. Payments to Disproportionate Share Hospitals (§ 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients (as defined in section 1886(d)(5)(F) of the Act) receive additional payments through the DSH adjustment. Section 4403(a) of Public Law 105–33 amended section 1886(d)(5)(F) of the Act to reduce the payment a hospital would otherwise receive under the current disproportionate share formula by 1 percent for FY 1998, 2 percent for FY 1999, 3 percent for FY 2000, 4 percent for FY 2001, 5 percent for 2002, and 0 percent for FY 2003 and each subsequent fiscal year. Subsequently, section 112 of Public Law 106–113 modified the amount of the reductions under Public Law 105–33 by changing the reduction to 3 percent for FY 2001 and 4 percent for FY 2002. The reduction continues to be 0 percent for FY 2003 and each subsequent fiscal year. We are proposing to revise § 412.106(e) to reflect the changes in the statute made by Public Law 106–113.

Section 112 of Public Law 106–113 also directs the Secretary to require prospective payment system hospitals to submit data on the costs incurred by the hospitals for providing inpatient and outpatient hospital services for which the hospitals are not compensated, including non-Medicare bad debt, charity care, and charges for medical and indigent care to the Secretary as part of hospitals' cost reports. These data are required for cost reporting periods beginning on or after October 1,

2001. We will be revising our instructions to hospitals for cost reports for FY 2002 to capture these data.

F. Medicare Geographic Classification Review Board (§§ 412.256 and 412.276)

With the creation of the Medicare Geographic Classification Review Board (MGCRB), beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in Subpart L of Part 412 (412.230 *et seq.*) set forth criteria and conditions for redesignations from rural to urban, rural to rural, or from an urban area to another urban area with special rules for SCHs and rural referral centers.

1. Provisions of Public Law 106–113

Section 401 of Public Law 106–113 amended section 1886(d)(8) of the Act by adding subparagraph (E), which creates a mechanism, separate and apart from the MGCRB, permitting an urban hospital to apply to the Secretary to be treated as being located in the rural area of the State in which the hospital is located. The statute directs the Secretary to treat a qualifying hospital as being located in a rural area for purposes of provisions under section 1886(d) of the Act. In addition, section 401 of Public Law 106–113 went on to incorporate the effects of such reclassifications from urban to rural for purposes of Medicare payments to outpatient departments and to hospitals that would qualify to become critical access hospitals.

Regulations implementing section 1886(d)(8)(E) of the Act are currently under development and will be published in a separate document. However, we note that the statutory language of section 1886(d)(8)(E) of the Act does not address the issue of interactions between changes in classification under section 1886(d)(8)(E) of the Act and the MGCRB reclassification process under section 1886(d)(10) of the Act. The Secretary has extremely broad authority under section 1886(d)(10) of the Act to establish criteria for reclassification under the MGCRB process. Section 401 of Public Law 106–113 does not amend section 1886(d)(10) of the Act to limit the agency's discretion under the provision in any way, nor does section 1886(d)(8)(E) of the Act (as added by section 401) refer to section 1886(d)(10) of the Act. However, we note that in the Conference Report accompanying Public Law 106–113, the language discussing the House bill (H.R. 3075, as passed) indicated that: ''[H]ospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the Medicare Geographic Reclassification Review Board for geographic reclassification to another area''.

We are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index (and thus also receive the higher payments that might result from being treated as being located in an urban area). That is, we are concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes. In light of the Conference Report language noted above discussing the House bill on the one hand, and the potential for inappropriately inconsistent treatment of the same hospital on the other hand, we are seeking public comment on this issue, and indicating our position that we may impose a limitation on such MGCRB reclassifications in the final rule for FY 2001, if such action appears warranted. We also are seeking specific comments on how such a limitation, if any, should be imposed.

For example, it could be argued that if a hospital has applied to be treated as being located in a rural area under section 1886(d)(8)(E) of the Act, then the hospital should be treated as rural for all purposes under section 1886(d), and it would be inappropriate to permit the hospital to be reclassified back to an urban area for any purpose. Under this approach, hospitals seeking reclassification under section 1886(d)(8)(E) of the Act would be treated as rural for all purposes under section 1886(d) and would be able to benefit from special provisions that apply to rural hospitals. They would not, however, be eligible for reclassification back to an urban area for either the wage index or the standardized amount. This would apply to hospitals seeking to reclassify either to their original MSA or to another MSA.

Under an alternative approach, hospitals reclassifying from urban to rural under section 1886(d)(8)(E) of the Act would be eligible to apply and be reclassified by the MGCRB like any other rural hospital (as long as applicable regulations governing MGCRB are met). This might allow hospitals to effectively pick from an array of urban and rural payment policies to maximize their Medicare payments. It could be argued that this would be the policy most consistent with the Conference Report language but we believe that it might lead to inappropriate, inconsistent classifications.

We are very concerned that the effect of unlimited MGCRB reclassifications back to the area from which a hospital was reclassified under section 1886(d)(8)(E) of the Act could have implications beyond those envisioned by Congress when it passed Public Law 106–113. However, in light of the Conference Report language, we are seeking comments on this issue. In the final rule, we might adopt one of the approaches discussed above or some other approach for addressing this issue.

Under section 152 of Public Law 106–113, certain counties are deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, effective for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. These provisions are addressed in section III.B. of this preamble, as they relate to calculation of the FY 2001 wage indexes for hospitals in the affected counties as if they were reclassified to the specified area; and in the Addendum to this preamble as they relate to the standardized amounts.

2. Revised Thresholds Applicable to Rural Hospitals for Wage Index Reclassifications

Existing §§ 412.230(e)(1)(iii) and (e)(1)(iv) provide that hospitals may obtain reclassification to another area for purposes of calculating and applying the wage index if the hospital's average hourly wages are at least 108 percent of the average hourly wages in the area where it is physically located, and at least 84 percent of the average hourly wages in a proximate area to which the hospital seeks reclassification. These thresholds apply equally to urban and rural hospitals seeking reclassification.

Historically, the financial performance of rural hospitals under the prospective payment system has lagged behind that of urban hospitals. Despite an overall increase in recent years of Medicare inpatient operating profit margins, some rural hospitals continue to struggle financially (as measured by Medicare inpatient operating prospective payment system payments minus costs, divided by payments). For example, during FY 1997, while the national average hospital margin was 15.1 percent, it was 8.9 percent for rural hospitals. In addition, approximately one-third of rural hospitals continue to experience negative Medicare inpatient margins despite this relatively high average margin.

In response to the lower margins of rural hospitals and the potential for a negative impact on beneficiaries' access to care if these hospitals were to close, we considered potential administrative changes that could help improve payments for rural hospitals. One approach in that regard would be to make it easier for rural hospitals to reclassify for purposes of receiving a higher wage index. The current thresholds for applying for wage index reclassification are based on our previous analysis showing the average hospital wage as a percentage of its area wage was 96 percent, and one standard deviation from that average was equal to 12 percentage points (see the June 4, 1992 proposed rule (57 FR 23635) and the September 1, 1992 final rule (57 FR 39770)). Because rural hospitals' financial performance has consistently remained below that of urban hospitals, we now believe that rural hospitals merit special dispensation with respect to qualifying for reclassification for purposes of the wage index. Therefore, we are proposing to change those average wage threshold percentages so more rural hospitals can be reclassified. Specifically, we are proposing to lower the upper threshold for rural hospitals to 106 percent and the lower threshold to 82 percent. The thresholds for urban hospitals seeking reclassification for purposes of the wage index would be unchanged. We would note that rural hospitals comprised nearly 90 percent of FY 2000 wage index reclassifications. Under this proposal, beginning October 1, 2000, rural hospitals would be able to reclassify for the wage index if, among other things, their average hourly wages are at least 106 percent of the area in which they are physically located, and at least 82 percent of the average hourly wages in the proximate area to which it seeks reclassification.

Although it is difficult to estimate precisely how many additional hospitals might qualify by lowering the thresholds because we do not have data indicating which hospitals meet all of the other reclassification criteria (*e.g.,* proximity), our analysis indicates that, if we were to raise the 108 percent threshold to 109 percent, approximately 20 rural hospitals would no longer qualify. If the upper threshold were to be raised to 110 percent, another 16 hospitals would not qualify. On the other hand, increasing the lower threshold from 84 percent to 85 percent would result in only 2 rural hospitals becoming ineligible to reclassify. Only 1 additional hospital would be affected by raising the threshold to 86 percent. Based on this analysis, we anticipate approximately 50 rural hospitals are likely to benefit from this proposed change.

We believe this proposal achieves an appropriate balance between allowing certain hospitals that are currently just below the thresholds to become eligible for reclassification, while not liberalizing the criteria so much that an excessive number of hospitals begin to reclassify. Because these reclassifications are budget neutral, nonreclassified hospitals' payments are negatively impacted by reclassification.

We believe there are many factors associated with lower margins among rural hospitals. We would note that section 410 of Public Law 106–113 requires the Comptroller General of the United States to ''conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices.'' In addition, section 411 of Public Law 106–113 requires MedPAC to conduct a study on the adequacy and appropriateness of the special payment categories and methodologies established for rural hospitals. We anticipate that the results of these studies will help identify other areas to help improve payments for rural hospitals, either through reclassifications or other means.

G. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based on the number of residents trained by the hospital. Section 1886(h) of the Act, as amended by section 4623 of Public Law 105–33, caps the number of residents that hospitals may count for direct GME.

Section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Public Law 99–272) established a methodology for determining payments to hospitals for the costs of approved GME programs at section 1886(h)(2) of the Act. Section 1886(h)(2) of the Act, as implemented in regulations at § 413.86(e), sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not adjusted for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care/obstetrics and gynecology residents and non-primary care residents have two separate PRAs for FY 1994 and, thereafter, one for primary care and one for non-primary care. (Thus, for purposes of this proposed rule, when we refer to a hospital's PRA, this amount is inclusive of any CPI–U adjustments the hospital may have received since the hospital's base-year, including any CPI-U adjustments the hospital may have received because the hospital trains primary care/non-primary care residents, as specified under existing § 413.86(e)(3)(ii)).

2. Use of National Average Per Resident Amount Methodology in Computing Direct GME Payments

Section 311 of Public Law 106–113 amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. Generally, section 311 establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be

revised. Accordingly, we are proposing to implement section 311 by setting forth the prescribed methodology for calculation of the weighted average PRA. We then discuss the proposed steps for determining whether a hospital's PRA will be adjusted based upon the proposed calculated weighted average PRA, in accordance with the methodology specified under section 311 of Public Law 106–113.

We propose to calculate the weighted average PRA based upon data from hospitals' cost reporting periods ending during FY 1997 (October 1, 1996 through September 30, 1997), as directed by section 311 of Public Law 106–113. We accessed these FY 1997 cost reporting data from the Hospital Cost Report Information System (HCRIS) and also obtained the necessary data for those hospitals that are not included in HCRIS (because they file manual cost reports), from those hospitals' fiscal intermediaries. If a hospital had more than one cost reporting period ending in FY 1997, we propose to include all of its cost reports ending in FY 1997 in our calculations. However, if a hospital did not have a cost reporting period ending in FY 1997, such as a hospital with a long cost reporting period beginning in FY 1996 and ending in FY 1998, the hospital is excluded from our calculations. One hospital is excluded from our calculation even though it did have a cost reporting period ending during FY 1997 because, at that time, it was a new teaching hospital with no established PRA (the first year of training for a new teaching hospital is paid for by Medicare on a cost basis; a PRA is applied in calculating a hospital's payment beginning with the hospital's second year of residency training). The total number of hospitals that we include in our calculation is 1,235. Thirty-five of these hospitals are hospitals with more than one cost report.

In accordance with section 311 of Public Law 106–113, we propose to calculate the weighted average PRA in the following manner:

Step 1: We determine each hospital's single PRA by adding each hospital's primary care and non-primary care PRAs, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

Step 2: We standardize each hospital's single PRA by dividing it by the 1999 geographic adjustment factor (GAF) (which is an average of the three geographic index values (weighted by the national average weight for the work component, practice expense component, and malpractice component)) in accordance with section 1848(e) of the Act and 42 CFR 414.26 (which is used to adjust physician payments for the different wage areas), for the physician fee schedule area in which the hospital is located.

Step 3: We add all the standardized hospital PRAs (as calculated in Step 2), each weighted by hospitals' respective FTEs, and then divide by the total number of FTEs.

Based upon this three-step calculation, we have determined the proposed weighted average PRA (for cost reporting periods ending during FY 1997) to be $68,487.

For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), the national average PRA is applied using the following three steps:

Step 1: Update the weighted average PRA for inflation. Under section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, the weighted average PRA is updated by the estimated percentage increase in the consumer price index for all urban consumers (CPI–U) during the period beginning with the month that represents the midpoint of the cost reporting *periods* ending during FY 1997 and ending with the midpoint of the hospital's cost reporting *period* that begins in FY 2001. Therefore, the weighted average standardized PRA ($68,487) would be updated by the increase in CPI–U for the period beginning with the midpoint of *all cost* reporting periods for hospitals with cost reporting periods ending during FY 1997 (October 1, 1996), and ending with the midpoint of the *individual* hospital's cost reporting period that begins during FY 2001.

For example, Hospital A has a calendar year cost reporting period. Thus, for Hospital A, the weighted average PRA is updated from October 1, 1996 to July 1, 2001, because July 1 is the midpoint of its cost reporting period beginning on or after October 1, 2000. Or, for example, if Hospital B has a cost reporting period starting October 1, the weighted average PRA is updated from October 1, 1996 to April 1, 2001, the midpoint of the cost reporting period for Hospital B. Therefore, the starting point for updating the weighted average PRA is the same date for all hospitals (October 1, 1996), but the ending date is different because it is dependent upon the cost reporting period for each hospital.

Step 2: Adjust for locality. In accordance with section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, once the weighted average PRA is updated according to each hospital's cost reporting period, the updated weighted average PRA (the national average PRA) would be further adjusted to calculate a locality-adjusted national average PRA for each hospital. This is done by multiplying the updated national average PRA by the 1999 GAF (as specified in the October 31, 1997 **Federal Register** (62 FR 59257)) for the fee schedule area in which the hospital is located.

Step 3: Determine possible revisions to the PRA. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, the locality-adjusted national average PRA, as calculated in Step 2, is then compared to the hospital's individual PRA. Based upon the provisions of section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, a hospital's PRA would be revised, if appropriate, according to the following:

- Floor—For cost reporting periods beginning in FY 2001, to determine which PRAs (primary care and non-primary care separately) are below the 70 percent floor, a hospital's locality-adjusted national average PRA is multiplied by 70 percent. This resulting number is then compared to the hospital's PRA that is updated for inflation to the current cost reporting period. If the hospital's PRA would be less than 70 percent of the locality-adjusted national average PRA, the individual PRA is replaced by 70 percent of the locality-adjusted national average PRA for that cost reporting period and would be updated for inflation in future years by the CPI–U.

We note that there may be some hospitals with primary care and non-primary care PRAs where both PRAs are replaced by 70 percent of the locality-adjusted national average PRA. In these situations, the hospital would receive identical PRAs; no distinction in PRAs would be made for differences in inflation (because a hospital has both primary care and non-primary care PRAs, each of which is updated as described in § 413.86(e)(3)(ii)) as of cost reporting periods beginning on or after October 1, 2000.

For example, if the FY 2001 locality-adjusted national average PRA for Area X is $100,000, then 70 percent of that amount is $70,000. If, in Area X, Hospital A has a primary care FY 2001 PRA of $69,000 and a non-primary care FY 2001 PRA of $67,000, both of Hospital A's FY 2001 PRAs are replaced by the $70,000 floor. Thus, $70,000 is the amount that would be used to determine Hospital A's direct GME payments for both primary care and

non-primary care FTEs in its cost reporting period beginning in FY 2001, and the $70,000 PRA would be updated for inflation by the CPI–U in subsequent years.

• *Ceiling*—For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), a ceiling that is equal to 140 percent of each locality-adjusted national average PRA would be calculated and compared to each individual hospital's PRA. If the hospital's PRA is greater than 140 percent of the locality-adjusted national average PRA, the PRA would be adjusted depending on the fiscal year as follows:

a. FY 2001

For cost reporting periods beginning in FY 2001, each hospital's PRA from the preceding cost reporting period (that is, FY 2000) is compared to the FY 2001 locality-adjusted national average PRA. If the individual hospital's FY 2000 PRA exceeds 140 percent of the FY 2001 locality-adjusted national average PRA, the PRA is frozen at the FY 2000 PRA, and is not updated in FY 2001 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

For example, if the FY 2001 locality-adjusted national average PRA ''ceiling'' for Area Y is $140,000 (that is, 140 percent of $100,000, the hypothetical locality-adjusted national average PRA), and if, in this area, Hospital B has a FY 2000 PRA of $140,001, then for FY 2001, Hospital B's PRA is frozen at $140,001 and is not updated by the CPI–U for FY 2001.

b. FY 2002

For cost reporting periods beginning in FY 2002, the methodology used to calculate each hospital's individual PRA would be the same as described in section IV.G.2.a. above for FY 2001. Each hospital's PRA from the preceding cost reporting period (that is, FY 2001) is compared to the FY 2002 locality-adjusted national average PRA. If the individual hospital's FY 2001 PRA exceeds 140 percent of the FY 2002 locality-adjusted national average PRA, the PRA is frozen at the FY 2001 PRA, and is not updated in FY 2002 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

c. FY 2003, FY 2004, and FY 2005

For cost reporting periods beginning in FY 2003, FY 2004, and FY 2005, if the hospital's PRA for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period (for example, for the cost reporting period beginning in FY 2003, compare the hospital's PRA from the FY 2002 cost reporting period to the locality-adjusted national average PRA from FY 2002), then, subject to the limitation in section IV.G.2.d. of this preamble, the hospital's PRA is updated in accordance with section 1886(h)(2)(D)(i) of the Act, except that the CPI–U applied is reduced (but not below zero) by 2 percentage points.

For example, for purposes of Hospital A's FY 2003 cost report, Hospital A's PRA for FY 2002 is compared to Hospital A's locality-adjusted national average PRA ceiling for FY 2002. If, in FY 2002, Hospital A's PRA is $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000, then for FY 2003, Hospital A's PRA is updated with the FY 2003 CPI–U minus 2 percent. If, in this scenario, the CPI–U for FY 2003 is 1.024, Hospital A would update its PRA in FY 2003 by 1.004 (the CPI–U minus 2 percentage points). However, if the CPI–U factor for FY 2003 is 1.01 and subtracting 2 percentage points of 1.01 yields 0.99, the PRA for FY 2003 would not be updated, and would remain $100,001.

We note that, while the language in section 1886(h)(2)(D)(iv)(I) and in section 1886(h)(2)(D)(iv)(II) of the Act (the sections that describe the adjustments to PRAs for hospitals that exceed 140 percent of the locality-adjusted national average PRA) is very similar, the language does differ. Section 1886(h)(2)(D)(iv)(I) of the Act states that for a cost reporting period beginning during FY 2000 or FY 2001, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and period* * * *, the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for such preceding cost reporting period.'' (Emphasis added.) Section 1886(h)(2)(D)(iv)(II) of the Act states that for a cost reporting period beginning during FY 2003, FY 2004, or FY 2005, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and preceding period*, the approved FTE resident amount for the period involved shall be updated * * . *.'' (Emphasis added.) Accordingly, for FYs 2001 and 2002, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA of the current cost reporting period. For FY 2003, FY 2004, or FY 2005, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA from the previous cost reporting period.

d. General Rule for Hospitals That Exceed the Ceiling

For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA exceeds 140 percent of the locality-adjusted national average PRA and it is adjusted under any of the above criteria, the current year PRA cannot be reduced below 140 percent of the locality-adjusted national average PRA.

For example, to determine the PRA of Hospital A, in FY 2003, Hospital A had a FY 2002 PRA of $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000. For FY 2003, applying an update of the CPI–U factor minus 2 percentage points (for example, 1.024 − .02 = 1.004 would yield an updated PRA of $100,401) while the locality-adjusted national average PRA (before calculation of the ceiling) is updated for FY 2003 with the full CPI–U factor (1.024) so that the ceiling of $100,000 is now increased to $102,400 (that is, $100,000 × 1.024 = $102,400). Therefore, applying the adjustment would result in a PRA of $100,401, which is under the ceiling of $102,400 for FY 2003. In this situation, for purposes of the FY 2003 cost report, Hospital A's PRA equals $102,400.

We note that if the hospital's PRA *does not* exceed 140 percent of the locality-adjusted national average PRA, the PRA is updated by the CPI–U for the respective fiscal year. If a hospital's PRA is updated by the CPI–U because it is less than 140 percent of the locality-adjusted national average PRA for a respective fiscal year, and once updated, the PRA exceeds the 140 percent ceiling for the respective fiscal year, the updated PRA would still be used to calculate the hospital's direct GME payments. Whether a hospital's PRA exceeds the ceiling is determined *before* the application of the update factors; if a hospital's PRA exceeds the ceiling only because of the application of the update factors, the hospital's PRA would retain the CPI–U factors.

For example, if, in FY 2001, the locality-adjusted national average PRA ceiling for Area Y is $140,000, and if, in this area, Hospital B has a FY 2000 PRA of $139,000, then for FY 2001, Hospital B's PRA is updated for inflation for FY 2001 because the PRA is below the ceiling. However, once the update factors are applied, Hospital B's PRA is now $142,000 (that is, above the $140,000 ceiling). In this scenario,

Hospital B's inflated PRA would be used to calculate its direct GME payments because Hospital B has only exceeded the ceiling *after* the application of the inflation factors.

• *PRAs greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA is greater than or equal to 70 percent and less than or equal to 140 percent of the locality-adjusted national average PRA, the hospital's PRA is updated using the existing methodology specified in § 413.86(e)(3)(i).

For cost reporting periods beginning in FY 2006 and thereafter, a hospital's PRA for its preceding cost reporting period would be updated using the existing methodology specified in § 413.86(e)(3)(i).

We are proposing to redesignate the existing § 413.86(e)(4) as § 413.86(e)(5) and add the rules implementing section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, in the vacated § 413.86(e)(4). Because we are proposing to apply the methodology for updating the PRA for inflation that is described in existing § 413.86(e)(3), we also are proposing to amend § 413.86(e)(3) to make those rules applicable to the cost reporting periods (FY 2001 through FY 2005) specified in the proposed § 413.86(e)(4), and in subsequent cost reporting periods.

In addition, we are proposing to make a conforming change by amending proposed redesignated § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base period and establish a PRA in a cost reporting period beginning on or after October 1, 2000. We believe there are two factors to consider when a new teaching hospital establishes its PRA under proposed redesignated § 413.86(e)(5). First, for example, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean of the PRAs in the hospital's census region (as specified in § 412.62(f)(1)(i)), the hospitals' PRAs used to calculate the weighted mean values are subject to the provisions of proposed § 413.86(e)(4), the national average PRA methodology. Second, the resulting PRA established under proposed redesignated § 413.86(e)(5) also would be subject to the national average PRA methodology specified in proposed § 413.86(e)(4).

We also are making a clarifying amendment to the proposed redesignated § 413.86(e)(5)(i)(B) to account for an oversight in the regulations text when we amended our regulations on August 29, 1997 (62 FR 46004). In the preamble of the August 29, 1997 final rule, in setting forth our policy on the determination of per resident amounts for hospitals that did not have residents in the 1984 GME base period, we stated that we would use a ''weighted'' average of the per resident amounts for hospitals located in the same geographic area. However, we inadvertently did not include a specific reference to ''weighted'' in the language of the regulation text. Therefore, we are proposing to specify that the ''weighted mean value'' of per resident amounts of hospitals located in the same geographic wage area is used for determining the base period for certain hospitals for cost reporting periods beginning in the same fiscal years.

H. Outliers: Miscellaneous Change

Under the provisions of section 1886(d)(5)(A)(i) of the Act, the Secretary does not pay for day outliers for discharges from hospitals paid under the prospective payment systems that occur after September 30, 1997. We are proposing to make a conforming change to § 412.2(a) by deleting the reference to an additional payment for both inpatient operating and inpatient capital-related costs for cases that have an atypically long length of stay.

V. The Prospective Payment System for Capital-Related Costs: The Last Year of the Transition Period

Since FY 2001 is the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs, for the readers' benefit, we are providing a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals, and the policy for providing exceptions payments during the transition period.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The 10-year transition period established to phase in the prospective payment system for capital-related costs is effective for discharges occurring on or after October 1, 1991 (FY 1992) through discharges occurring on or before September 30, 2001. For FY 2001, hospitals paid under the fully prospective transition period methodology will be paid 100 percent of the Federal rate and zero percent of their hospital-specific rate, while hospitals paid under the hold-harmless transition period methodology will be paid 85 percent of their allowable old capital costs (100 percent for sole community hospitals) plus a payment for new capital costs based on the Federal rate. Fiscal year 2001 is the final year of the capital transition period and, therefore, the last fiscal year for which a portion of a hold-harmless hospital's capital costs per discharge will be paid on a cost basis (except for new hospitals). Also, since fully prospective hospitals will be paid based on 100 percent of the Federal rate and zero percent of their hospital-specific rate, we will not determine a hospital-specific rate update for FY 2001 in section IV of the Addendum of this proposed rule. Beginning with discharges occurring on or after October 1, 2001 (FY 2002), payment for capital-related costs will be determined based solely on the capital standard Federal rate. Hospitals that were defined as ''Anew'' for the purposes of capital payments during the transition period (§ 412.30(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324.

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with a base year hospital-specific rate lower than the Federal rate is paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate is paid under the hold-harmless payment methodology during the transition period. A hospital paid under the hold-harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate or (2) a

payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated as of December 31, 1990, but put in use for patient care after December 31, 1990, also may be recognized as old capital if certain conditions are met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990. Beginning in FY 2001, at the conclusion of the transition period for the capital prospective payment system, capital payments will be based solely on the Federal rate for the vast majority of hospitals.

During the transition period, new hospitals are exempt from the prospective payment system for capital-related costs for their first 2 years of operation and are paid 85 percent of their reasonable cost during that period. The hospital's first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) beginning at least 1 year after the hospital accepts its first patient serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation, the hospital is paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the transition period.

The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (GAF) × (Large Urban Add-on, if applicable) x (COLA Adjustment for Hospitals Located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor).

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments.

During the capital prospective payment system transition period, a hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs for qualifying classes of hospitals. For up to 10 years after the conclusion of the transition period, a hospital may also receive an additional payment under a special exceptions process if certain qualifying criteria are met and its total inpatient capital-related payments are less than the 70 percent minimum percentage of its allowable Medicare inpatient capital-related costs.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, under amendments to the Act enacted by section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

In the August 30, 1991 final rule, we established a capital exceptions policy, which provides for exceptions payments during the transition period (§ 412.348). Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules. The minimum payment percentages for regular capital exceptions payments by class of hospitals for FY 2001 are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The provision for regular exceptions payments will expire at the end of the transition period. Payments will no longer be adjusted to reflect regular exceptions payments at § 412.348. Accordingly, for cost reporting periods beginning on or after October 1, 2001, hospitals will receive only the per discharge payment based on the Federal rate for capital costs (plus any applicable DSH or IME and outlier adjustments) unless a hospital qualifies for a special exceptions payment under § 412.348(g).

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals. The capital special exceptions process is budget neutral; that is, even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited

special exceptions policy will allow for exceptions payments for 10 years beyond the conclusion of the 10-year capital transition period or through September 30, 2011.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§ 413.40(b)(4) and (g))

1. Updated Caps

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105–33) establishes caps on the target amounts for certain existing excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The caps on the target amounts apply to the following three classes of excluded hospitals: Psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000), and the July 30, 1999 final rule (64 FR 41529). For purposes of calculating the caps on existing facilities, the statute required us to calculate the national 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage to the applicable fiscal year. However, section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. We intend to publish an interim final rule with comment period implementing this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. This proposed rule addresses the wage adjustment to the caps for cost reporting periods beginning on or after October 1, 2000.

For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Furthermore, section 1886(b)(3)(H)(iii), as added by Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

Consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment, we propose to account for differences in wage-related costs by adjusting the caps to account for the following:

First, we would adjust each hospital's target amount to account for area differences in wage-related costs. For each class of hospitals (psychiatric, rehabilitation, and long-term care), we would determine the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the labor-related portion of costs (or 0.71553). Similarly, we would determine the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, we would account for wage differences among hospitals within each class by dividing the labor-related portion of each hospital's target amount by the hospital's FY 1998 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), as shown in Tables 4A and 4B of the August 29, 1997 final rule (62 FR 46070). Within each class, each hospital's wage-adjusted target amount would be calculated by adding the wage-adjusted labor-related portion of its target amount and the nonlabor-related portion of its target amount. Then, the wage-adjusted target amounts for hospitals within each class would be arrayed in order to determine the national 75th percentile caps on the target amounts for each class.

This adjustment methodology for the national 75th percentile of the target amounts is identical to the methodology we utilized for the wage index adjustment described in the August 29, 1997 final rule (62 FR 46020) to calculate the wage-adjusted 110 percent of the national median target amounts for new excluded hospitals and units. Again, we recognize that wages may differ for prospective payment hospitals and excluded hospitals, but we believe that the wage data reflect area differences in wage-related costs. Moreover, in light of the short timeframe for implementing this provision, we would use the wage data for acute hospitals since they are the most feasible data source.

In the July 30, 1999 final rule (64 FR 41529), we established the FY 2000 caps on the target amounts as follows:

- Psychiatric hospitals and units: $11,110.
- Rehabilitation hospitals and units: $20,129.
- Long-term care hospitals: $39,712.

Therefore, based on these previously calculated caps on the target amounts and consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment to the caps, we have determined the labor-related and nonlabor-related portions of the proposed caps on the target amounts for FY 2001 using the methodology outlined above.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$8,106	$3,223
Rehabilitation	15,108	6,007
Long-Term Care	29,312	11,654

These labor-related and nonlabor-related portions of the proposed caps on the target amounts for FY 2001 are based on the current estimate of the market basket increase for excluded hospitals and units for FY 2001 of 3.1 percent.

In the interim final rule with comment period that we plan to publish, we will revise §§ 413.40(c)(4)(i) and (c)(4)(ii) to incorporate the changes in the formula used to determine the limitation on the target amounts for excluded hospitals and units, as provided for by section 121 of Public Law 106–113.

Finally, to determine payments described in § 413.40(c), the cap on the hospital's target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap. A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2001, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system (see § 412.63), for cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30,

2001 as shown in Tables 4A and 4B of this proposed rule. A hospital's applicable wage index corresponds to the area in which the hospital or unit is physically located (MSA or rural area) and is not subject to prospective payment system hospital reclassification under section 1886(d)(10) of the Act.

2. Updated Caps for New Excluded Hospitals and Units (§ 413.40(f))

Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and that first receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows: For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case; or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels.

The proposed amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2001. These figures are updated to reflect the projected market basket increase of 3.1 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$6,592	$2,623
Rehabilitation	12,964	5,154
Long-Term Care	16,708	6,643

3. Development of Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

Section 4421 of Public Law 105–33 added section 1886(j) to the Act. Section 1886(j) of the Act mandates the phase-in of a case-mix adjusted prospective payment system for inpatient rehabilitation services (freestanding hospitals and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The prospective payment system will be fully implemented for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) was amended by section 125 of Public Law 106–113 to require the Secretary to use the discharge as the payment unit under the prospective payment system for inpatient rehabilitation services and to establish classes of patient discharges by functional-related groups.

We will issue a separate notice of proposed rulemaking in the **Federal Register** on the prospective payment system for inpatient rehabilitation facilities. That document will discuss the requirements in section 1886(j)(1)(A)(i) of the Act for a transition phase covering the first two cost reporting periods under the prospective payment system. During this transition phase, inpatient rehabilitation facilities will receive a payment rate comprised of a blend of the facility specific rate (the TEFRA percentage) based on the amount that would have been paid under Part A with respect to these costs if the prospective payment system would not be implemented and the inpatient rehabilitation facility prospective payment rate (prospective payment percentage). As set forth in sections 1886(j)(1)(C)(i) and (ii) of the Act, the TEFRA percentage for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, is 66⅔ percent; the prospective payment percentage is 33⅓ percent. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the TEFRA percentage is 33⅓ percent and the prospective payment percentage is 66⅔ percent.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the average inpatient operating and capital costs of rehabilitation facilities and units. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, outlier status and any other factors the Secretary determines necessary. We will propose to set prospective payment amounts in effect during FY 2001 so that total payments under the system are projected to equal 98 percent of the amount of payments that would have been made under the current payment system. Outlier payments in a fiscal year may not be projected or estimated to exceed 5 percent of the total payments based on the rates for that fiscal year.

4. Continuous Improvement Bonus Payment

Under § 413.40(d)(4), for cost reporting periods beginning on or after October 1, 1997, an ''eligible'' hospital may receive continuous improvement bonus payments in addition to its payment for inpatient operating costs plus a percentage of the hospital's rate-of-increase ceiling (as specified in § 413.40(d)(2)). An eligible hospital is a hospital that has been a provider excluded from the prospective payment system for at least three full cost reporting periods prior to the applicable period and the hospital's operating costs per discharge for the applicable period are below the lowest of its target amount, trended costs, or expected costs for the applicable period. Prior to enactment of Public Law 106–113, the amount of the continuous improvement bonus payment was equal to the lesser of—

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

(b) 1 percent of the ceiling.

Section 122 of Public Law 106–113 amended section 1886(b)(2) of the Act to provide, for cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, for an increase in the continuous improvement bonus payment for long-term care and psychiatric hospitals and units. Under section 1886(b)(2) of the Act, as amended, a hospital that is within one of these two classes of hospitals (psychiatric hospitals or units and long-term-care hospitals) will receive the lesser of 50 percent of the amount by which the operating costs are less than the expected costs for the period, or the increased percentages mandated by statute as follows:

(a) For a cost reporting period beginning on or after October 1, 2000 and before September 30, 2001, 1.5 percent of the ceiling; and

(b) For a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent of the ceiling.

We are proposing to revise § 413.40(d)(4) to incorporate this provision of the statute.

B. Responsibility for Care of Patients in Hospitals-Within-Hospitals (§ 413.40(a)(3))

Effective October 1, 1999, for hospitals-within-hospitals, we implemented a policy that allows for a 5-percent threshold for cases in which a patient discharged from an excluded hospital-within-a-hospital and admitted to the host hospital was subsequently

readmitted to the excluded hospital-within-a-hospital. With respect to these cases, if the excluded hospital exceeds the 5-percent threshold, we do not include any previous discharges to the prospective payment hospital in calculating the excluded hospital's cost per discharge. That is, the entire stay is considered one Medicare ''discharge'' for purposes of payments to the excluded hospital. The effect of this rule, as explained more fully in the May 7, 1999 proposed rule (64 FR 24716) and in the July 30, 1999 final rule (64 FR 41490), is to prevent inappropriate Medicare payment to hospitals having a large number of such stays.

In the existing regulations at § 413.40(a)(3), we state that the 5-percent threshold is determined based on the total number of discharges from the hospital-within-a-hospital. We have received questions as to whether, in determining whether the threshold is met, we consider Medicare patients only or all patients (Medicare and non-Medicare). To avoid any further misunderstanding, we are clarifying the definition of ''ceiling'' in § 413.40(a)(3) by specifying that the 5-percent threshold is based on the *Medicare* inpatients discharged from the hospital-within-a-hospital in a particular cost reporting period, not on total Medicare and non-Medicare inpatient discharges.

C. Critical Access Hospitals (CAHs)

1. Election of Payment Method (§ 413.70)

Section 1834(g) of the Act, as in effect before enactment of Public Law 106–113, provided that the amount of payment for outpatient CAH services is the reasonable costs of the CAH in providing such services. However, the reasonable costs of the CAH's services to outpatients included only the CAH's costs of providing facility services, and did not include any payment for professional services. Physicians and other practitioners who furnished professional services to CAH outpatients billed the Part B carrier for these services and were paid under the physician fee schedule in accordance with the provisions of section 1848 of the Act.

Section 403(d) of Public Law 106–113 amended section 1834(g) of the Act to permit the CAH to elect to be paid for its outpatient services under another option. CAHs making this election would be paid amounts equal to the sum of the following, less the amount that the hospital may charge as described in section 1866(a)(2)(A) of the Act (that is, Part A and Part B deductibles and coinsurance):

(1) For facility services, not including any services for which payment may be made as outpatient professional services, the reasonable costs of the CAH in providing the services; and

(2) For professional services otherwise included within outpatient CAH services, the amounts that would otherwise be paid under Medicare if the services were not included in outpatient CAH services.

Section 403(d) of Public Law 106–113 added section 1834(g)(3) to the Act to further specify that payment amounts under this election are be determined without regard to the amount of the customary or other charge.

The amendment made by section 403(d) is effective for cost reporting periods beginning on or after October 1, 2000.

We are proposing to revise § 413.70 to incorporate the provisions of section 403(d) of Public Law 106–113. The existing § 413.70 specifies a single set of reasonable cost basis payment rules applicable to both inpatient and outpatient services furnished by CAHs. As section 403(d) of Public Law 106–113 provides that CAHs may elect to be paid on a reasonable cost basis for facility services and on a fee schedule basis for professional services, we are proposing to revise the section to allow for separate payment rules for CAH inpatient and outpatient services.

We are proposing to place the provisions of existing § 413.70(a) and (b) that relate to payment on a reasonable cost basis for inpatient services furnished by a CAH under proposed § 413.70(a). Proposed § 413.70(a)(2) would also state that payment to a CAH for inpatient services does not include professional services to CAH inpatients and is subject to the Part A hospital deductible and coinsurance determined under 42 CFR part 409, Subpart G.

We are proposing to include under § 413.70(b) the payment rules for outpatient services furnished by CAHs, including the option for CAHs to elect to be paid on the basis of reasonable costs for facility services and on the basis of the physician fee schedule for professional services. Under proposed § 413.70(b)(2), we would retain the existing provision that unless the CAH elects the option provided for under section 403 of Public Law 106–113, payment for outpatient CAH services is on a reasonable cost basis, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in Parts 413 and 415 (except for certain payment principles that do not apply; that is, the lesser of costs or charges, RCE limits, any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7), and blended payment amounts for ambulatory surgical center services, radiology services, and other diagnostic services.

Under proposed § 413.70(b)(3), we would specify that any CAH that elects to be paid under the optional method must make an annual request in writing, and deliver the request for the election to the fiscal intermediary at least 60 days before the start of the affected cost reporting period. In addition, proposed § 413.70(b)(3) states that if a CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following two amounts:

- For facility services, not including any outpatient professional services for which payment may be made on a fee schedule basis, the amount would be the reasonable costs of the services as determined in accordance with applicable principles of cost reimbursement in 42 CFR Parts 413 and 415, except for certain payment principles that would not apply as specified above; and
- For professional services, otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts would be those amounts that would otherwise be paid for the services if the CAH had not elected payment under this method.

We would also specify that payment to a CAH for outpatient services would be subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161. Final payment to the CAH for its facility services to inpatients and outpatients furnished during a cost reporting would be based on a cost report for that period, as required under § 413.20(b).

2. Condition of Participation: Organ, Tissue, and Eye Procurement (§ 485.643)

Sections 1820(c)(2)(B) and 1861(mm) of the Act set forth the criteria for designating a CAH. Under this authority, the Secretary has established in regulations the minimum requirements a CAH must meet to participate in Medicare (42 CFR part 485, Subpart F).

Section 1905(a) of the Act provides that Medicaid payments may be made for any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary. The Secretary has specified CAH services as Medicaid services in regulations, specifically, the regulations at 42 CFR 440.170(g)(1)(i), and defined CAH services under Medicaid as those services furnished by a provider

meeting the Medicare conditions of participation (CoP).

Section 1138 of the Act provides that a CAH participating in Medicare must establish written protocols to identify potential organ donors that: (1) Assures that potential donors and their families are made aware of the full range of options for organ or tissue donation as well as their rights to decline donation; (2) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of those families; and (3) require that an organ procurement agency designated by the Secretary be notified of potential organ donors.

On June 22, 1998, as part of the Medicare hospital conditions of participation under Part 482, subpart C, we added to the regulations at § 482.45, a condition that specifically addressed organ, tissue, and eye procurement. However, Part 482 does not apply to CAHs, as CAHs are a distinct type of provider with separate CoP under Part 485. Therefore, we are proposing to add a CoP for organ, tissue, and eye procurement for CAHs at a new § 485.643 that generally parallels the CoP at § 482.45 for all Medicare hospitals with respect to the statutory requirement in section 1138 of the Act concerning organ donation. CAHs are not full service hospitals and therefore are not equipped to perform organ transplantations. Therefore, we are not including the standard applicable to Medicare hospitals that CAHs must be a member of the Organ Procurement and Transplantation Network (OPTN), abide by its rules and provide organ transplant-related data to the OPTN, the Scientific Registry, organ procurement agencies, or directly to the Department on request of the Secretary.

The proposed CoP for CAHs includes several requirements designed to increase organ donation. One of these requirements is that a CAH must have an agreement with the Organ Procurement Organization (OPO) designated by the Secretary, under which the CAH will contact the OPO in a timely manner about individuals who die or whose death is imminent. The OPO will then determine the individual's medical suitability for donation. In addition, the CAH must have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes, as long as the agreement does not interfere with organ donation. The proposed CoP would require a CAH to ensure, in collaboration with the OPO with which it has an agreement, that the family of every potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The CAH may choose to have OPO staff perform this function, have CAH and OPO staff jointly perform this function, or rely exclusively on CAH staff. Research indicates that consent to organ donation is highest when the formal request is made by OPO staff or by OPO staff and hospital staff together. While we require collaboration, we also recognize that CAH staff may wish to perform this function and may do so when properly trained. Moreover, the CoP would require the CAH to ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as designated requestors.

Finally, the CoP would require the CAH to work with the OPO and at least one tissue bank and one eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of organs and tissues is underway.

We are sensitive to the possible burden this proposed CoP may place on CAHs. Therefore, we are particularly interested in comments and information concerning the following requirements: (1) Developing written protocols for donations; (2) developing agreements with OPOs, tissue banks, and eye banks; (3) referring all deaths to the OPO; (4) working cooperatively with the designated OPO, tissue bank, and eye bank in educating staff on donation issues, reviewing death records, and maintaining potential donors. We note that the proposed requirement allow some degree of flexibility for the CAH. For example, the CAH would have the option of using an OPO-approved education program to train its own employees as routine requestors or deferring requesting services to the OPO, the tissue bank, or the eye bank to provide requestors.

VII. MedPAC Recommendations

We have reviewed the March 1, 2000 report submitted by MedPAC to Congress and have given it careful consideration in conjunction with the proposals set forth in this document. MedPAC's recommendations and our responses are set forth below.

We note that MedPAC's March 1, 2000 report did not contain a recommendation concerning the update factors for inpatient hospital operating costs under the prospective payment system or for hospitals and hospital units excluded from the prospective payment system. However, at its April 13, 2000 public meeting, MedPAC announced that it was recommending a combined update of between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001. This recommendation is higher than the current law amount as prescribed by Public Law 105–33 and proposed in this rule. Because of the timing of MedPAC's announcement in relation to the publication of this proposed rule, we intend to respond to MedPAC's recommendation in the FY 2001 final rule to be issued in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation.

A. Combined Operating and Capital Prospective Payment Systems (Recommendation 3J)

Recommendation: The Congress should combine prospective payment system operating and capital payment rates to create a single prospective rate for hospital inpatient care. This change would require a single set of payment adjustments—in particular, for indirect medical education and disproportionate share hospital payments—and a single payment update.

Response: We responded to a similar comment in the July 30, 1999 final rule (64 FR 41552), the July 31, 1998 final rule (63 FR 41013), and the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. However, we have not yet developed such a single framework as the actual operating system update has been determined by Congress through FY 2002. In the meantime, we intend to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We maintain our goal of combining the update frameworks at the end of the 10-year capital transition period (the end of FY 2001) and may examine combining the payment systems post-transition. Because of the similarity of the update frameworks, we believe that they could be combined with little difficulty.

In the discussion of its recommendation, MedPAC notes that it ''is examining broad reforms to the prospective payment system, including DRG refinement and modifications of the graduate medical education payment and the IME and DSH adjustments. The Commission believes that a combined hospital prospective payment rate should be established

whether or not broader reforms are undertaken. However, if the Congress acts on any or all of the Commission's recommendations, it should consider combining operating and capital payments as part of a larger package.''

We agree that ultimately the operating and capital prospective payment systems should be combined into a single system. However, we believe that, because of MedPAC's ongoing analysis and the Administration's pending DSH report to Congress, any such unification should occur within the context of other system refinements.

B. Continuing Postacute Transfer Payment Policy (Recommendation 3K)

Recommendation: The Commission recommends continuing the existing policy of adjusting per case payments through an expanded transfer policy when a short length of stay results from a portion of the patient's care being provided in another setting.

Response: As noted in section IV.A. of this preamble, we have undertaken (through a contract with HER) an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. That analysis (based on preliminary data covering only approximately 6 months of discharge data) showed a minimal impact on the rate of short-stay postacute transfers after implementation of the policy. However, average profit margins as measured by HER declined from $2,454 prior to implementation of the policy to $1,180 after implementation. We believe these preliminary findings demonstrate that the postacute transfer provision has had only marginal impact on existing practice patterns while more closely aligning the payments to hospitals for these cases with the costs incurred. Therefore, we agree with MedPAC's recommendation that the policy should be continued.

C. Disproportionate Share Hospitals (DSH) (Recommendations 3L and 3M)

Recommendation: To address longstanding problems and current legal and regulatory developments, Congress should reform the disproportionate share adjustment to: include the costs of all poor patients in calculating low-income shares used to distribute disproportionate share payments, and use the same formula to distribute payments to all hospitals covered by prospective payment.

Response: As we noted in section IV.E. of this preamble, Public Law 106–113 directed the Secretary to require subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Act) to submit data on costs incurred for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care. These data must be reported on the hospital's cost reports for cost reporting periods beginning on or after October 1, 2001, and will provide information that will enable MedPAC and us to evaluate potential refinements to the DSH formula to address issues referred to by MedPAC.

Medicare fiscal intermediaries will audit these data to ensure their accuracy and consistency. Our experience with administering the current DSH formula leads us to believe that this auditing function would necessarily be extensive, because the non-Medicare data that would be collected have never before been collected and reviewed by Medicare's fiscal intermediaries. The data would have to be determined to be accurate and usable, and corrected if necessary.

We agree that the current statutory payment formula could be improved, largely because of different threshold levels and different formula parameters applicable to different groups of hospitals. We are in the process of preparing a report to Congress on the Medicare DSH adjustment that includes several options for amending the statutory formula.

Recommendation: To provide further protection for the primarily voluntary hospitals with mid-level low-income shares, the minimum value, or threshold, for the low-income share that a hospital must have before payment is made should be set to make 60 percent of hospitals eligible to receive disproportionate share payments.

Response: Currently, approximately less than 40 percent of all prospective payment system hospitals receive DSH payments. Therefore, this recommendation would entail significant redistributions of existing DSH payments if implemented in a budget neutral manner. We are particularly concerned about the effect of this recommendation on hospitals receiving substantial DSH payments currently, including major teaching hospitals and public hospitals. The analysis by MedPAC demonstrates that these hospitals would be negatively impacted if more hospitals were made eligible for DSH payments.

VIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at http://www.hcfa.gov/stats/pubfiles.html. Data files are listed below with the cost of each. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to HCFA–PUF) to cover the cost to the following address: Health Care Financing Administration, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, Maryland 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. Expanded Modified MedPAR-Hospital (National)

The Medicare Provider Analysis and Review (MedPAR) file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in the United States. (The file is a Federal fiscal year file, that is, discharges occurring October 1 through September 30 of the requested year.) The records are stripped of most data elements that would permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), and amended by the July 2, 1985 notice (50 FR 27361). The national file consists of approximately 11 million records. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. For all files requiring a signed agreement, please write or call to obtain a blank agreement form before placing an order. Two versions of this file are created each year. They support the following:

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 1999 MedPAR file used for the FY 2001 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $3,655.00 per fiscal year

Periods Available: FY 1988 through FY 1999

2. Expanded Modified MedPAR-Hospital (State)

The State MedPAR file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in a particular State. The records are stripped of most data elements that will permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the December 24, 1984 **Federal Register** notice, and amended by the July 2, 1985 notice. This file is a subset of the Expanded Modified MedPAR-Hospital (National) as described above. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 1999 MedPAR file used for the FY 2001 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $1,130.00 per State per year
Periods Available: FY 1988 through FY 1999

3. HCFA Wage Data

This file contains the hospital hours and salaries for FY 1997 used to create the proposed FY 2001 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

4. HCFA Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/most recent year on the Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

5. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Area (MSA).

Media: Diskette/Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

6. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

7. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XIII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, and PPS–XV Minimum Data Sets are part of the PPS–XIII, PPS–XIV, and PPS–XV Hospital Date Set Files).

File Cost: $770.00 per year

8. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

	Periods beginning on or after	and before
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, and PPS–XV Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV Hospital Data Set files.)

File Cost: $770.00 per year

9. PPS–XIII to PPS–XV Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to HCFA. The data set are updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet

File Cost: $2,500.00

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98

10. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet
File Cost: $265.00
Periods Available: FY 2001 PPS Update

11. HCFA Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet
Price: $165.00 per year/per file
Periods Available: FY 1985 through FY 1999

12. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative description, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**

- NPRM.
- Final rule.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2001 PPS Update

13. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2001 PPS Update

14. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refers to statistical outliers, not payment outliers.) Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2001 PPS Update

For further information concerning these data tapes, contact The HCFA Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Stephen Phillips at (410) 786–4531.

B. Information Collection Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.
- We are soliciting public comment on each of these issues for the sections that contain information collection requirements.

Section 412.77, Determination of the Hospital-Specific Rate for Inpatient Operating Costs for Certain Sole Community Hospitals Based on a Federal Fiscal Year 1996 Base Period, and 412.92, Special Treatment: Sole Community Hospitals

Sections 412.77(a)(2) and 412.92(d)(1)(ii) state that an otherwise eligible hospital that elects not to receive payment based on its hospital-specific rate as determined under § 412.77 must notify its fiscal intermediary of its decision prior to the beginning of its cost reporting period beginning on or after October 1, 2000.

We estimate that it will take each hospital that notifies its intermediary of its election not to receive payments based on its hospital-specific rate as determined under § 412.77 an hour to draft and send its notice. However, we are unable at this time to determine how many hospitals will make this election and, therefore, will need to notify their intermediaries of their decision.

Section 485.643, Condition of Participation: Organ, Tissue, and Eye Procurement

It is important to note that because of the inherent flexibility of this proposed regulation, the extent of the information collection requirements is dependent upon decisions that will be made either by the CAH or by the CAH in conjunction with the OPO or the tissue and eye banks, or both. Thus, the paperwork burden on individual CAHs will vary and is subject, in large part, to their decisionmaking.

The burden associated with the requirements of this section include: (1) The requirement to maintain protocol documentation demonstrating that the five requirements of this section have been met; (2) the requirement for a CAH to notify an OPO, a tissue bank, or an eye bank of any imminent or actual death; and (3) the time required for a hospital to document and maintain OPO referral information.

We estimate that, on average, the requirement to maintain protocol documentation demonstrating that the requirements of this section have been met will impose one hour of burden on each CAH (on 161 CAHs) on an annual basis (a total of 161 annual burden hours).

The CoP in this section would require CAHs to notify the OPO about every

death that occurs in the CAH. The average Medicare hospital has approximately 165 beds and 200 deaths per year. However, by statute and regulation, CAHs may use no more than 15 beds for acute care services. Assuming that the number of deaths in a hospital is related to the number of acute care beds, there should be approximately 18 deaths per year in the average CAH. We estimated that the average notification telephone call to the OPO takes 5 minutes. Based on this estimate, a CAH would need approximately 90 minutes per year to notify the OPO about all deaths and imminent deaths.

Under the proposed CoP, a CAH may agree to have the OPO determine medical suitability for tissue and eye donation or may have alternative arrangements with a tissue bank and an eye bank. These alternative arrangements could include the CAH's direct notification of the tissue and eye bank of potential tissue and eye donors or direct notification of all deaths. If a CAH chose to contact both a tissue bank and an eye bank directly on all deaths, it would need an additional 6 hours per year (that is, 5 minutes per call) in order to call both the tissue and eye bank directly. Again, the impact is small, and the proposed regulation permits the CAH to decide how this process will take place. Note that many communities already have a one-phone call system in place. In addition, some OPOs are also tissue banks or eye banks, or both. A CAH that chose to use the OPO's tissue and eye bank services in these localities would need to make only one telephone call on every death.

We estimate that additional time would be needed by the CAH to annotate the patient record or fill out a form regarding the disposition of a call to the OPO or the tissue bank or the eye bank, or both. This recordkeeping should take no more than 5 minutes per call. Therefore, the paperwork burden associated with the call(s) would add up to an additional 270 minutes per year per CAH.

In summary, the information collection requirements of this section would be a range of from 3 to 9 hours per CAH, or 483 to 1,449 hours annually nationally.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1118-P; and

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

These new information collection and recordkeeping requirements have been submitted to the Office of Management and Budget (OMB) for review under the authority of PRA. We have submitted a copy of the proposed rule to OMB for its review of the information collection requirements. These requirements will not be effective until they have been approved by OMB.

The requirements associated with a hospital's application for a geographic redesignation, codified in Part 412, are currently approved by OMB under OMB approval number 0938–0573, with an expiration date of September 30, 2002.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES** section of this preamble and respond to those comments in the preamble to that rule. We emphasize that section 1886(e)(5) of the Act requires the final rule for FY 2001 to be published by August 1, 2000, and we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 485

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

42 CFR Chapter IV is proposed to be amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

1. The authority citation for Part 412 continues to read as follows:

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

2. Section 412.2 is amended by revising the last sentence of paragraph (a) to read as follows:

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* * * * An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

* * * * *

§ 412.4 [Amended]

3. In § 412.4(f)(3), the reference to ''§ 412.2(e)'' is removed and '' 412.2(b)'' is added in its place.

4. Section 412.63 is amended by:

a. Revising paragraph (s);

b. Redesignating paragraphs (t), (u), (v), and (w) as paragraphs (u), (v), (w), and (x) respectively; and

c. Adding a new paragraph (t), to read as follows:

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

* * * * *

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas.

(t) *Applicable percentage change for fiscal year 2002.* The applicable percentage change for fiscal year 2002 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.1 percentage points for hospitals in all areas.

* * * * *

5. Section 412.73 is amended by revising paragraph (c)(12) and adding paragraphs (c)(13), (c)(14), and (c)(15), to read as follows:

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

* * * * *

(c) *Updating base-year costs* * * *

(12) *For Federal fiscal years 1996 through 2000.* For Federal fiscal years

1996 through 2000, the update factor is the applicable percentage change for other prospective payment hospitals in each respective year as set forth in §§ 412.63(n) through (r).

(13) *For Federal fiscal year 2001.* For Federal fiscal year 2001, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(14) *For Federal fiscal year 2002.* For Federal fiscal year 2002, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.1 percentage points.

(15) *For Federal fiscal year 2003 and for subsequent years.* For Federal fiscal year 2003 and subsequent years, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

* * * * *

§ 412.75 [Amended]

6. In § 412.75(d), the cross reference ''§ 412.73 (c)(5) through (c)(12)'' is removed and ''§ 412.75(c)(15)'' is added in its place.

§ 412.76 [Redesignated]

7. Section 412.76 is redesignated as a new § 412.78.

8. A new § 412.77 is added to read as follows:

§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for certain sole community hospitals based on a Federal fiscal year 1996 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.72, that received payment for its cost reporting period beginning during 1999 based on its hospital-specific rate for either fiscal year 1982 under § 412.73 or fiscal year 1987 under § 412.75, and that elects under paragraph (a)(2) of this section to be paid based on a fiscal year 1996 base period.

(2) Hospitals that are otherwise eligible for but elect not to receive payment on the basis of their Federal fiscal year 1996 updated costs per case must notify their fiscal intermediary of this decision prior to the beginning of their cost reporting period beginning on or after October 1, 2000, for which such payments would otherwise be made. If a hospital does not make the notification to its fiscal intermediary before the end of the cost reporting period, the hospital is deemed to have elected to have section 1886(b)(3)(I) of the Act apply to the hospital.

(3) This section applies only to cost reporting periods beginning on or after October 1, 2000.

(4) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Base-period costs for hospitals subject to fiscal year 1996 rebasing.* (1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1997 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and does have a cost reporting period beginning on or after October 1, 1995 and before October 1, 1996, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 1996, the hospital will not have a hospital-specific rate based on fiscal year 1996.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1996, the update factor is determined using the methodology set forth in § 412.73(c)(12) through (c)(15).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Phase-in of fiscal year 1996 base-period rate.* The intermediary calculates the hospital-specific rates determined on the basis of the fiscal year 1996 base period rate as follows:

(1) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the hospital-specific rate for fiscal year 1982 or fiscal year 1987 (the § 412.73 or § 412.75 target amount), plus 25 percent of the hospital-specific rate for fiscal year 1996 (the § 412.77 target amount).

(2) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the § 412.73 or § 412.75 target amount and 50 percent of the § 412.77 target amount.

(3) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the § 412.73 or § 412.75 target amount and 75 percent of the § 412.77 target amount.

(4) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the § 412.77 target amount.

(h) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1996 base period.

(i) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(j) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the

hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under§ 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

9. Section 412.92 is amended by revising paragraph (d)(1) to read as follows:

§ 412.92 Special treatment: sole community hospitals.

* * * * *

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.* (1) *General rules.* (i) Except as provided in paragraph (d)(1)(ii) of this section, for cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(A) The Federal payment rate applicable to the hospitals as determined under § 412.63.

(B) The hospital-specific rate as determined under § 412.73.

(C) The hospital-specific rate as determined under § 412.75.

(ii) For cost reporting periods beginning on or after October 1, 2000, a sole community hospital that was paid for its cost reporting period beginning during 1999 on the basis of the hospital-specific rate specified in paragraph (d)(1)(i)(B) or (d)(1)(i)(C) of this section, may elect to use the hospital-specific rate as determined under § 412.77.

* * * * *

10. Section 412.105 is amended by:

a. Revising paragraph (d)(3)(v);

b. Republishing paragraph (f)(1) introductory text and revising paragraph (f)(1)(vii);

c. Adding new paragraphs (f)(1)(viii) and (f)(1)(ix); and

d. Revising paragraph (g), to read as follows:

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

* * * * *

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

(3) * * *

(v) For discharges occurring during fiscal year 2001, 1.54.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

* * * * *

(vii) If a hospital establishes a new medical residency training program, as defined in § 413.86(g)(9) of this subchapter, the hospital's full-time equivalent cap may be adjusted in accordance with the provisions of §§ 413.86(g)(6) (i) through (iv) of this subchapter.

(viii) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its full-time equivalent cap in accordance with the provisions of § 413.86(g)(7) of this subchapter.

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in § 413.86(g)(8) of this subchapter.

* * * * *

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in §§ 413.86(d)(3)(i) through (d)(3)(v) of this subchapter.

11. In § 412.106, the introductory text of paragraph (e) is republished and paragraphs (e)(4) and (e)(5) are revised to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(e) *Reduction in payment for FYs 1998 through 2002.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

* * * * *

(4) For FY 2001, 3 percent.

(5) For FY 2002, 4 percent.

* * * * *

12. Section 412.230 is amended by:

a. Republishing the introductory text of paragraph (e)(1); and

b. Revising paragraph (e)(1)(iii) and (e)(1)(iv)(A), to read as follows:

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

* * * * *

(e) *Use of urban or other rural area's wage index—(1) Criteria for use of area's wage index.* Except as provided in paragraphs (e)(3) and (e)(4) of this section, to use an area's wage index, a hospital must demonstrate the following:

* * * * *

(iii) The hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent, and, in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the

area in which the hospital is located; and

(iv) * * *

(A) The hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

* * * * *

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

B. Part 413 is amended as follows:

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

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

2. In § 413.40, paragraph (a)(3) is amended by revising paragraph (B) in the definition of ''ceiling'' and paragraph (d)(4) is revised, to read as follows:

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

(a) *Introduction.* * * *

(3) *Definitions.* * * *

Ceiling. * * *

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of Medicare inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

* * * * *

(d) *Application of the target amount in determining the amount of payment.* * * *

(4) *Continuous improvement bonus payments.* (i) For cost reporting periods beginning on or after October 1, 1997 and ending before October 1, 2000, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

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

(B) 1 percent of the ceiling.

(ii) For cost reporting periods beginning on or after October 1, 2000, and ending before October 1, 2001, eligible psychiatric hospitals and units and long-term care hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

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

(B) 1.5 percent of the ceiling.

(iii) For cost reporting periods beginning on or after October 1, 2001, and ending before October 1, 2002, eligible psychiatric hospitals and units and long-term care hospitals receive payments in addition to those in paragraph (d)(5) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the periods; or

(B) 2 percent of the ceiling.

* * * * *

3. Section 413.70 is revised to read as follows:

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH.* (1) Payment for inpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs; and

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers.

(2) Payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(b) *Payment for outpatient services furnished by a CAH.* (1) *General.* Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is the amount determined under paragraph (b)(2) of this section.

(2) *Reasonable costs for facility services.* (i) Payment for outpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of costs or charges;

(B) RCE limits;

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

(D) Blended payment amounts for ambulatory surgical services, radiology services, and other diagnostic services;

(ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients, and is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.* (i) A CAH may elect to be paid for outpatient services in any cost reporting period under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section. This election must be made in writing, made on an annual basis, and delivered to the intermediary at least 60 days before the start of each affected cost reporting period. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following amounts:

(A) For facility services, not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts that otherwise would be paid for the services if the CAH had not elected payment under this method.

(iii) Payment to a CAH is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161 of this chapter.

(c) *Final payment based on cost report.* Final payment to the CAH for CAH facility services to inpatients and outpatients furnished during a cost reporting is based on a cost report for that period, as required under § 413.20(b).

4. Section 413.86 is amended by:

a. Revising the first sentence of paragraph (d)(3);

b. Revising the introductory text of paragraph (e)(3);

c. Redesignating paragraph (e)(4) as paragraph (e)(5);

d. Adding a new paragraph (e)(4);

e. Revising newly designated paragraph (e)(5)(i)(B); and

f. Adding a new paragraph (e)(5)(iv), to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

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

(3) *Step Three.* For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. * * *

* * * * *

(e) *Determining per resident amounts for the base period.* * * *

(3) *For cost reporting periods beginning on or after July 1, 1986.* Subject to the provisions of paragraph (e)(4) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

* * * * *

(4) *For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(i) *General provisions.* For purposes of § 413.86(e)(4)—

(A) *Weighted average per resident amount.* The weighted average per resident amount is established as follows:

(*1*) Using data from hospitals' cost reporting periods ending during FY 1997, HCFA calculates each hospital's single per resident amount by adding each hospital's primary care and non-primary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

(*2*) Each hospital's single per resident amount calculated under paragraph (e)(4)(i)(A)(*1*) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under § 414.26 of this chapter) in which the hospital is located.

(*3*) HCFA calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (e)(4)(i)(A)(*2*) of this section. The resulting amount is the weighted average per resident amount.

(B) *Primary care/obstetrics and gynecology and non-primary care per resident amounts.* A hospital's per resident amount is an amount inclusive of any CPI–U adjustments that the hospital may have received since the hospital's base year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and non-primary care residents as specified under paragraph (e)(3)(ii) of this section.

(ii) *Adjustment beginning in FY 2001 and ending in FY 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount is adjusted in accordance with paragraphs (e)(4)(ii)(A) through (e)(4)(ii)(C) of this section, in that order:

(A) *Updating the weighted average per resident amount for inflation.* The weighted average per resident amount (as determined under paragraph (e)(4)(i)(A) of this section) is updated by the estimated percentage increase in the CPI–U during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(B) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (e)(4)(ii)(A) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician fee schedule area in which each hospital is located, established in accordance with § 414.26 of this subchapter.

(C) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (e)(4)(ii)(B) of this section, is compared to the hospital's per resident amount. Each hospital's per resident amount is revised, if appropriate, according to the following three categories:

(*1*) *Floor.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001. For subsequent cost reporting periods, the hospital's per resident amount is updated using the methodology specified under paragraph (e)(3)(i) of this section.

(*2*) *Ceiling.* If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2005:

(*i*) *FY 2001.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (e)(4)(ii)(B) of this section), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI–U factor.

(*ii*) *FY 2002.* For cost reporting periods beginning on or after October 1, 2001 and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI–U factor.

(*iii*) *FY 2003 through FY 2005.* For cost reporting periods beginning on or after October 1, 2002 and on or before September 30, 2005, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph

(e)(3)(i) of this section, except that the CPI–U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(*iv*) *General rule for hospitals that exceed the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria under paragraphs (e)(4)(ii)(C)(*2*)(*i*) through (*iii*) of this section, the current year per resident amount resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(*3*) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (e)(3)(i) of this section.

(5) *Exceptions*—(i) *Base period for certain hospitals.* * * *

(B) The weighted mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the weighted mean value, the calculation of the per resident amounts includes all hospitals in the hospital's region as that term is used in § 412.62(f)(1)(i) of this chapter.

* * * * *

(iv) Effective October 1, 2000, the per resident amounts established under paragraphs (e)(5)(i) through (iii) of this section are subject to the provisions of paragraph (e)(4) of this section.

* * * * *

PART 485B—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

C. Part 485 is amended as follows:

1. The authority citation for part 485 continues to read as follows:

Authority: Sec. 1820 of the Act (42 U.S.C. 1395i–4), unless otherwise noted.

2. A new § 485.643 is added to subpart F to read as follows:

§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term ''Organ'' means a human kidney, liver, heart, lung, or pancreas.

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

Dated: April 14, 2000.

Nancy Ann Min DeParle,

Administrator, Health Care Financing Administration

Dated: April 28, 2000.

Donna E. Shalala,

Secretary.

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

Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 2000 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2000

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 2000, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 25 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus 75 percent of the updated FY 1982 or FY 1987 hospital-specific rate. Section 405 of Public Law 106–113 amended section 1886(b)(3) of the Act to allow a sole community hospital that was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate to elect to rebase its hospital-specific rate based on its FY 1996 cost per discharge.

Section 404 of Public Law 106–113 amended section 1886(d)(5)(G) of the Act to extend the special treatment for Medicare-dependent, small rural hospitals. Therefore, Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference

between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a Federal national rate.

As discussed below in section II of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2001. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III of this Addendum, we discuss updates to the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. In section IV of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2001. Section V of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2001. The tables to which we refer in the preamble to this proposed rule are presented at the end of this Addendum in section VI.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 2001

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the proposed factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 2000. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 2001.

In summary, the proposed standardized amounts set forth in Tables 1A and 1C of section VI of this Addendum reflect—

- Updates of 2.0 percent for all areas (that is, the market basket percentage increase of 3.1 percent minus 1.1 percentage points);
- An adjustment to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 2000 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 2000 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

The standardized amounts set forth in table 1E of section VI of this Addendum, which apply to sole community hospitals, reflect updates of 3.1 percent (that is, the full market basket percentage increase) as provided for in section 406 of Public Law 106–113, but otherwise reflect the same adjustments as the national standardized amounts.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required us to determine the Medicare target amounts for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(B) and (d)(2)(C) of the Act required us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are proposing to revise the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1999 MedPAR file.

2. Computing Large Urban and Other Area Averages

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1 million. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be

based on the other standardized amount.

Based on 1997 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 2001. These areas are identified by a footnote in Table 4A.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban areas' and the other areas' average standardized amounts for FY 2001 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVI) of the Act specifies that the update factor for the standardized amounts for FY 2001 is equal to the market basket percentage increase minus 1.1 percentage points for hospitals, except sole community hospitals, in all areas. The Act, as amended by section 406 of Public Law 106–113, specifies an update factor equal to the market basket percentage increase for sole community hospitals.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2001 is 3.1 percent. Thus, for FY 2001, the proposed update to the average standardized amounts equals 3.1 percent for sole community hospitals and 2.0 percent for other hospitals.

As in the past, we are adjusting the FY 2000 standardized amounts to remove the effects of the FY 2000 geographic reclassifications and outlier payments before applying the FY 2001 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2001.

Although the update factors for FY 2001 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2001 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix D to this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 2000 relative weights and wage index to aggregate payments using the proposed FY 2001 relative weights and wage index. The same methodology was used for the FY 2000 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.996506. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999753. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2000 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2000. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the Medicare Geographic Classification Review Board (MGCRB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Section 152(b) of Public Law 106–113 requires reclassifications under that subsection to be treated as reclassifications under section 1886(d)(10) of the Act. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.994270 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2000 budget neutrality adjustment factor. We note that the proposed FY 2001 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 29, 2000. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2001 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment published in the final rule for FY 2001.

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs (cost outliers). Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other area national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to adjust the large urban and other standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates.

i. FY 2001 outlier thresholds. For FY 2000, the fixed loss cost outlier threshold was equal to the prospective payment for the DRG plus $14,050 ($12,827 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) was 80 percent. We applied an outlier adjustment to the FY 2000 standardized amounts of 0.948859 for the large urban and other areas rates and 0.9402 for the capital Federal rate.

For FY 2001, we propose to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $17,250 ($15,763 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we propose to maintain the marginal cost factor for cost outliers at 80 percent.

To calculate FY 2001 outlier thresholds, we simulated payments by applying FY 2001 rates and policies to the December 1999 update of the FY 1999 MedPAR file and the December 1999 update of the provider-specific file. As we have explained in the past, to calculate outlier thresholds, we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 1999, we used a cost inflation factor of minus 1.724 percent. For FY 2000, we used a cost inflation factor (or cost adjustment factor) of zero percent. To set the proposed FY 2001 outlier thresholds, we are using a cost inflation factor of 1.0 percent. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1999 is higher than we projected before the beginning of FY 1999, and that the percentage of actual outlier payments for FY 2000 will likely be higher than we projected before the beginning of FY 2000. The calculations of ''actual'' outlier payments are discussed further below.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the proposed FY 2001 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2001 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.8 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors to be applied to the standardized amounts for FY 2001 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948865	0.9416
Puerto Rico ...	0.975408	0.9709

We apply the proposed outlier adjustment factors after removing the effects of the FY 2000 outlier adjustment factors on the standardized amounts.

Table 8A in section VI of this Addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios would replace the ratios published in the July 30, 1999 final rule (64 FR 41620). Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.201132 or greater than 1.308495 and capital cost-to-charge ratios lower than 0.01266 or greater than 0.16901. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2001 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. FY 1999 and FY 2000 outlier payments. In the July 30, 1999 final rule (64 FR 41547), we stated that, based on available data, we estimated that actual FY 1999 outlier payments would be approximately 6.3 percent of actual total DRG payments. This was computed by simulating payments using the March 1998 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1999 bills but instead reflected the application of FY 1999 rates and policies to available FY 1998 bills. Our current estimate, using available FY 1999 bills, is that actual outlier payments for FY 1999 were approximately 7.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1999 discharges continues to be updated. Thus, the data indicate that, for FY 1999, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1999 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1999). In fact, the data indicate that the proportion of actual outlier payments for FY 1999 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1999.

We currently estimate that actual outlier payments for FY 2000 will be approximately 6.1 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 2000. This estimate is based on simulations using the December 1999 update of the provider-specific file and the December 1999 update of the FY 1999 MedPAR file (discharge data for FY 1999 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2000 by applying FY 2000 rates and policies to available FY 1999 bills.

5. FY 2001 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A (Table 1E for sole community hospitals) contains the two national standardized amounts that we are proposing to be applicable to all hospitals, except hospitals in Puerto Rico. Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A, 1C and 1E, as set forth in this Addendum, contain the proposed labor-related and nonlabor-related shares that would be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of this preamble, we discuss the data and methodology for the proposed FY 2001 wage index. The proposed wage index is set forth in Tables 4A through 4F of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2001, we propose to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2000, we will publish them in the final rule and use them in determining FY 2001 payments.

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

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

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2001. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2001

General Formula for Calculation of Prospective Payment Rates for FY 2001

Prospective payment rate for all hospitals located outside of Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if the sole community hospital was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate and elects rebasing, 25 percent of its updated hospital-specific rate based on FY 1996 cost per discharge plus 75 percent of its updated FY 1982 or FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate, or, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 100 percent of the Federal rate plus 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

Prospective payment rate for Puerto Rico = 50 percent of the Puerto Rico rate + 50 percent of a discharge-weighted average of the national large urban standardized amount and the Federal national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 2000 and before October 1, 2001, except for sole community hospitals, Medicare-dependent, small rural hospitals and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Table 1A or 1E in section VI of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4A, 4B, and 4C of section VI of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI of this Addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals)

Section 1886(b)(3)(C) of the Act, as amended by section 405 of Public Law 106–113, provides that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if the sole community hospital was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific

rate and elects rebasing, 25 percent of its updated hospital-specific rate based on FY 1996 cost per discharge plus 75 percent of the updated FY 1982 or FY 1987 hospital-specific rate.

Section 1886(d)(5)(G) of the Act, as amended by section 404 of Public Law 106–113, provides that Medicare-dependent, small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 cost per discharge, the FY 1987 cost per discharge or, for qualifying sole community hospitals, the FY 1996 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 2001

We are proposing to increase the hospital-specific rates by 3.1 percent (the hospital market basket rate of increase) for sole community hospitals and by 2.0 percent (the hospital market basket percentage increase minus 1.1 percentage points) for Medicare-dependent, small rural hospitals for FY 2001. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for sole community hospitals in FY 2001, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2001, is the market basket rate of increase minus 1.1 percentage points.

b. Calculation of Hospital-Specific Rate

For sole community hospitals, the applicable FY 2001 hospital-specific rate would be the greater of the following: the hospital-specific rate for the preceding fiscal year, increased by the applicable update factor (3.1 percent); or, if the hospital qualifies to rebase its hospital-specific rate based on cost per case in FY 1996 and elects rebasing, 75 percent of the hospital-specific rate for the preceding fiscal year, increased by the applicable update factor, plus 25 percent of its rebased FY 1996 hospital-specific rate updated through FY 2001. For Medicare-dependent, small rural hospitals, the applicable FY 2001 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (2.0 percent), which is the same as the update for all prospective payment hospitals, except sole community hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 0.996506) as discussed in section II.A.4.a. of this Addendum. The resulting rate is used in determining under which rate a sole community hospital or Medicare-dependent, small rural hospital is paid for its discharges beginning on or after October 1, 2000, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2000 and Before October 1, 2001

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section VI of the Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI of the Addendum).

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section VI of the Addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI of the Addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI of the Addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Changes to the Payment Rates for Blood Clotting Factor for Hemophilia Inpatients

For the past 2 years in the **Federal Register** (63 FR 41010 and 64 FR 41549), we have discussed section 4452 of Public Law 105–33, which amended section 6011(d) of Public Law 101–239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1997. In these prior rules, we have described the payment policy and specifically listed the updated add-on payment amounts for each clotting factor, as described by HCFA's Common Procedure Coding System (HCPCS). Because we are not changing the policy established 2 years ago, we are proposing to discontinue listing these amounts in the annual proposed and final rules. Instead, the program manuals will instruct fiscal intermediaries to follow this policy and obtain the average wholesale price (AWP) for each relevant HCPCS from either their corresponding local carrier or the Medicare durable medical equipment regional carrier (DMERC) that has jurisdiction in their area. Carriers already calculate the AWP based on the median AWP of the several products available in each category of factor. The payment amount for clotting factors covered by this inpatient benefit is equal to 85 percent of the AWP, subject to the Part A deductible and coinsurance requirements.

The payment amounts will be determined using the most recent AWP data available to the carrier at the time the intermediary performs these annual update calculations. These amounts are updated annually and are effective for discharges beginning on or after October 1 of the current year through September 30 of the following year. Payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

IV. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2001

The prospective payment system for hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, hospital inpatient capital-related costs are paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the proposed Federal rate and the hospital-specific rates for FY 2001. The rates will be effective for discharges occurring on or after October 1, 2000.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of Public Law 105–33, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002.

For each hospital, the hospital-specific rate was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment adjustment factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. Since FY 1992, the hospital-specific rate has been updated annually for inflation and for changes in the exceptions payment adjustment factor. For FYs 1992 through 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor. For discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital-specific rate is reduced by 17.78 percent. A small part of this reduction will be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the exceptions payment adjustment factor, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the model is still used to estimate the exceptions payment adjustment and other factors. The model and its application are described in greater detail in Appendix B of this proposed rule.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

In the July 30, 1999 final rule (64 FR 41551), we established a Federal rate of $377.03 for FY 2000. As a result of the changes we are proposing to the factors used to establish the Federal rate in this addendum, the proposed FY 2001 Federal rate is $383.06.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2001 Federal rate. In particular, we explain why the proposed FY 2001 Federal rate has increased 1.60 percent compared to the FY 2000 Federal rate. We also estimate aggregate capital payments will increase by 5.89 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions, the increase in case-mix, and the increase in the Federal blend percentage from 90 to 100 percent for fully prospective payment hospitals.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 2001 compared to FY 2000.

1. Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the standard Federal rate is updated on the basis of

an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2001 under that framework is 0.9 percent. This proposal is based on a projected 0.9 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 1999 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2001 CIPI projection in section II.D of this Addendum. In this section IV of the Addendum, we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1999 DRG reclassification and recalibration as part of our FY 2001 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2001, we are projecting a 0.5 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.5 percent in FY 2001. Therefore, the proposed net adjustment for case-mix change in FY 2001 is 0.0 percentage points.

We estimate that FY 1999 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update recommendation for FY 2001.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.0 percentage points was calculated for the FY 1999 update. That is, current historical data indicate that the FY 1999 CIPI used in calculating the forecasted FY 1999 update factor did not overstate or understate realized price increases. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2001.

Under the capital prospective payment system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. The use of total charges in the calculation of the proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 2001, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1995 through 1999 data. In determining case-mix constant intensity, we found that observed case-mix increase was 1.7 percent in FY 1995, 1.6 percent in FY 1996, 0.3 percent in FY 1997, −0.4 percent in FY 1998, and −0.3 in FY 1999. For FY 1995 and FY 1996, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G.M. Carter, J.P. Newhouse, and D.A. Relles, R–4098–HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1995 through FY 1999. Based on this analysis, we believe that all of the observed case-mix increase for FY 1997, FY 1998, and FY 1999 is real. The increases for FY 1995 and FY 1996 were in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level

changes (the CPI for hospital and related services), and changes in real case-mix. Given estimates of real case-mix of 1.0 percent for FY 1995, 1.0 percent for FY 1996, 0.3 percent for FY 1997, −0.4 for FY 1998, and −0.3 for FY 1999, we estimate that case-mix constant intensity declined by an average 0.7 percent during FYs 1995 through 1999, for a cumulative decrease of 3.6 percent. If we assume that real case-mix increase was 1.4 percent for FY 1995, 1.4 percent for FY 1996, 0.3 percent for FY 1997, −0.4 for FY 1998, and −0.3 for FY 1999, we estimate that case-mix constant intensity declined by an average 0.9 percent during FYs 1995 through 1999, for a cumulative decrease of 4.5 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 2001. We note that the operating recommendation addressed in Appendix D of this proposed rule reflects the possible range that a negative adjustment could span (−0.6 percent to 0.0 percent adjustment) based on our analyses that intensity has declined during that 5-year period. While the calculation of the adjustment for intensity is identical in both the capital and the operating update frameworks, consistent with past capital update recommendations and the FY 2001 proposed operating recommendation, we are not making a negative adjustment for intensity in the FY 2001 proposed capital update.

b. Comparison of HCFA and MedPAC Update Recommendations

MedPAC's FY 2001 update recommendation for capital prospective payments was not included in its March 2000 Report to Congress. However, MedPAC did announce at its April 13, 2000 public meeting that it was recommending a combined update of between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001. This recommendation is higher than the current law amount as prescribed by Public Law 105–33. Because of the timing of the announcement and our need for ample time to perform a proper analysis of the recommendation, we will address the comparison of HCFA's update recommendation and MedPAC's update recommendation in the FY 2001 final rule in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation.

In section IV.A.l.a. of this Addendum, we describe the basis of the components used to develop our proposed 0.9 percent FY 2001 capital update factor as shown in Table 1 below.

TABLE 1.—HCFA'S PROPOSED FY 2001 CAPITAL UPDATE FACTOR

Capital Input Price Index	0.9
Intensity	0.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	−0.5
Real Across DRG Change	0.5
Subtotal	0.0
Effect of FY 1999 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	0.9

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 100 percent for cost reporting periods beginning in FY 2001 for hospitals paid under the fully prospective payment methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of outlier payments under the Federal rate to total inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments. The inpatient capital-related outlier reduction factor reflects the inpatient capital-related outlier payments that would be made if all hospitals were paid 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model payments as if all hospitals were paid 100 percent of the Federal rate because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

In the July 30, 1999 final rule, we estimated that outlier payments for capital in FY 2000 would equal 5.98 percent of inpatient capital-related payments based on the Federal rate (64 FR 41553). Accordingly, we applied an outlier adjustment factor of 0.9402 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d. of this Addendum, we estimate that outlier payments for capital will equal 5.84 percent of inpatient capital-related payments based on the Federal rate in FY 2001. Therefore, we are proposing an outlier adjustment factor of 0.9416 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2001 is lower than the percentage for FY 2000.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the proposed net change in the outlier adjustment to the Federal rate for FY 2001 is 1.0015 (0.9416/0.9402). The outlier adjustment increases the FY 2001 Federal rate by 0.15 percent compared with the FY 2000 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model, described in Appendix B of this proposed rule, to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 2000, we calculated a GAF/DRG budget neutrality factor of 0.9985. For FY 2001, we are proposing a GAF/DRG budget neutrality factor of 0.9986. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 2000 to FY 2001 is 0.9986. The proposed cumulative change in the rate due to this adjustment is 1.0060 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996,

FY 1997, FY 1998, FY 1999, FY 2000, and the proposed incremental factor for FY 2001:
$0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9986 = 1.0000$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2001 geographic reclassification decisions made by the MGCRB compared to FY 2000 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total payments under the hospital-specific rate and Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to determine the exceptions payment adjustment factor. We describe that model in Appendix B to this proposed rule.

For FY 2000, we estimated that exceptions payments would equal 2.70 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9730 (1 − 0.0270) in determining the Federal rate. For this proposed rule, we estimate that exceptions payments for FY 2001 will equal 2.04 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we are proposing an exceptions payment reduction factor of 0.9796 to the Federal rate for FY 2001. The proposed exceptions reduction factor for FY 2001 is 0.68 percent higher than the factor for FY 2000.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the proposed net adjustment to the FY 2001 Federal rate is 0.9796/0.9730, or 1.0068.

5. Standard Capital Federal Rate for FY 2001

For FY 2000, the capital Federal rate was $377.03. As a result of changes we are proposing to the factors used to establish the Federal rate, the proposed FY 2001 Federal rate is $383.06. The proposed Federal rate for FY 2001 was calculated as follows:

- The proposed FY 2001 update factor is 1.0090; that is, the proposed update is 0.90 percent.
- The proposed FY 2001 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9986.
- The proposed FY 2001 outlier adjustment factor is 0.9416.
- The proposed FY 2001 exceptions payments adjustment factor is 0.9796.

Since the Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we propose to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2001 affected the computation of the proposed FY 2001 Federal rate in comparison to the FY 2000 Federal rate. The proposed FY 2001 update factor has the effect of increasing the Federal rate by 0.90 percent compared to the rate in FY 2000, while the proposed geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.14 percent. The proposed FY 2001 outlier adjustment factor has the effect of increasing the Federal rate by 0.15 percent compared to FY 2000. The proposed FY 2001 exceptions reduction factor has the effect of increasing the Federal rate by 0.68 percent compared to the exceptions reduction for FY 2000. The combined effect of all the proposed changes is to increase the proposed Federal rate by 1.60 percent compared to the Federal rate for FY 2000.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2000 FEDERAL RATE AND PROPOSED FY 2001 FEDERAL RATE

	FY 2000	Proposed FY 2001	Change	Percent change
Update factor [1]	1.0030	1.0090	1.0090	0.90
GAF/DRG Adjustment Factor [1]	0.9985	0.9986	0.9986	−0.14
Outlier Adjustment Factor [2]	0.9402	0.9416	1.0015	0.15
Exceptions Adjustment Factor [2]	0.9730	0.9796	1.0068	0.68
Federal Rate	$377.03	$383.06	1.0160	1.60

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 2000 to FY 2001 resulting from the application of the 0.9986 GAF/DRG budget neutrality factor for FY 2001 is 0.9986.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 2001 outlier reduction factor is 0.9416/0.9402, or 1.0015.

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section IV of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a geographic adjustment factor (GAF) to both portions of the blended rate. The GAF is calculated using the operating prospective payment system wage index and varies depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Since we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget

neutrality factor is 1.0031, while the DRG adjustment is 1.0002, for a combined cumulative adjustment of 1.0033.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of Public Law 105–33.

For FY 2000, before application of the GAF, the special rate for Puerto Rico hospitals was $174.81. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2001 special rate for Puerto Rico is $185.38.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2001

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two payment methodologies—the fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

The result is the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of the following:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1994 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis for the remainder of the transition period.

Payment for each discharge under the fully prospective methodology is based on the applicable transition blend percentage of the hospital-specific rate and the adjusted Federal rate.

Thus, for FY 2001 payments under the fully prospective methodology will be based on 100 percent of the adjusted Federal rate and zero percent of the hospital-specific rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that portion is 100 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 2001. Thus, a fully prospective hospital will receive 100 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 2001. For hold-harmless hospitals that are paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The proposed outlier thresholds for FY 2001 are in section II.A.4.c. of this Addendum. For FY 2001, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $17,250.

During the capital prospective payment system transition period, a hospital also may receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The proposed minimum payment levels for portions of cost reporting periods occurring in FY 2001 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent or that receive more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent; and
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period. New hospitals are exempted from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December

31, 1990, or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, American Hospital Association (AHA) data, and Securities Data Company data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent explanation of the CIPI was discussed in the final rule with comment period for FY 1998 published on August 29, 1997 (62 FR 46050).

2. Forecast of the CIPI for Federal Fiscal Year 2001

We are forecasting the CIPI to increase 0.9 percent for FY 2001. This reflects a projected 1.5 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.5 percent increase in other capital expense prices in FY 2001, partially offset by a 1.3 percent decline in vintage-weighted interest rates in FY 2001. The weighted average of these three factors produces the 0.9 percent increase for the CIPI as a whole.

V. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in regulations at § 413.40. Under these limits, a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). In the case of a psychiatric hospital or hospital unit, a rehabilitation hospital or hospital unit, or a long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts adjusted to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the update factor for a hospital or unit depends on the hospital's or hospital unit's costs in relation to the ceiling for the most recent cost reporting period for which information is available. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 2001 for hospitals and hospital units excluded from the prospective payment system is 3.1 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2001 would be between 0.6 and 3.1 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its rate-of-increase limit.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class.

Section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. We intend to publish an interim final rule with comment period implementing this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. This proposed rule addresses the wage adjustment to the caps for cost reporting periods beginning on or after October 1, 2000.

As discussed in section VI. of the preamble of this proposed rule, under section 121 of Public Law 106–113, the cap on the target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap (the labor-related portion of costs equals 0.71553 and the nonlabor-related portion of costs equals 0.28447). A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the wage index under the hospital inpatient prospective payment system (see § 412.63), without taking into account reclassifications under sections 1886(a)(10) and (d)(8)(B) of the Act.

For cost reporting periods beginning in FY 2001, the proposed caps are as follows:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$8,106	$3,223
Rehabilitation	15,108	6,007
Long-Term Care	29,312	11,654

Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at §413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 1E (a new table, as described in section II of this Addendum), 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 7A, 7B, 8A, and 8B are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 1E—National Adjusted Operating Standardized Amounts for Sole Community Hospitals, Labor/Nonlabor
Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1999 and Hospital Average Hourly Wage for Federal Fiscal Year 2001 Wage Index
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4D—Average Hourly Wage for Urban Areas
Table 4E—Average Hourly Wage for Rural Areas
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Arithmetic Mean Length of Stay Points Used in the Prospective Payment System
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Revised Diagnosis Code Titles
Table 6E—Revised Procedure Codes
Table 6F—Additions to the CC Exclusions List
Table 6G—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 99 MEDPAR Update 12/99 GROUPER V17.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 99 MEDPAR Update 12/99 GROUPER V18.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 2000
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 2000

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor related
$2,856.71	$1,161.17	$2,811.49	$1,142.79

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$2,832.11	$1,151.16	$2,832.11	$1,151.16
Puerto Rico	1,373.19	552.74	1,351.45	543.99

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$383.06
Puerto Rico	185.38

TABLE 1E.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR SOLE COMMUNITY HOSPITALS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,887.52	$1,173.69	$2,841.81	$1,155.11

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
010001	1.4278	16.48	010052	1.0036	16.97	010109	1.0212	15.33	020005	0.8798	34.13	030025	0.9391	13.27	030085	1.4869	19.44
010004	1.0044	18.05	010053	1.0194	14.68	010110	0.8850		020006	1.1483	31.85	030027	0.9273	16.22	030086	3.7429	19.83
010005	1.2480	17.66	010054	1.1445	18.51	010112	1.0528	15.23	020007	0.9380	29.28	030030	1.6808	21.20	030087	1.5545	21.43
010006	1.4005	16.52	010055	1.4568	19.26	010113	1.6470	17.01	020008	1.0787	29.56	030033	1.2105	19.76	030088	1.3535	19.87
010007	1.1113	15.58	010056	1.3395	19.25	010114	1.3085	15.26	020009	0.8178	20.45	030034	0.9505	17.14	030089	1.5928	20.40
010008	1.0850	15.00	010058	0.9947	16.92	010115	0.8637	14.81	020010	0.9175	26.72	030035	1.2644	19.50	030092	1.5998	16.26
010009	1.0667	19.19	010059	1.0876	19.35	010118	1.2302		020011	0.9195	30.48	030036	1.2424	20.76	030093	1.3244	19.87
010010	1.0880	16.53	010061	0.9942	15.11	010119	0.7846	18.81	020012	1.2732	25.24	030037	2.0155	23.11	030094	1.2428	21.62
010011	1.6150	20.81	010062	1.1101	15.10	010120	0.9620	17.34	020013	1.0626	24.47	030038	1.5713	22.80	030095	0.9887	13.73
010012	1.3045	17.81	010064	1.8161	20.51	010121	1.2250	14.74	020014	1.1975	29.43	030040	1.0698	18.96	030099	0.9042	16.18
010015	0.9885	15.53	010065	1.2896	16.52	010123	1.2688	16.64	020017	1.6744	26.77	030041	0.8919	16.42	030100	1.9339	
010016	1.2621	17.28	010066	0.8539	15.77	010124		16.19	020018	0.9153		030043	1.2572	21.06	030101	1.5440	
010018	1.0469	18.08	010068	1.2576	15.31	010125	1.0259	15.71	020019	0.8528		030044	0.9287	16.86	030102	2.5438	
010019	1.1669	16.39	010069	1.1548	13.99	010126	1.0986	19.69	020021	0.8346		030047	0.8511	22.78	030103	1.6998	
010021	1.1984	16.38	010072	1.1114	15.08	010127		19.53	020024	1.0545	24.09	030049	0.8952	19.63	040001	1.1033	15.30
010022	1.0132	18.93	010073	0.8978	14.15	010128	0.9027	14.62	020025	0.8695	21.78	030054	0.8303	15.37	040002	1.0913	13.15
010023	1.7280	16.19	010078	1.2693	17.97	010129	1.0588	14.86	020026	1.4409		030055	1.2365	16.43	040003	1.0704	14.57
010024	1.3789	16.31	010079	1.2290	16.63	010130	0.9895	16.85	020027	0.9912		030059	1.3346	24.08	040004	1.6137	18.04
010025	1.2878	15.24	010081	1.3804		010131	1.2724		030001	1.3884	20.41	030060	1.1248	19.25	040005	0.9870	13.31
010027	0.8252	13.87	010083	1.1286	16.91	010134	0.8020	20.58	030002	1.8195	21.78	030061	1.6762	18.94	040007	1.6837	22.13
010029	1.5749	17.73	010084	1.4695	18.53	010137	1.3159	12.12	030003	2.2304	23.99	030062	1.1606	17.72	040008	1.0106	16.25
010031	1.3683	18.78	010085	1.3068	18.60	010138	0.9615	13.19	030004	0.8905	14.17	030064	1.7355	19.64	040010	1.2831	18.75
010032	0.8616	12.84	010086	1.0467	16.69	010139	1.5811	18.47	030006	1.5664	18.32	030065	1.7670	20.60	040011	0.9495	14.97
010033	2.0389	20.47	010087	1.7488	19.03	010143	1.1549	21.75	030007	1.2621	19.72	030067	1.1041	14.49	040014	1.4163	17.92
010034	1.0754	15.23	010089	1.2804	16.84	010144	1.4251	17.17	030008	2.0733	22.37	030068	1.0055	17.59	040015	1.1470	17.02
010035	1.2529	20.25	010090	1.6551	18.39	010145	1.2446	20.42	030009	1.1418	18.28	030069	1.3547	19.19	040016	1.6706	19.04
010036	1.0593		010091	0.9348	14.08	010146	1.2935	18.56	030010	1.3827	19.15	030071	0.8901		040017	1.1720	13.03
010038	1.2051	18.27	010092	1.3926	17.05	010148	0.9818	12.34	030011	1.3897	19.33	030072	0.9288		040018	1.1338	17.75
010039	1.6101	20.18	010095	0.9413	12.70	010149	1.2070	18.56	030012	1.2263	19.09	030073	1.0146		040019	1.0841	24.51
010040	1.4448	19.06	010097	0.8645	13.21	010150	1.0460	18.15	030013	1.2632	20.84	030074	0.9404		040020	1.5875	18.36
010043	1.0006	38.25	010098	0.9268	16.03	010152	1.3025	17.83	030014	1.5248	20.05	030075	0.8153		040021	1.2297	17.91
010044	0.9812	22.99	010099	1.1312	16.03	010155	1.0695	9.36	030016	1.3278	19.70	030076	0.8824		040022	1.4451	17.16
010045	1.1916	15.62	010100	1.2961	17.27	010157	1.1997		030017	1.4749	23.11	030077	0.8316		040024	1.0611	14.61
010046	1.5065	17.44	010101	1.1235	15.45	010158	1.0853	17.24	030018	1.8380	20.52	030078	1.1559		040025	0.8692	11.59
010047	0.9422	13.41	010102	0.9079	14.02	010159	1.1094		030019	1.2068	21.76	030079	0.8532		040026	1.6035	19.88
010049	1.1846	14.77	010103	1.8380	18.01	020001	1.4984	28.36	030022	1.4836	15.20	030080	1.3803	20.60	040027	1.3965	16.30
010050	1.0824	18.66	010104	1.7096	17.80	020002	1.0103	24.89	030023	1.4898	23.86	030083	1.2592	21.08	040028	0.9947	14.91
010051	0.8974	12.19	010108	1.1564	18.37	020004	1.0683	30.98	030024	1.7420	22.82	030084	1.1379		040029	1.2723	18.03

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
040030	0.9396	13.93	040090	0.8630	18.35	050033	1.4729	25.01	050090	1.2709	23.64	050138	2.1622	37.84	050207	1.2349	21.65
040032	0.9438	14.03	040091	1.2296	17.53	050036	1.7390	21.36	050091	1.1410	25.29	050139	1.1982	33.13	050211	1.2346	31.95
040035	0.9216	13.01	040093	0.9349	12.78	050038	1.3755	28.81	050092	0.8504	16.86	050140	1.3758	34.43	050213	1.5148	21.50
040036	1.3589	18.98	040100	1.1438	14.87	050039	1.5488	22.70	050093	1.5478	25.37	050144	1.4526	28.29	050214	1.5278	21.84
040037	1.0868	15.10	040105	0.9922	15.78	050040	1.2641	33.40	050095		35.99	050145	1.3372	32.41	050215	1.5854	30.03
040039	1.2271	14.46	040106	1.0883	15.86	050042	1.2409	24.99	050096	1.0790	20.54	050146	1.6424		050217	1.2598	19.60
040040	0.9470	18.23	040107	1.0434	19.01	050043	1.5334	33.33	050097	1.4223	16.40	050148	1.0688	22.00	050219	1.0474	21.83
040041	1.2165	16.08	040109	1.1328	14.77	050045	1.2221	19.88	050099	1.4583	24.98	050149	1.3785	24.71	050222	1.6060	27.54
040042	1.2980	15.35	040114	1.8654	18.87	050046	1.1393	26.07	050100	1.7205	30.18	050150	1.2152	25.13	050224	1.6205	23.61
040044	1.0474	12.80	040116		20.35	050047	1.6262	30.13	050101	1.4103	31.14	050152	1.3259	34.39	050225	1.5004	31.58
040045	0.9487	15.24	040118	1.4710	19.61	050051	0.9881	18.18	050102	1.2911	22.30	050153	1.6067	30.64	050226	1.4298	27.83
040047	1.0359	17.09	040119	1.1794	15.59	050054	1.1959	20.75	050103	1.5882	25.01	050155	1.0591	24.84	050228	1.3532	34.31
040050	1.1708	13.80	040124	0.9563	19.26	050055	1.1956	29.72	050104	1.4022	25.67	050158	1.2985	27.84	050230	1.5494	27.88
040051	1.0438	15.99	040126	0.9145	12.72	050056	1.3751	27.51	050107	1.4130	21.70	050159	1.3185	23.54	050231	1.5745	26.19
040053	1.0545	16.66	040132		22.62	050057	1.6438	21.42	050108	1.8758	23.62	050167	1.4456	21.96	050232	1.7691	24.56
040054	1.0183	15.43	040134	2.6352	18.08	050058	1.4738	23.34	050110	1.1566	20.62	050168	1.5914	23.46	050234	1.1381	26.03
040055	1.4727	17.25	040135	1.4738	22.68	050060	1.5538	20.87	050111	1.2612	21.19	050169	1.4356	22.55	050235	1.5844	25.46
040058	1.0376	17.82	040136	2.2661		050061	1.3808	23.74	050112	1.4206	25.37	050170	1.4332	24.06	050236	1.3946	27.29
040060	0.9530	13.75	050002	1.5128	39.36	050063	1.3292	25.16	050113	1.2119	29.30	050172	1.2213	20.18	050238	1.5409	24.47
040062	1.5948	23.18	050006	1.4846	19.18	050065	1.7146	24.28	050114	1.3399	24.85	050173	1.1939	25.08	050239	1.6537	22.66
040064	1.0306	11.06	050007	1.4729	30.71	050066	1.3859	16.69	050115	1.5070	21.41	050174	1.7347	31.50	050240	1.5264	26.54
040066	1.0685	18.42	050008	1.4666	26.73	050067	1.2756	23.15	050116	1.5553	25.24	050175	1.3795	27.96	050241		26.37
040067	1.0625	14.70	050009	1.6262	27.06	050068	1.0637	21.52	050117	1.3992	23.39	050177	1.2057	21.80	050242	1.3988	31.31
040069	1.0577	17.80	050013	1.9833	22.96	050069	1.5647	25.94	050118	1.1741	23.77	050179	1.2162	22.06	050243	1.5571	29.12
040070	0.9170	17.07	050014	1.1307	22.98	050070	1.3225	32.87	050121	1.3144	19.60	050180	1.5819	31.96	050245	1.5661	23.85
040071	1.5990	17.07	050015	1.4834	26.26	050071	1.2657	33.34	050122	1.6021	26.34	050183		20.36	050248	1.2079	26.33
040072	1.0365	16.30	050016	1.2089	20.67	050072	1.2791	33.53	050124	1.2563	22.88	050186	1.3599	22.79	050251	1.0433	22.39
040074	1.2996	18.48	050017	2.1001	23.22	050073	1.2635	33.65	050125	1.3273	29.60	050188	1.4760	28.30	050253	1.4115	16.07
040075	0.9771	13.40	050018	1.2245	15.49	050075	1.2788	34.10	050126	1.4554	24.03	050189	0.9957	23.30	050254	1.1387	19.40
040076	1.1181	19.37	050021		26.03	050076	2.3071	27.82	050127	1.2415	22.19	050191	1.3715	20.91	050256	1.7386	23.81
040077	1.0444	13.09	050022	1.6509	24.12	050077	1.5543	24.15	050128	1.5294	25.89	050192	1.0556	18.68	050257	1.0952	15.32
040078	1.5847	19.15	050024	1.3078	21.57	050078	1.3423	23.35	050129	1.6749	26.64	050193	1.1442	22.86	050260	0.9729	23.62
040080	1.0164	19.53	050025	1.7364	23.45	050079	1.5386	33.54	050131	1.2584	31.24	050194	1.2706	35.58	050261	1.2542	20.10
040081	0.8832	11.39	050026	1.5282	27.92	050080		9.75	050132	1.3424	24.18	050195	1.5371	31.73	050262	1.8299	28.95
040082	1.0656	16.71	050028	1.3459	16.61	050082	1.6267	22.15	050133	1.2297	25.34	050196	1.3094	18.52	050264	1.3077	32.34
040084	1.1044	17.31	050029	1.2962	24.97	050084	1.5992	23.67	050135	1.3515	23.28	050197	2.0328	35.59	050267	1.7131	26.61
040085	1.1034	17.17	050030	1.2994	21.25	050088	0.9057	20.84	050136	1.2602	25.49	050204	1.4464	23.69	050270	1.3463	24.10
040088	1.3771	17.56	050032	1.2823	25.20	050089	1.2844	20.42	050137	1.3354	33.15	050205	1.2961	23.79	050272	1.3864	22.55

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
050274		21.90	050336	1.3148	21.11	050411	1.3325	35.12	050482	0.9444	18.33	050557	1.4917	21.19	050616	1.3945	23.24
050276	1.2294	30.14	050337	1.3409		050414	1.2163	24.21	050483		22.72	050559	1.3253	23.97	050618	0.9941	23.36
050277	1.3544	20.11	050342	1.2318	20.36	050417	1.2669	21.72	050485	1.5748	23.02	050561	1.1922	34.74	050623	1.3428	31.48
050278	1.5520	25.08	050343		17.21	050419	1.4211	24.35	050488	1.3457	34.75	050564	1.5745	23.81	050624	1.3036	22.73
050279	1.2438	21.49	050348	1.7938	24.04	050420	1.2836	22.37	050491	1.1162	26.54	050565		23.80	050625	1.6119	24.49
050280	1.6911	25.35	050349	0.8931	14.98	050423	1.1073	17.37	050492	1.4207	19.55	050566	0.9362	17.63	050630	1.1955	23.92
050281	1.4283	19.89	050350	1.4083	24.94	050424	1.8977	22.86	050494	1.2611	29.94	050567	1.5233	24.77	050633	1.3384	23.19
050282	1.3177	28.95	050351	1.4618	25.59	050425	1.2423	33.01	050496	1.6631	32.63	050568	1.2199	19.62	050636	1.3775	21.49
050283	1.5413	29.91	050352	1.3581	26.44	050426	1.4516	25.41	050497	0.8187	14.88	050569	1.2256	26.84	050638	1.2242	18.30
050286		17.82	050353	1.5558	23.07	050427	0.9257	21.09	050498	1.2010	25.23	050570	1.5758	25.35	050641	1.1934	22.08
050289	1.7695	34.63	050355	0.8485	23.11	050430	0.9850	27.11	050502	1.7562	22.26	050571	1.4012	26.67	050643	0.8109	
050290	1.6650	28.62	050357	1.3840	22.77	050432	1.5787	24.47	050503	1.3611	24.50	050573	1.5665	25.04	050644	1.0478	22.61
050291	1.2493	30.37	050359	1.2337	17.86	050433	0.9702	18.78	050506	1.3777	25.26	050575	1.0859	19.56	050660	1.3988	
050292	1.0279	21.61	050360	1.3884	31.55	050434	1.0486	20.11	050510	1.1881	33.68	050577	1.3890	25.18	050661		19.69
050293	1.3962	22.40	050366	1.2354	23.85	050435	1.2440	26.85	050512	1.3509	35.79	050578	1.3082	29.18	050662	0.7821	33.69
050295	1.4548	21.44	050367	1.2265	28.47	050436		14.82	050515	1.3677	35.59	050579	1.3288	30.66	050663	1.0923	31.69
050296	1.1963	27.85	050369	1.3186	27.11	050438	1.7067	25.19	050516	1.4960	24.85	050580	1.2433	26.07	050667	0.9630	31.43
050298	1.2708	24.45	050373	1.3850	25.58	050440	1.2249	24.04	050517	1.1888	20.96	050581	1.4087	23.94	050668	1.0342	90.35
050299	1.4014	26.61	050376	1.5450	25.95	050441	1.9566	33.91	050522	1.1530	35.75	050583	1.5685	24.46	050670	0.7818	20.09
050300	1.5156	23.47	050377	0.9251	17.68	050443	0.7635	20.72	050523	1.2555	27.10	050584	1.1277	21.24	050674	1.2419	35.29
050301	1.2115	21.96	050378	1.1115	26.25	050444	1.3293	21.66	050526	1.2341	24.10	050585	1.2603	26.14	050675		15.68
050305	1.5654	34.96	050379	0.9780	17.02	050446	0.8819	20.67	050528	1.1751	19.06	050586	1.2224	23.57	050676	0.9591	21.14
050307		23.86	050380	1.6373	31.53	050447	1.0026	17.98	050531	1.1211	22.73	050588	1.3006	25.56	050677	1.3600	35.65
050308	1.4622	29.42	050382	1.3438	25.57	050448	1.0667	18.32	050534	1.2604	24.07	050589	1.1422	24.87	050678	1.3388	26.89
050309	1.2943	23.86	050385	1.4093	24.94	050449	1.4294	23.88	050535	1.2211	26.03	050590	1.3372	22.89	050680	1.2248	28.06
050312	1.9924	27.26	050388	0.8404	22.89	050454	1.7486	28.83	050537	1.2836	22.42	050591	1.2395	24.04	050682	0.8984	37.06
050313	1.2089	22.01	050390	1.1935	25.41	050455	1.9528	20.23	050539	1.2990	20.92	050592	1.2596	21.85	050684	1.2854	22.35
050315	1.2679	24.87	050391	1.2246	19.09	050456	1.1464	20.62	050541	1.5705	34.58	050594	1.7218	30.50	050685	1.2160	32.57
050317		21.69	050392	0.9510	23.02	050457	1.6199	38.30	050542	1.0198	16.49	050597	1.2903	22.90	050686	1.2508	35.54
050320	1.2272	31.15	050393	1.4703	25.91	050464	1.7424	25.38	050543	0.8629	22.41	050598	1.2550	25.68	050688	1.1258	31.29
050324	2.0207	26.99	050394	1.5619	23.14	050468	1.5316	23.79	050545	0.7727	31.73	050599	1.5637	29.33	050689	1.4986	30.73
050325	1.2393	25.57	050396	1.6585	24.14	050469	1.0325	23.93	050546	0.6865	32.09	050601	1.4770	31.42	050690	1.3144	33.15
050327	1.6181	24.06	050397	0.8335	20.97	050470	1.0961	16.17	050547	0.8104	33.16	050603	1.3658	23.36	050693	1.2162	26.96
050329	1.2744	17.46	050401	0.9837	21.00	050471	1.6658	25.72	050548		35.76	050604	1.4187	34.21	050694	1.3336	23.23
050331	1.4044	22.28	050404	1.0558	17.60	050476	1.3077	22.66	050549	1.6508	27.33	050608	1.2767	18.25	050695	1.1842	21.16
050333	1.0599	19.76	050406	1.0536	18.88	050477	1.4892	28.58	050550	1.3328	24.79	050609	1.5732	35.23	050696	2.0674	27.90
050334	1.7234	34.42	050407	1.2790	29.97	050478	0.9611	24.58	050551	1.3155	25.61	050613	1.0324	26.17	050697	1.1678	21.16
050335	1.3895	23.50	050410	0.9752	17.68	050481	1.4495	28.11	050552	1.1761	22.65	050615	1.4612	23.96	050699	0.5929	20.44

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
050701	1.3041	19.00	060031	1.4940	21.26	060107	1.2629	12.04	080004	1.2728	23.94	100034	1.7330	18.15*	100081	1.0733	14.84
050704	1.0440	22.90	060032	1.4783	22.71	060109	1.2053		080006	1.3233	19.72	100035	1.6432	20.24	100082		18.78
050707	1.0969	26.27	060033	1.0888	15.91	070001	1.8220	26.01	080007	1.3638	21.08	100038	1.8869	23.47	100084	1.5856	22.70
050708	1.4624	22.78	060034	1.5456	21.79	070002	1.8248	26.29	090001	1.5805	21.77	100039	1.5107	21.54	100085		22.12
050709	1.2384	21.96	060036	1.1020	15.38	070003	1.1624	25.82	090002	1.2115	19.71	100040	1.7877	19.17	100086	1.2173	21.79
050710	1.3005	26.91	060037	0.9888	15.75	070004	1.2746	22.49	090003	1.3600	22.13	100043	1.2939	18.91	100087	1.8911	23.35
050713	0.8043	17.73	060038	0.8834	14.22	070005	1.4166	26.70	090004	1.8650	24.36	100044	1.3454	21.53	100088	1.6760	20.02
050714	1.2788	24.94	060041	0.8407	17.78	070006	1.3491	27.66	090005	1.3332	23.91	100045	1.3468	21.01	100090	1.3664	21.70
050717	1.3784	26.85	060042	0.9951	19.65	070007	1.3027	26.48	090006	1.3410	21.08	100046	1.3502	20.05	100092	1.5614	20.17
050718	0.8088	17.61	060043	0.8853	13.86	070008	1.2561	23.42	090007	1.5039	22.20	100047	1.8051	20.12	100093	1.6726	16.66
050719	2.5595	25.55	060044	1.3091	19.90	070009	1.1586	23.71	090008	1.4737	20.23	100048	0.9430	15.25	100098	1.0452	19.30
050720	0.8806		060046	1.0232	19.44	070010	1.6689	25.99	090010	1.1445	24.13	100049	1.1975	18.85	100099	1.1700	15.88
050721	1.3599		060047	1.0139	17.57	070011	1.3718	23.44	090011	2.1410	27.40	100050	1.2993	17.25	100102	1.0391	19.10
050722	1.1328		060049	1.3706	32.06	070012	1.2279	23.31	100001	1.5535	19.03	100051	1.3413	22.98	100103	0.9650	17.24
050723	1.1372		060050	1.2370	18.38	070015	1.4039	23.83	100002	1.3985	20.80	100052	1.3219	19.36	100105	1.4124	21.81
060001	1.6607	21.50	060052	1.0063	13.86	070016	1.4794	24.96	100004	0.9642	14.85	100053	1.1962	20.24	100106	1.0387	17.39
060003	1.2464	19.91	060053	0.9789	16.01	070017	1.4040	26.43	100006	1.6035	21.02*	100054	1.2561	22.69	100107	1.2762	20.19
060004	1.2407	23.03	060054	1.3802	22.95	070018	1.3593	28.13	100007	1.8823	22.81	100055	1.3620	18.09	100108	0.9784	20.56
060006	1.1971	19.51	060056	0.9290	18.32	070019	1.2555	25.73	100008	1.6963	20.53	100056	1.5305	25.90	100109	1.3755	17.03
060007	1.1130	17.69	060057	1.0415	26.56	070020	1.3599	24.18	100009	1.5188	21.35	100057	1.3391	20.24	100110	1.3848	21.16
060008	1.0591	18.10	060058	0.9435	16.62	070021	1.1984	25.36	100010	1.4760	21.92	100059	1.9893		100112	1.0418	
060009	1.5798	21.75	060060	0.8847	16.03	070022	1.8512	26.79	100012	1.6474	19.61	100060	1.7354	23.44	100113	1.7293	24.16
060010	1.6149	24.21	060062	0.8820	18.70	070024	1.3331	25.36	100014	1.4035	19.16	100061	1.4170	21.70	100114	1.3604	21.76
060011	1.3116	23.61	060064	1.4307	21.41	070025	1.8542	25.32	100015	1.4231	18.61	100062	1.7076	19.09	100117	1.2254	20.74
060012	1.4015		060065	1.3054	21.74	070027	1.3019	23.74	100017	1.6819	19.19	100063	1.2343	19.01	100118	1.1397	26.62
060013	1.3105	23.47	060066	0.9651	18.00	070028	1.5485	24.77	100018	1.5502	20.39	100067	1.3635	18.15	100121	1.1637	
060014	1.8362	22.91	060070	1.1094	17.42	070029	1.3317	22.18	100019	1.6468	20.97	100068	1.3245	20.28	100122	1.1574	19.42
060015	1.5978	21.07	060071	1.2312	17.84	070030	1.0954	29.05	100020	1.2541	21.53	100069	1.3151	16.83	100124	1.2712	17.13
060016	1.1378	16.78	060073	0.8801	16.02	070031	1.2789	23.88	100022	1.7844	26.79	100070	1.4642	16.75	100125	1.2053	18.95
060018	1.2592	20.41	060075	1.2325	24.22	070033	1.3762	30.60	100023	1.3041	20.33	100071	1.2406	17.56	100126	1.4299	19.79
060020	1.6920	18.53	060076	1.4509	20.14	070034	1.4300	29.61	100024	1.2288	22.07	100072	1.2476	20.90	100127	1.5688	20.16
060022	1.5334	21.14	060085	0.9227	14.79	070035	1.4153	23.19	100025	1.7128	18.78*	100073	1.7104	21.24	100128	2.2110	20.44
060023	1.6360	19.53	060088	1.0675	27.99	070036	1.7766	28.86	100026	1.6560	20.81	100075	1.5161	18.41	100129	1.2952	19.16
060024	1.6914	22.04	060090	0.8350	22.36	070038	0.9784		100027	0.9696	19.29	100076	1.3282	17.98	100130	1.2695	18.67
060027	1.6360	21.04	060096	1.2942	22.28	070039	0.9154	30.12	100028	1.2189	19.36	100077	1.3677	22.00	100131	1.3142	23.33
060028	1.5280	23.25	060100	1.5432	21.42	080001	1.6499	25.62	100029	1.2934	20.95	100078	1.0126	18.65	100132	1.2678	18.18
060029	0.8602	21.44	060103	1.3721	24.82	080002		19.77	100030	1.2240	21.95	100079	1.4734		100134	1.0026	15.71
060030	1.3103	20.76	060104	1.2589	22.24	080003	1.3355	22.29	100032	1.8440	19.74	100080	1.6017	22.16	100135	1.5395	18.96*

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
100137	1.2039	18.79	100204	1.5506	20.14	100256	2.0964	20.81	110018	1.1364	19.74	110069	1.2541	19.38	110120	1.0471	15.26
100138	0.9867	17.91	100206	1.3714	19.65	100258	1.6079	21.42	110020	1.2453	18.29	110070	1.1370	22.19	110121	1.1598	16.30
100139	1.0410	15.96	100208	1.3622	20.77	100259	1.3122	20.52	110023	1.3537	23.93	110071	1.0981	15.22	110122	1.3667	21.23
100140	1.1463	17.12	100209	1.4895	22.11	100260	1.4172	20.37	110024	1.3610	20.77	110072	0.9629	12.83	110124	1.1254	
100142	1.2539	19.68	100210	1.5739	21.65	100262	1.3754	20.04	110025	1.3340	19.95	110073	1.1550	15.45	110125	1.2699	20.18
100144		12.29	100211	1.3116	20.90	100264	1.3555	18.90	110026	1.1413	17.00	110074	1.5135	21.44	110127	0.9462	17.30
100146	0.9755	18.16	100212	1.6038	19.42	100265	1.3060	18.92	110027	1.1318	16.86	110075	1.3350	18.65	110128	1.2154	18.46
100147	1.0461	14.97	100213	1.5127	20.55	100266	1.3878	18.30	110028	1.7739	19.90	110076	1.4376	21.43	110129	1.6410	19.27
100150	1.3626	21.46	100217	1.2329	21.02	100267	1.3403	20.45	110029	1.3622	20.68	110078	1.7632	22.39	110130	0.9648	16.57
100151	1.7573	21.22*	100220	1.6372	20.56	100268	1.2059	23.94	110030	1.3111	18.77	110079	1.3823	21.18	110132	1.1773	16.45
100154	1.5564	20.23	100221	1.9727	17.44	100269	1.4284	21.71	110031	1.2248	19.24	110080	1.2814	18.48	110134	0.9264	12.58
100156	1.1115	19.26	100223	1.4609	20.02	100270	1.0078	13.04	110032	1.2322	15.77	110082	2.0916	23.91	110135	1.3458	17.75
100157	1.5744	22.68	100224	1.3095	20.28	100271	1.8579	20.42	110033	1.4387	22.45	110083	1.7825	23.23	110136	1.1662	21.44
100159	0.8689	10.28	100225	1.2952	20.71	100275	1.3926	21.00	110034	1.6681	19.65	110086	1.3511	18.60	110140	0.9171	18.29
100160	1.1972	20.56	100226	1.3762	19.94	100276	1.2174	22.64	110035	1.3958	19.44	110087	1.3976	21.91	110141	1.0114	13.25
100161	1.6930	22.48	100228	1.2631	21.29	100277	0.9851	22.71	110036	1.8407	17.51	110089	1.2177	18.67	110142	0.9250	14.88
100162	1.4197	19.80	100229	1.3076	19.76	100279	1.2484	20.03	110038	1.5125	17.87	110091	1.2450	19.53	110143	1.3856	20.20
100165		19.15	100230	1.3689	20.52	100280	1.3265	17.37	110039	1.3617	20.96	110092	1.0867	17.52	110144	1.0713	16.87
100166	1.4570	20.09	100231	1.6423	18.00	100281	1.2848	22.48	110040	1.0234	17.64	110093	0.9417		110146	1.1440	16.13
100167	1.4347	23.39	100232	1.2503	19.51	100282	1.0730	21.01	110041	1.1572	19.24	110094	0.9977	14.71	110149	1.1393	18.13
100168	1.3326	20.22	100234	1.3547	20.48	100284	1.1182		110042	1.1760	24.39	110095	1.3290	16.50	110150	1.3930	20.36
100169	1.8050	20.41	100235		17.41	100366	0.5957		110043	1.8283	20.17	110096	1.1208	16.85	110152	1.0312	15.40
100170	1.3538	18.70	100236	1.3938	20.17	110001	1.2994	19.34	110044	1.1327	16.51	110097	1.0167	16.21	110153	1.1318	19.28
100172	1.4356	14.62	100237	2.1470	22.13	110002	1.2790	17.23	110045	1.1495	20.33	110098	0.9545	17.24	110154	1.0059	15.15
100173	1.6941	18.70	100238	1.6304	19.77	110003	1.3398	18.41	110046	1.3087	20.23	110100	0.9897	18.72	110155	1.0125	15.66
100174	1.3537	26.64	100239	1.4050	21.58	110004	1.3361	19.98	110048	1.1241	16.43	110101	1.0025	11.06	110156	1.0322	15.18
100175	1.1222	17.45	100240	0.8726	20.71	110005	1.1325	18.20	110049	1.1587	16.18	110103	0.9633	15.15	110161	1.2930	21.74
100176	2.1358	23.33	100241	0.8330	15.16	110006	1.4064	21.07	110050	1.1060	21.16	110104	1.1311	16.19	110162	0.7571	
100177	1.3008	26.39	100242	1.4081	18.04	110007	1.6005	27.56	110051	1.0215	17.48	110105	1.3065	17.21	110163	1.5140	20.50
100179	1.7907	17.85	100243	1.3648	21.43	110008	1.1634	22.14	110054	1.4006		110107	1.9709	19.44	110164	1.4087	20.50
100180	1.4286	20.26	100244	1.3264	18.65	110009	1.1607	16.31	110056	1.0315	15.65	110108	0.9625	23.29	110165	1.5036	21.40
100181	1.2051	23.32	100246	1.4822	19.79	110010	2.1808	23.39	110059	1.1805	16.67	110109	1.1051	16.54	110166	1.4852	20.68
100183	1.2036	24.61	100248	1.5204	20.79	110011	1.1584	18.78	110061	1.0899	15.04	110111	1.2216	15.10	110168	1.7175	20.95
100187	1.4004	20.36	100249	1.2561	19.33	110013	1.0518	16.30	110062	0.9080	19.28	110112	1.0140	20.90	110169	1.2966	20.64
100189	1.3222	21.37	100252	1.2092	17.85	110014	0.9597	16.32	110063	1.0042	17.16	110113	1.0481	16.82	110171	1.6355	24.38
100191	1.3015	17.64	100253	1.3553	21.17	110015	1.1568	21.21	110064	1.4462	18.96	110114	1.1384	14.75	110172	1.4379	23.79
100199		21.79	100254	1.5509	19.15	110016	1.1898	23.96	110065	1.0364	15.25	110115	1.7009		110174	0.8945	14.10
100200	1.3088	22.58	100255	1.2584	23.81	110017	0.9476	13.78	110066	1.4927	21.10	110118	1.0955	23.51	110177	1.6242	20.68

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
110178		18.90	120009	1.0057	17.84	130026	1.1734	21.84	140025	1.0508	17.02	140070	1.1887	24.38	140121	1.3419	17.71
110179	1.1374	23.09	120010	1.7786	24.28	130027	0.9291	23.44	140026	1.1498	16.93	140074	0.9349	20.16	140122	1.5459	24.29
110181	0.9751	14.16	120011	1.4448	35.67	130028	1.2811	26.07	140027	1.2125	18.90	140075	1.2772	21.57	140124	1.1060	27.21*
110183	1.3534	23.55	120012	0.8988	23.92	130029	1.0949	18.84	140029	1.3319	22.54	140077	1.0509	17.54	140125	1.3141	18.28
110184	1.3226	22.20	120014	1.2487	23.30	130030	0.9563	19.23	140030	1.8578	21.75	140079	1.1963	23.68	140127	1.4113	20.21
110185	1.2365	16.97	120015	0.8200	48.18	130031	0.9559	18.68	140031	1.1664	19.90	140080	1.4883	21.22	140128	1.0088	19.99
110186	1.3170	17.36	120016	1.0310	52.50	130034	1.0449	17.70	140032	1.2580	18.16	140081	1.0321	16.97	140129	1.1860	18.45
110187	1.2613	20.12	120018	0.9098	32.43	130035	0.9055	19.68	140033	1.2931	24.30	140082	1.3063	22.30	140130	1.1985	18.29
110188	1.3286	25.40	120019	1.2769	23.15	130036	1.3872	14.05	140034	1.2076	19.47	140083	1.3317	19.64	140132	1.4693	23.48
110189	1.1100	22.08	120021	0.9952	26.79	130037	1.4342	18.96	140035	1.0669	16.10	140084	1.2544	20.98	140133	1.3805	21.21
110190	1.0680	18.87	120022	1.6672	21.83	130043	0.9501	16.51	140036	1.2546	18.82	140086	1.0728	18.71	140135	1.2660	17.24
110191	1.3128	20.20	120024	0.6619	51.59	130044	0.9331	18.32	140037	1.0534	13.12	140087	1.3629	16.12	140137	1.0603	17.26
110192	1.3985	21.64	120025		85.75	130045	0.9546	16.80	140038	1.0615	18.35	140088	1.7642	25.38	140138	0.9863	17.19
110193	1.2433	21.07	120026	1.2790	25.17	130048	1.0584	17.07	140040	1.1954	20.35	140089	1.2799	17.85	140139	1.0648	
110194	0.9213	15.45	120027	1.4784	24.56	130049	1.2594	20.47	140041	1.1947	18.85	140090	1.4459	23.88	140140	1.1302	17.82
110195	1.0290	14.03	120028	1.3724	27.53	130054	1.0083	17.36	140042	0.9820	15.62	140091	1.8712	21.06	140141	1.2260	17.74
110198	1.3135	23.96	130001	1.0337	19.01	130056	0.8268	18.65	140043	1.1608	19.67	140093	1.1358	19.69	140143	1.0788	19.39
110200	1.8356	17.49	130002	1.3192	16.76	130060	1.3135	22.21	140045	1.0035	16.35	140094	1.2582	21.72	140144	0.9808	21.98
110201	1.4260	20.49	130003	1.3082	21.63	130061		15.77	140046	1.3002	19.39	140095	1.3695	27.29	140145	1.1325	17.89
110203	0.9334	31.72	130005	1.3949	20.90	130062	0.7754	16.57	140047	1.1762	17.91	140097	0.9335	18.77	140146	1.0380	22.49
110204	0.7991	33.44	130006	1.8249	19.40	130063	1.6847	15.94	140048	1.3599	22.34	140100	1.3423	21.45	140147	1.2077	16.68
110205	1.0120	17.27	130007	1.6719	21.03	140001	1.2145	16.68	140049	1.6853	30.36	140101	1.1731	21.87	140148	1.8759	18.71
110207	0.9441	12.97	130008	0.9489	13.37	140002	1.2420	19.14	140051	1.4534	24.10	140102	1.0750	17.59	140150	1.5435	21.47
110208	0.9274	15.37	130009	0.9555	19.66	140003	1.0111	22.02	140052	1.2817	19.80	140103	1.3599	19.39	140151	0.9278	21.39
110209	0.6581	17.92	130010	0.9805	17.90	140004	1.1019	15.92	140053	2.0552	19.26	140105	1.2652	21.74	140152	1.1974	23.72
110211	0.9720	21.04	130011	1.2328	20.62	140005	0.9948	11.61	140054	1.3702	22.39	140107	0.9540	11.22	140155	1.3274	18.75
110212	1.0169	11.87	130012	0.9391	22.98	140007	1.4604	24.10	140055	0.9840	16.79	140108	1.3349	26.02	140158	1.3318	22.72*
110213		14.37	130013	1.3159	17.58	140008	1.4757	21.50	140058	1.3095	17.58	140109	1.1401	15.93	140160	1.1495	17.94
110215	1.1707	20.19	130014	1.2634	19.17	140010	1.3745	27.94	140059	1.1043	15.07	140110	1.1861	19.48	140161	1.1361	20.32
110216	1.6858		130015	0.8869	16.81	140011	1.1662	18.03	140061	1.1028	17.99	140112	1.0909	18.09	140162	1.8114	19.74
110217	1.0577		130016	0.9572	17.58	140012	1.2799	22.82	140062	1.2480	28.22	140113	1.5020	19.16	140164	1.4382	18.85
120001	1.7540	28.06	130017	1.0086	18.90	140013	1.5939	18.39	140063	1.4962	25.63	140114	1.3189	21.42	140165	1.1144	15.02
120002	1.2815	25.07	130018	1.4858	19.74	140014	1.1517	22.85	140064	1.2611	19.27	140115	1.2987	21.28	140166	1.1636	20.53
120003	1.0698	26.46	130019	1.1067	19.58	140015	1.2389	16.84	140065	1.4178	22.38	140116	1.2351	22.94	140167	1.1025	17.45
120004	1.2052	24.81	130021	1.1733	13.27	140016	1.0256	13.17	140066	1.1876	17.46	140117	1.5533	20.80	140168	1.2011	16.97
120005	1.2648	23.77	130022	1.2526	16.85	140018	1.3475	23.18	140067	1.7548	19.38	140118	1.7417	18.56	140170	1.1423	16.57
120006	1.2589	25.24	130024	1.1081	19.54	140019	1.0146	16.92	140068	1.4635	19.42	140119	1.7596	36.39	140171	0.9868	14.23
120007	1.7566	22.93	130025	1.1204	17.58	140024	0.9850	17.45	140069	0.9770	17.23	140120	1.3480	15.52	140172	1.7242	21.67

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
140173	0.9322	16.95	140231	1.5294	23.98	150011	1.1585	18.69	150054	1.2297	17.50	150101	1.0464	16.85	160018	0.9389	14.62
140174	1.5623	20.68	140233	1.7468	19.66	150012	1.5923	23.09	150056	1.8571	21.52	150102	1.0818	19.75	160020	1.1361	15.87
140176	1.2127	23.41	140234	1.2132	19.46	150013	1.0472	17.15	150057	2.1553	16.83	150103	1.0077	16.26	160021	1.0003	16.88
140177	1.3061	18.76	140236		7.62	150014	1.5418	23.54	150058	1.7023	20.85	150104	1.0517	17.66	160023	1.0324	15.34
140179	1.3324	21.32	140239	1.6466	18.88	150015	1.2954	23.63	150059	1.4207	21.78	150105	1.2897	21.89	160024	1.5676	19.78
140180	1.4295	23.76	140240	1.3571	23.79	150017	1.8547	18.80	150060	1.1522	13.12	150106	0.9748	13.64	160026	0.9777	19.11
140181	1.4247	20.78	140242	1.6250	24.18	150018	1.4847	20.43	150061	1.2127	17.74	150109	1.4461	18.76	160027	1.0597	16.98
140182	1.3455	22.20	140245	1.1866	13.48	150019	1.1071	10.53	150062	1.0030	20.80	150110	0.9738	17.33	160028	1.2297	20.24
140184	1.1885	17.82	140246	1.0445	13.54	150020	1.0754	15.40	150063	1.0279	34.54	150111	1.1107	21.80	160029	1.5420	20.79*
140185	1.4702	17.74	140250	1.2949	25.23	150021	1.6487	19.56	150064	1.1317	18.38	150112	1.2495	21.03	160030	1.3379	20.14
140186	1.3253	19.98	140251	1.3477	21.20	150022	1.1219	34.07	150065	1.1822	20.08	150113	1.2253	15.27	160031	1.0457	15.38
140187	1.6341	18.01	140252	1.4860	25.28	150023	1.5935	14.73	150066	0.9689	15.49	150114	0.9413	19.85	160032	1.1105	17.44
140188	0.9867	15.60	140253	1.1846	18.00	150024	1.3963	19.62	150067	1.1267	18.48	150115	1.2701	17.41	160033	1.8669	19.07
140189	1.2402	21.34	140258	1.5226	23.47	150025	1.4278	18.79	150069	1.1725	23.17	150122	1.1113	21.26	160034	1.1044	15.12
140190	1.0811	16.91	140271	0.9409	12.64	150026	1.2243	21.26	150070	0.9413	18.31	150123	1.0230	15.87	160035	0.8424	16.37
140191	1.3919	26.13	140275	1.2797	20.61	150027	1.0116	17.42	150071	1.1045	16.98	150124	1.1597	14.74	160036	0.9862	18.39
140193	0.9706	16.16	140276	2.0040	27.10	150029	1.3671	24.65	150072	1.1972	16.34	150125	1.4701	20.71	160037	1.0340	19.31
140197	1.2487	18.82	140280	1.4493	20.25	150030	1.2747	18.15	150073	1.0451	23.02	150126	1.4199	21.52	160039	1.0222	17.85
140199	1.0745	18.76	140281	1.6266	24.08*	150031	1.0534	17.46	150074	1.6460	16.94	150127	1.0387	19.74	160040	1.3519	18.37
140200	1.5277	21.88	140285	1.2589	18.35	150033	1.5650	22.26	150075	1.1630	15.84	150128	1.2584	18.51	160041	1.0093	16.98
140202	1.3151	22.27	140286	1.1210	20.51	150034	1.4363	22.15	150076	1.1131	23.62	150129	1.1500	24.16	160043	1.0518	15.92
140203	1.1800	20.13	140288	1.6143	25.24	150035	1.4780	20.51	150078	1.0215	19.68	150130	1.3292	18.47	160044	1.2213	16.95
140205	1.3543	18.68	140289	1.3225	17.22	150036	1.0024	20.93	150079	1.2053	19.15	150132	1.4176	16.04	160045	1.7235	18.57
140206	1.2300	21.33	140290	1.3084	21.01	150037	1.2352	22.08	150082	1.5235	17.66	150133	1.2309	16.95	160046	0.9295	14.58
140207	1.2556	22.46	140291	1.3210	25.18	150038	1.1475	21.39	150084	1.9332	19.57	150134	1.0730	19.85	160047	1.4782	18.51
140208	1.6993	26.05	140292	1.2043	21.65	150039	0.9631	18.85	150086	1.2064	19.17	150136	0.8719	19.83	160048	1.1574	14.86
140209	1.5937	18.32	140294	1.1361	17.83	150042	1.2981	18.47	150088	1.3253	17.15	150145		16.69	160049	0.9884	14.60
140210	1.1269	15.96	140300	1.5103	13.58	150043	1.1319	18.81	150089	1.5044	23.29	160001	1.2877	18.73	160050	1.0153	17.86
140211	1.2322	21.91	150001	1.0957	26.36	150044	1.2398	18.73	150090	1.4092	21.17	160002	1.0992	16.23	160051	1.0519	14.90
140213	1.2808	20.79	150002	1.4832	20.21	150045	1.1096	16.91	150091	1.0178	21.59	160003	1.0319	16.26	160052	0.9904	18.25
140215	0.9836	16.20	150003	1.7985	21.07	150046	1.4223	17.74	150092	1.0648	16.93	160005	1.1415	18.05	160054	1.0986	16.35
140217	1.3134	22.58	150004	1.5367	20.93	150047	1.5506	19.33	150094	1.0057	15.52	160007	1.0002	13.21	160055	0.9200	14.85
140218	0.9792	15.25	150005	1.1291	21.53	150048	1.1828	19.44	150095	1.0586	17.44	160008	1.1113	16.23	160056	1.1024	16.69
140220	1.1316	18.06	150006	1.2658	20.90	150049	1.1880	17.20	150096	0.9845	23.66	160009	1.1937	17.28	160057	1.2729	18.52
140223	1.5140	25.05	150007	1.1809	16.89	150050	1.0893	16.66	150097	1.0621	19.57	160012	0.9913	17.01	160058	1.8122	21.21
140224	1.3999	25.54	150008	1.3775	22.28	150051	1.4773	19.21	150098	1.1272	15.25	160013	1.2073	18.47	160060	1.0746	16.83
140228	1.6649	19.74	150009	1.3774	19.30	150052	1.0272	15.52	150099		22.57	160014	1.0396	16.11	160061	1.0826	18.11
140230	0.9221	18.09	150010	1.3388	22.49	150053	0.9660	19.45	150100	1.5702	16.30	160016	1.1903	19.84	160062	0.9842	19.19

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
160063	1.0211	17.04	160108	1.0646	16.13	170014	1.0176	18.04	170067	0.9801	14.98	170117	0.8927	17.16	180006	0.9735	11.69
160064	1.5659	20.89	160109	1.2001	17.69	170015	0.9416	16.75	170068	1.3082	15.29	170119	0.9504	16.19	180007	1.4008	17.39
160065	1.0393	17.21	160110	1.5342	19.35	170016	1.6722	19.13	170070	0.9589	14.39	170120	1.2807	17.79	180009	1.3429	21.59
160066	1.0697	17.30	160111	1.0094	15.13	170017	1.1999	18.00	170072	0.8337	12.80	170122	1.7035	20.23	180010	1.9313	19.24
160067	1.4185	17.99	160112	1.3703	17.16	170018	1.0352	15.54	170073	1.0589	18.34	170123	1.7174	22.72	180011	1.3328	17.34
160068	1.0723	18.58	160113	1.0596	14.91	170019	1.2559	15.27	170074	1.1480	17.64	170124	1.0059	11.13	180012	1.3887	18.78
160069	1.5079	20.15	160114	0.9688	16.14	170020	1.4610	17.54	170075	0.9131	12.46	170126	0.9279	12.96	180013	1.4581	18.45
160070	0.9292	17.26	160115	0.9783	16.20	170022	1.1251	18.92	170076	0.9228	14.59	170128	0.9649	15.17	180014	1.6406	21.36
160072	1.0487	15.01	160116	1.0496	17.15	170023	1.4054	19.39	170077	0.9011	14.33	170131		10.36	180016	1.2475	19.90
160073	0.9884	11.92	160117	1.3358	18.15	170024	1.0585	14.05	170079	1.0030	14.33	170133	1.0859	18.35	180017	1.2688	15.47
160074	0.9931	20.17	160118	1.0374	17.86	170025	1.1883	18.89	170080	1.0169	13.01	170134	0.8900	14.23	180018	1.2839	17.48
160075	1.1054	19.72	160120	0.9606	10.74	170026	1.0303	16.85	170081	0.9175	13.81	170137	1.1928	17.95	180019	1.1622	17.03
160076	1.0718	18.00	160122	1.0901	19.12	170027	1.2437	17.56	170082	0.9560	14.08	170139	0.9665	15.26	180020	1.0889	17.87
160077	1.1129	13.07	160124	1.2761	18.32	170030	0.9983	15.07	170084	0.8997	12.77	170142	1.3127		180021	1.0609	15.54
160079	1.4266	17.73	160126	1.0585	19.21	170031	0.8973	13.96	170085	0.8802	15.48	170143	1.0799	15.75	180023	0.8665	15.88
160080	1.1622	19.15	160129	0.9327	17.12	170032	1.0182	15.85	170086	1.6293	20.46	170144	1.4694	19.40	180024	1.2659	16.10
160081	1.1172	17.06	160130	1.0192	16.57	170033	1.3730	16.99	170088	0.9382	13.46	170145	1.0640	17.51	180025	1.1444	14.25
160082	1.8726	19.70	160131	1.0662	15.62	170034	1.0450	15.85	170089	0.8582	19.30	170146	1.4356	20.84	180026	1.1076	14.95
160083	1.6807	20.78	160134	0.9873	13.56	170035	0.9164	27.81	170090	1.0301	12.36	170147	1.1943	22.36	180027	1.2091	16.98
160085	1.0382	18.04	160135	0.9326	18.66	170038	0.8638	14.73	170093	0.9153	14.13	170148	1.2950	16.92	180028	1.0858	20.41
160086	0.9072	18.60	160138	1.0465	16.87	170039	1.0413	16.15	170094	0.9426	20.53	170150	1.1364	15.72	180029	1.2276	17.97
160088	1.0949	22.04	160140	1.1065	18.54	170040	1.6272	22.55	170095	1.0077	15.66	170151	1.0244	13.99	180030	1.1120	17.69
160089	1.2305	17.23	160142	0.9674	16.43	170041	1.0890	11.80	170097	0.9080	16.49	170152	0.9660	15.00	180031	1.0033	15.16
160090	1.0153	17.25	160143	1.1451	16.83	170044	0.9420	15.36	170098	1.1150	15.66	170160	0.9345	13.83	180032	1.0535	17.17
160091	0.9832	13.17	160145	1.0588	14.65	170045	1.0835	15.93	170099	1.2266	14.22	170164	0.9491	16.94	180033	1.0826	18.01
160092	1.0496	16.11	160146	1.4375	16.74	170049	1.4427	20.04	170101	0.8928	14.65	170166	1.0387	29.44	180034	1.0203	15.58
160093	1.0734	18.39	160147	1.2878	17.60	170051	0.9580	15.15	170102	1.0037	13.78	170171	1.0039	13.58	180035	1.5441	20.13
160094	1.1678	19.06	160151	0.9959	17.16	170052	1.0777	15.08	170103	1.2993	17.38	170175	1.3130	17.36	180036	1.1678	19.90
160095	1.0552	15.59	160152	1.0254	15.81	170053	0.9645	7.58	170104	1.4782	20.84	170176	1.5640	18.28	180037	1.2569	20.09
160097	1.1329	16.32	160153	1.7606	20.38	170054	1.0498	14.50	170105	1.1438	16.79	170180		16.66	180038	1.4853	16.72
160098	0.9348	16.38	170001	1.1892	18.19	170055	0.9154	17.21	170106	0.9683	19.62	170182	1.4966	22.23	180040	1.9519	19.66
160099	0.9635	13.95	170004	1.0619	15.12	170056	0.9143	17.81	170109	1.0107	17.48	170183	1.9776	20.35	180041	1.1638	15.15
160101	1.1114	18.80*	170006	1.2255	17.42	170057		13.18	170110	0.9667	17.19	170185	1.0648		180042	1.1410	17.00
160102	1.3545	19.03	170008	0.9966	15.02	170058	1.1530	19.53	170112	1.1397	14.39	170186	2.9004		180043	1.1423	16.20
160103	0.9429	17.82	170009	1.1527	21.21	170060	0.9519	18.32	170113	1.1136	14.08	180001	1.3209	18.11	180044	1.1999	18.56
160104	1.1628	18.93	170010	1.2814	19.07	170061	1.1127	16.08	170114	0.9557	14.68	180002	1.0407	18.14	180045	1.2684	18.05
160106	1.1341	17.49	170012	1.4501	17.92	170063	0.8893	14.04	170115	0.9614	12.92	180004	1.0444	17.73	180046	1.0406	18.99
160107	1.1097	18.29	170013	1.4698	18.88	170066	0.9044	16.60	170116	1.0952	17.14	180005	1.2267	21.28	180047	1.0352	16.86

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
180048	1.2342	18.46	180118	0.9295	15.86	190019	1.7402	18.62	190102	1.6401	20.15	190164	1.1634	15.23	200006	1.0504	18.34
180049	1.3081	16.49	180120	0.9692	16.34	190020	1.1626	17.72	190103	0.9168	13.07	190167	1.0900	16.76	200007	1.0330	18.66
180050	1.2654	18.12	180121	1.1361	15.43	190025	1.2831	19.10	190106	1.1527	18.83	190170	0.9043	14.70	200008	1.2740	21.38
180051	1.4125	16.45	180122	1.1059	18.99	190026	1.5272	18.44	190109	1.1514	16.53	190173	1.3080	24.21	200009	1.8712	22.24
180053	1.0502	15.97	180123	1.3658	20.19	190027	1.4898	17.13	190110	0.9774	16.24	190175	1.4262	19.62	200012	1.1265	18.52
180054	1.1186	19.95	180124	1.2790	17.32	190029	1.1610	16.93	190111	1.5886	19.89	190176	1.5572	17.58	200013	1.1611	18.17
180055	1.2850	15.59	180125	1.0624	20.54	190034	1.1761	17.00	190112	1.5532	21.17	190177	1.6845	18.82	200016	1.0177	17.92
180056	1.1852	17.20	180126	1.0687	12.92	190036	1.6914	21.71	190113	1.3710	12.58	190178	0.9686	11.07	200017		17.32
180058	0.9988	16.24	180127	1.2661	18.96	190037	0.9934	13.43	190114	1.0211	12.84	190182	1.1484	20.04	200018	1.1142	19.07
180059	0.8724	13.79	180128	1.0360	17.74	190039	1.4035	19.89	190115	1.2492	20.74	190183	1.1608	16.88	200019	1.2344	19.28
180063	1.1129	13.18	180129	0.9539	18.74	190040	1.3555	21.73	190116	1.2103	15.75	190184	0.9908	17.20	200020	1.1903	22.43
180064	1.2176	15.42	180130	1.4281	19.63	190041	1.5882	17.75	190118	0.9775	15.03	190185	1.3260	20.14	200021	1.1099	19.99
180065	1.0270	12.16	180132	1.2196	17.43	190043	1.0172	15.92	190120	1.0735	13.96	190186	0.9141	19.92	200023	0.8538	17.27
180066	1.0038	18.24	180133	1.3312	21.82	190044	1.1783	17.39	190122	1.2423	15.50	190190	0.9308	17.46	200024	1.4168	19.21
180067	1.9385	20.68	180134	1.0873	13.22	190045	1.5202	21.88	190124	1.6154	20.98	190191	1.1531	20.11	200025	1.1537	20.25
180069	1.1014	18.10	180136		17.39	190046	1.4126	20.14	190125	1.4919	20.70	190196	0.8609		200026	1.0690	18.52
180070	1.1376	13.21	180138	1.1657	19.49	190048	1.1250	16.99	190128	1.1739	20.51	190197	1.2088	19.68	200027	1.2369	19.36
180072	1.0863	17.77	180139	1.0346	18.72	190049	0.9687	17.37	190130	0.9784	15.30	190199	1.2281	18.40	200028	0.9575	19.74
180078	1.1264	21.12	180140	0.9789	16.82	190050	1.0589	16.49	190131	1.2667	20.98	190200	1.5588	22.26	200031	1.2493	16.02
180079	1.1866	15.56	180141	1.7255	20.90	190053	1.1156	13.27	190133	0.9987	14.11	190201	1.2230	18.72	200032	1.2939	19.16
180080	1.0600	16.51	180142	1.7748		190054	1.3643	19.36	190134		12.17	190202	1.2092		200033	1.8152	21.90
180087	1.2453	14.93	180143	1.6713		190059	0.9281	16.09	190135	1.4479	21.91	190203	1.4662	21.83	200034	1.2558	20.58
180088	1.6592	22.07*	190001	0.8917	17.68	190060	1.4169	14.80	190136	0.9830	12.44	190204	1.4704	21.56	200037	1.2094	18.89
180092	1.2198	18.36	190002	1.7001	19.30	190064	1.5448	20.60	190140	0.9599	14.39	190205	1.8433	21.67	200038	1.1364	23.44
180093	1.5278	17.11	190003	1.4207	23.28	190065	1.4650	21.78	190142	0.9520	16.28	190206	1.6335	21.98	200039	1.2510	19.45
180094	0.9855	13.76	190004	1.4551	17.90	190071	0.9282	14.64	190144	1.1809	16.17	190207	1.1343	20.80	200040	1.1934	20.04
180095	1.0831	14.12	190005	1.4422	17.32	190077	0.9399	15.78	190145	0.9721	15.63	190208	0.8369	20.10	200041	1.1042	18.91
180099	1.0837	13.64	190006	1.2264	19.86	190078	1.1615	15.05	190146	1.5435	21.42	190218	0.9927	20.20	200043	0.8145	16.72
180101	1.0972	18.29	190007	1.0824	14.29	190079	1.2231	18.24	190147	0.9621	14.58	190227	0.9050		200050	1.2217	20.64
180102	1.5083	18.20	190008	1.5961	18.88	190081	0.8914	15.42	190148	0.8903	16.95	190231	1.4047	15.84	200051	0.9584	22.34
180103	2.2793	19.89	190009	1.2260	15.36	190083	0.9797	20.21	190149	0.9671	18.01	190236	1.5081	19.42	200052	0.9893	17.42
180104	1.5805	18.96	190010	1.0669	20.37	190086	1.3593	15.90	190151	0.9894	14.98	190237	2.1390		200055	1.0118	19.20
180105	0.8843	15.54	190011	1.1347	15.95	190088	1.1898	21.26	190152	1.4623	22.25	190238	2.2526		200062	0.9345	17.38
180106	0.8753	14.35	190013	1.2718	17.15	190089	1.1204	13.22	190156	0.9339	15.85	190239	1.2930		200063	1.1802	20.06
180108	0.8405	15.06	190014	1.1193	17.29	190090	1.1154	16.92	190158	1.2518	20.67	190240	0.9632		200066	1.1361	17.50
180115	1.0497	16.94	190015	1.2874	18.63	190095	1.0285	16.45	190160	1.2121	17.17	200001	1.2976	18.08	210001	1.3753	20.93
180116	1.2350	18.02	190017	1.3229	16.35	190098	1.7160	20.77	190161	0.9821	15.57	200002	1.1110	19.55	210002	1.9621	20.25
180117	1.0918	17.92	190018	1.1762	15.87	190099	1.2031	20.10	190162	1.1565	20.73	200003	1.1109	16.91	210003	1.5525	20.33

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
210004	1.3195	24.36	210051	1.3690	22.45	220051	1.1868	21.31	220106	1.1892	26.07	230036	1.2472	24.18	230097	1.6653	20.93
210005	1.2864	21.67	210054	1.3457	22.34	220052	1.2382	23.63	220108	1.1615	22.00	230037	1.2306	20.59	230099	1.1348	21.28
210006	1.0880	18.94	210055	1.2832	29.26	220053	1.1723	19.51	220110	2.0549	29.09	230038	1.7327	23.44	230100	1.1966	16.01
210007	1.8468	23.14	210056	1.3525	19.36	220055		21.43	220111	1.2402	23.82	230040	1.1241	21.57	230101	1.0863	20.23
210008	1.2729	21.22	210057	1.3546	23.99	220057	1.2992	22.75	220116	1.8631	25.84	230041	1.3354	20.40	230103	0.9822	23.27
210009	1.9467	20.56	210058	1.4744	22.14	220058	1.0710	20.24	220119	1.2669	23.39	230042	1.1918	22.20	230104	1.6221	23.05
210010	1.0715	18.75	210059	1.2079	23.18	220060	1.1968	28.28	220123	1.0807	25.91	230046	1.9200	25.53	230105	1.7571	21.33
210011	1.3803	21.47	210060	1.2209		220062	0.5885	20.47	220126	1.1977	22.65	230047	1.3071	21.70	230106	1.1915	21.17
210012	1.7055	20.87	210061	1.1161	17.69	220063	1.2558	20.56	220133	0.6689	25.67	230053	1.5884	25.64	230107	0.9343	19.02
210013	1.3654	19.85	220001	1.3269	22.08	220064	1.2030	22.53	220135	1.2664	25.65	230054	1.8717	19.51*	230108	1.2425	19.20
210015	1.3139	16.61	220002	1.4321	24.08	220065	1.2552	20.32	220153	0.9380		230055	1.1122	20.94	230110	1.3541	18.68
210016	1.7837	23.94	220003	1.0434	17.22	220066	1.3453	20.85	220154	0.9464	28.01	230056	0.9356	16.37	230113		14.94
210017	1.2279	19.03	220006	1.3490	22.46	220067	1.2798	26.69	220162	1.5785		230058	1.0859	20.74	230115	0.9648	
210018	1.2197	22.29	220008	1.3304	24.54	220070	1.1694	20.22	220163	1.9703	29.66	230059	1.4308	20.01	230116	0.9124	16.62
210019	1.6598	19.32	220010	1.3469	21.75	220071	1.9010	25.57	220171	1.7354	24.62	230060	1.4109	19.95	230117	1.8491	25.05
210022	1.4512	22.69	220011	1.1263	26.26	220073	1.3545	25.63	230001	1.1432	19.90	230062	0.9267	17.80	230118	1.0884	21.44
210023	1.3946	23.38	220012	1.3271	32.27	220074	1.3030	25.89	230002	1.2587	22.56	230063		20.44	230119	1.3257	21.19
210024	1.7214	20.57	220015	1.1649	22.66	220075	1.8206	23.05	230003	1.1858	19.98	230065	1.3511	22.61	230120	1.1253	19.01
210025	1.2928	19.65	220016	1.3228	23.63	220076	1.1840	23.08	230004	1.6726	23.36	230066	1.3369	22.06	230121	1.1805	27.13
210026	1.3244	12.12	220017	1.3167	22.70	220077	1.8427	25.61*	230005	1.2682	18.73	230069	1.2097	22.94	230122		19.49
210027	1.2599	17.79	220019	1.1179	19.79	220079	0.7692	22.84	230006	1.0054	19.33	230070	1.5124	20.13	230124	1.1531	20.03
210028	1.1842	19.64	220020	1.1917	21.46	220080	1.3225	21.62	230007		15.55	230071	1.1479	22.91	230128	1.3896	23.94
210029	1.2433	21.54	220023		16.53	220081	0.9782	29.81	230012	0.7495	15.15	230072	1.2377	20.83	230130	1.6936	23.55
210030	1.2541	21.75	220024	1.1828	21.66	220082	1.3036	21.71	230013	1.3276	20.86	230075	1.4576	20.14	230132	1.3969	26.37
210031	1.1427	16.30	220025	1.1444	20.83	220083	1.1983	24.00	230015	1.0852	20.27	230076	1.4467	11.61	230133	1.2282	17.90
210032	1.1942	17.73	220028	1.4819		220084	1.3035	23.82	230017	1.6066	21.31	230077	1.9906	21.08	230135	1.1630	22.88
210033	1.2612	20.87	220029	1.1950	23.49	220086	1.7729	25.66	230019	1.5438	19.33	230078	1.1603	17.78	230137		19.23
210034	1.2813	15.89	220030	1.1353	18.82	220088	1.6330	23.64	230020	1.7453	20.09	230080	1.2280	19.98	230141	1.6463	22.21
210035	1.2819	20.33	220031	1.6735	30.43	220089	1.2429	23.45	230021	1.5029	19.19	230081	1.2131	19.14	230142	1.2627	22.09
210037	1.2115	18.47	220033	1.2509	20.39	220090	1.2954	22.01	230022	1.1988	18.83	230082	1.0447	18.75	230143	1.2367	16.42
210038	1.4383	23.59	220035	1.2874	21.73	220092	1.1430	18.41	230024	1.3911	23.77	230085	1.2776	20.32	230144	1.0633	25.13
210039	1.1984	20.05	220036	1.6121	24.49	220094		24.31*	230027	1.0489	14.78	230086	1.0381	19.66	230145	1.1070	20.26
210040	1.2826	21.53	220038	1.3121	22.89	220095	1.2192	21.76	230029	1.6419	19.40	230087	1.0390	19.12	230146	1.3342	20.23
210043	1.2928	19.68	220041	1.2370	23.80	220098	1.2597	21.61	230030	1.3297	17.62	230089	1.3188	22.15	230147	1.3684	22.01
210044	1.3691	22.62	220042	1.2292	25.51	220100	1.3682	26.04	230031	1.4203	19.50	230092	1.3544	19.48	230149	1.1978	21.83
210045	1.1048	11.63	220046	1.3433	22.93	220101	1.4111	25.92*	230032	1.7072	21.90	230093	1.1861	20.16	230151	1.4626	20.69
210048	1.3354	23.11	220049	1.2918	25.83	220104		24.12	230034	1.2389	19.05	230095	1.1826	17.38	230153	0.9925	19.39
210049	1.1471	19.08	220050	1.1650	22.48	220105	1.2463	21.49	230035	1.1329	17.78	230096	1.0658	23.34	230154	0.8789	15.63

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
230155	0.9751	18.09	230227	1.4814	23.71	240017	1.1398	18.89	240073	0.8879	16.11	240117	1.1109	18.24	240172	0.9255	20.08
230156	1.6603	24.37	230230	1.5512	22.26	240018	1.2441	21.24	240075	1.1861	21.28	240119	0.8309	22.23	240173	0.9557	17.49
230157	0.9068	20.49	230235	1.0232	17.08	240019	1.3349	22.33	240076	1.0872	21.88	240121	0.9259	24.40	240179	0.9770	17.50
230159		20.18	230236	1.3535	22.67	240020	1.1768	21.61	240077	0.9462	16.24	240122	0.9925	20.01	240184	0.9886	16.99
230162	0.9995	23.34	230239	1.1417	18.25	240021	0.9236	23.29	240078	1.5281	23.92	240123	1.0359	17.51	240187	1.2632	20.43
230165	1.8185	23.02	230241	1.1341	19.33	240022	1.1192	22.02	240079	0.9403	18.84	240124	0.9314	19.85	240193	0.9640	17.95
230167	1.7841	20.72	230244	1.3672	21.78	240023	0.9420	22.89	240080	1.6105	24.42	240125	0.9009	12.41	240196	0.7812	24.35
230169	1.3469	26.34	230253	0.9338	20.89	240025	1.1749	18.61	240082	1.0530	18.42	240127	1.0022	17.83	240200	0.9238	14.74
230171	0.9835	13.39	230254	1.2766	22.00	240027	1.0210	20.01	240083	1.2035	20.32	240128	1.0644	17.41	240205	0.9292	
230172	1.2283	20.86	230257	0.9939	15.84	240028		20.83	240084	1.3005	19.85	240129	0.9580	14.52	240206	0.8149	
230174	1.3677	22.99	230259	1.1232	22.49	240029	1.1435	21.22	240085	1.0275	23.20	240130	0.9422	14.96	240207	1.1578	24.11
230175	2.7123	16.89	230264	1.4272	17.17	240030	1.2664	18.86	240086	1.0112	17.33	240132	1.2570	23.11	240210	1.2505	24.22
230176	1.2163	21.80	230269	1.3192	23.46	240031	0.9686	19.92	240087	1.1033	19.19	240133	1.1703	19.21	240211	0.9918	32.21
230178	1.0059	17.57	230270	1.2256	20.47	240036	1.5890	22.35	240088	1.3578	21.94	240135	0.8382	17.41	250001	1.6021	18.45
230180	1.1010	15.89	230273	1.5809	22.95	240037	1.0055	19.46	240089	0.9769	21.38	240137	1.1273	21.80	250002	0.8541	17.34
230184	1.2708	19.06	230275	0.5165	50.25	240038	1.4979	25.33	240090	1.0655	22.31	240138	0.9458	14.38	250003	1.0110	18.09
230186	1.1092	20.02	230276	0.5142	26.55	240040	1.3172	20.64	240093	1.2556	18.80	240139	1.0006	18.72	250004	1.5571	18.12
230188	1.0835	15.77	230277	1.3004	23.05	240041	1.1233	20.33	240094	0.9185	21.77	240141	1.1332	23.81	250005	0.9376	13.03
230189	0.9337	16.70	230278		18.21	240043	1.2402	17.97	240096	1.0307	20.97	240142	1.0390	32.04	250006	0.9859	17.04
230190	0.9231	26.82	230279	0.6318	17.70	240044	1.1420	19.26	240097	1.0219	25.42	240143	0.8917	19.43	250007	1.2463	19.29
230191	0.9599	19.50	230280	1.6338	15.94	240045	1.1356	22.12	240098	0.9495	21.82	240144	1.0412	20.03	250008	1.0057	15.19
230193	1.2745	19.78	230283	1.6032	27.96	240047	1.5606	22.83	240099	1.0577	15.27	240145	0.9259	19.10	250009	1.3310	18.84
230195	1.3298	21.93	230284	1.5037		240050	1.2115	25.30	240100	1.2690	21.07	240146	0.9265	16.22	250010	0.9978	13.79
230197	1.3911	23.51	230285	1.0969		240051	0.9195	20.76	240101	1.1731	19.65	240148	0.9095	17.03	250012	0.9798	14.35
230199	1.0859	23.70	230286	1.0244		240052	1.2790	21.11	240102	0.8423	15.00	240150	0.7099	13.99	250015	0.9903	13.61
230201	1.2386	17.40	240001	1.5053	24.98	240053	1.4428	23.03	240103	1.2331	20.79	240152	1.0040	21.19	250017	1.0363	18.42
230204	1.4472	25.44	240002	1.7887	22.90	240056	1.2526	23.85	240104	1.1455	23.24	240153	1.0139	17.10	250018	0.8886	13.49
230205	0.9745	14.76	240004	1.5988	25.70	240057	1.8032	24.31	240105		16.38	240154	0.9857	18.22	250019	1.5534	16.82
230207	1.2289	20.64	240005	0.8805	20.16	240058	0.9257	16.89	240106	1.3842	23.53	240155	0.9366	20.91	250020	0.9611	13.59
230208	1.2219	16.10	240006	1.1279	25.67	240059	1.0530	24.81	240107	0.9555	21.20	240157	0.9767	14.25	250021	1.0083	9.63
230211	0.9313	19.89	240007	1.0807	18.68	240061	1.7533	27.26	240108	0.9445	17.03	240160	0.9988	15.79	250023	0.9090	15.05
230212	0.9634	23.33	240008	1.1244	23.87	240063	1.4523	23.85	240109	0.9456	13.75	240161	0.9772	15.88	250024	0.9307	13.65
230213	0.9759	16.03	240009	0.9532	17.06	240064	1.3396	23.87	240110	0.9132	21.28	240162	1.0664	16.85	250025	1.0566	19.09
230216	1.6156	20.38	240010	1.9585	23.66	240065	1.0358	13.49	240111	1.0063	18.14	240163	0.9663	20.49	250027	0.9856	16.49
230217	1.2423	21.45	240011	1.1592	21.67	240066	1.2749	23.44	240112	1.0169	15.88	240166	1.0852	17.28	250029	0.8437	16.90
230219	0.8448	19.63	240013	1.2614	21.05	240069	1.1553	20.04	240114	0.9025	17.42	240169		16.67	250030	0.9016	17.99
230222	1.3656	21.05	240014	1.0934	23.47	240071	1.1332	20.27	240115	1.5957	23.78	240170	1.0869	20.29	250031	1.1990	18.02
230223	1.2716	21.25	240016	1.3575	20.69	240072	0.9545	21.26	240116	0.8640	18.17	240171	0.9467	17.29	250032	1.2695	17.45

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
250033	0.9665	18.38	250085	0.9453	14.51	260001	1.7328	18.23	260053	1.1626	13.61	260113	1.2685	14.70	260191	1.3272	18.03
250034	1.5072	16.83	250088	0.9697	17.88	260002	1.3530	23.17	260054	1.3058	20.90	260115	1.1534	19.35	260193	1.2299	21.50
250035	0.8325	15.34	250089	1.0860	13.55	260003	1.1100	14.71	260055	0.9775	12.12	260116	1.0757	16.40	260195	1.1984	18.38
250036	0.9375	15.89	250093	1.1745	15.42	260004	0.9089	13.51	260057	1.0397	17.59	260119	1.1362	17.50	260197	1.2424	19.74
250037	0.9007	17.94	250094	1.3039	18.26	260005	1.5338	19.74	260059	1.2133	16.74	260120	1.1550		260198	1.2942	11.98
250038	0.9443	16.97	250095	0.9883	17.11	260006	1.5282	20.06	260061	1.0891	14.87	260122	1.0929	15.30	260200	1.1751	20.63
250039	1.0136	14.34	250096	1.2290	19.36	260008	0.9499	13.92	260062	1.1846	20.31	260123	0.9861	14.88	260205	1.5117	17.63
250040	1.3211	17.38	250097	1.2230	17.23	260009	1.2927	18.59	260063	1.0362	18.43	260127	1.1114	18.60	260206	3.5316	
250042	1.2334	16.05	250098	0.8744	13.40	260011	1.5623	19.26	260064	1.3131	16.78	260128	1.0236	13.32	270002	1.3162	44.27
250043	0.8710	17.08	250099	1.2374	14.87	260012	1.0117	14.51	260065	1.7689	18.52	260131	1.1656	17.87	270003	1.1746	22.07
250044	0.9690	16.33	250100	1.3062	17.43	260013	1.1288	16.32	260066	1.0195	15.27	260134	1.1677	16.46	270004	1.7430	19.01
250045	1.2069	22.09	250101	0.9519	18.64	260014	0.7243		260067	0.8996	14.47	260137	1.7546	16.17	270006	0.8758	19.99
250047	0.9759	14.07	250102	1.5081	24.36	260015	1.1812	12.16	260068	1.6771	20.30	260138	1.8734	22.92	270007	1.0195	11.79
250048	1.5789	16.97	250104	1.4611	18.26	260017	1.2006	17.07	260070	0.9995		260141	1.9634	17.74	270009	1.0859	16.59
250049	0.8831	11.67	250105	0.9051	14.69	260018	0.8929	12.20	260073	1.0504	14.43	260142	1.1199	17.59	270011	1.0198	21.09
250050	1.2031	14.43	250107	0.9189	15.46	260019	1.1495	18.99	260074	1.2867	19.19	260143	1.0676	13.23	270012	1.5757	19.99
250051	0.8618	9.35	250109	0.8763	25.32	260020	1.7727	20.61	260077	1.7892	18.78	260147	0.9506	14.13	270014	1.9162	19.21
250057	1.1763	16.08	250112	0.9711	15.56	260021	1.3792	22.26	260078	1.1333	15.76	260148	0.8693	11.90	270016	0.8704	22.89
250058	1.1829	15.74	250117	1.0317	16.23	260022	1.1787	17.37	260079	1.0014	14.70	260158	1.0756	12.38	270017	1.2561	21.18
250059	1.0700	16.32	250119	1.0871	15.37	260023	1.3615	16.77	260080	0.9746	13.71	260159	0.9760	20.66	270019	1.1190	13.59
250060	0.7470	12.98	250120	1.1576	15.36	260024	0.9362	15.50	260081	1.5753	21.21	260160	1.1133	16.07	270021	1.0770	17.94
250061	0.8374	11.63	250122	1.1737	18.95	260025	1.3046	15.65	260082	1.1317	16.12	260162	1.6557	19.57	270023	1.2707	22.76
250063	0.8479	13.48	250123	1.1742	19.05	260027	1.6840	21.42	260085	1.5453	20.70	260163	1.3105	16.49	270026	0.9368	18.46
250065	0.8667	12.92	250124	0.9029	13.18	260029	1.1627	21.05	260086	0.9260	14.49	260164	0.8816	15.12	270027	1.0309	14.19
250066	0.8903	15.84	250125	1.3322	20.86	260030	1.0962	13.80	260091	1.6732	20.15	260166	1.2190	20.18	270028	1.1098	21.40
250067	1.1545	16.43	250126	0.9695	18.54	260031	1.5501	19.66	260094	1.2045	18.25	260172	0.9495	15.87	270029	0.9229	18.11
250068	0.8249	13.84	250127	0.8232		260032	1.7853	20.29	260095	1.3972	20.06	260173	1.0138	12.92	270032	1.1140	18.64
250069	1.2727	18.15	250128	1.0249	14.06	260034	0.9597	17.87	260096	1.5336	23.21	260175	1.1555	17.11	270033	0.8100	19.19
250071	0.8816	14.92	250131	1.0314	13.07	260035	0.9708	13.18	260097	1.1343	16.62	260176	1.5702	27.03	270035	0.9569	17.35
250072	1.4249	18.33	250134	0.9404	17.05	260036	0.9895	16.89	260100	0.9519	15.98	260177	1.2853	21.37	270036	0.9056	17.61
250076		18.49	250136	0.9008	19.06	260039	1.0792	14.39	260102	0.9961	21.22	260178	1.5350	19.82	270039	1.0428	16.98
250077	0.9821	12.29	250138	1.2425	18.41	260040	1.6302	17.44	260103	1.3583	18.81	260179	1.6145	20.04	270040	1.1295	19.22
250078	1.5178	15.76	250141	1.2485	19.21	260042	1.0374	20.25	260104	1.6018	21.27	260180	1.6060	19.67	270041	1.1196	20.55
250079	0.8699	16.67	250145	0.8593	10.25	260044	0.9647	16.31	260105	1.8164	24.78	260183	1.6356	20.12	270044	1.0627	16.90
250081	1.2872	17.69	250146	0.9420	14.67	260047	1.5659	19.25*	260107	1.4601	19.97	260186	1.6413	19.40	270048	0.9841	18.45
250082	1.5718	16.26	250148	1.0949	18.17	260048	1.3267	20.28	260108	1.8703	19.52	260188	1.2121	21.03	270049	1.7313	22.63
250083	0.9060	14.31	250149	0.9679	13.29	260050	1.0056	16.12	260109	1.0531	13.99	260189	0.8331	11.39	270050	1.0847	20.97
250084	1.1566	17.10	250150	2.0233		260052	1.3582	18.14	260110	1.6714	17.91	260190	1.1997	18.53	270051	1.3361	20.49

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
270052	0.9741	12.27	280032	1.3356	19.31	280081	1.6620	20.30	290010	1.1158	15.80	300023	1.4296	22.11	310039	1.2730	22.22
270057	1.2837	21.25	280033	0.9923	15.85	280082	0.9945	14.40	290011	0.9723	21.94	300024	1.2962	20.30	310040	1.2258	23.99
270058	0.9710	15.73	280035	1.0577	16.59	280083	1.0399	12.40	290012	1.3585	21.97	300028	1.2814	17.48	310041	1.3094	25.01
270059	0.7762	14.76	280037	1.0080	18.19	280084	0.9594	12.68	290013	1.0146	18.41	300029	1.5954	24.05	310042	1.2556	23.41
270060	0.9641	15.55	280038	1.0720	17.42	280085		28.26	290014	1.0354	18.95	300033	1.0719	17.44	310043	1.1489	21.97
270063	1.0414	12.75	280039	1.0243	16.14	280088		20.40	290015	0.9487	20.30	300034	2.1195	23.66	310044	1.3189	21.75
270073	1.1955	15.45	280040	1.7205	19.77	280089	0.9483	18.66	290016	1.0947	14.65	310001	1.7546	26.77	310045	1.4622	28.58
270074	0.8908		280041	0.9366	16.53	280090		14.19	290019	1.3058	21.42	310002	1.8249	28.36	310047	1.3288	25.35
270075	0.9693		280042	1.0236	16.77	280091	1.0630	16.05	290020	0.9203	21.61	310003	1.3210	29.23	310048	1.2889	23.67
270076	0.8683		280043	1.0166	16.66	280092	1.0073	14.24	290021	1.6576	21.63	310005	1.3371	21.85	310049	1.2090	22.72
270079	0.9317	17.21	280045	1.0114	17.02	280094	0.9541	17.76	290022	1.6306	24.64	310006	1.2934	21.66	310050	1.3129	26.34
270080	1.0699	16.58	280046	1.0450	18.52	280097	1.0200	15.48	290027	0.9135	17.74	310008	1.3619	23.79	310051	1.4157	26.08*
270081	0.9728	16.39	280047	1.0745	18.27	280098	0.9297	13.55	290029	0.9152		310009	1.3152	23.74	310052	1.2478	22.98
270082	1.0783	18.16	280048	1.0610	16.33	280101	1.0304	14.87	290032	1.4454	23.48	310010	1.2651	20.32	310054	1.3220	26.30
270083	1.0150	19.07	280049	1.1349	19.24	280102		14.18	290038	0.8689	20.67	310011	1.2148	23.21	310057	1.2602	21.33
270084	0.9263	16.51	280050	0.9046	16.90	280104	0.9158	13.98	290039	1.3644	25.41	310012	1.6363	26.56	310058	1.2197	30.35
280001	1.0557	18.71	280051	0.9767	15.89	280105	1.3290	18.84	290041	1.2948		310013	1.3263	21.23	310060	1.2779	19.20
280003	2.1228	22.58*	280052	1.0544	14.16	280106	0.9666	16.56	290043	1.4491		310014	1.6471	28.00	310061	1.2311	23.49
280005	1.3911	19.32	280054	1.2274	20.85	280107	1.0640	13.33	300001	1.5554	22.14	310015	2.0193	27.30	310062		20.64
280009	1.7901	20.04*	280055	0.9476	13.58	280108	1.1057	17.60	300003	1.8803	23.06	310016	1.2898	24.39*	310063	1.3686	22.08
280010	0.8079	18.95	280056	0.8587	12.70	280109	0.9708	12.90	300005	1.2655	20.98	310017	1.3429	25.87	310064	1.3430	24.70
280011	0.8768	15.91	280057	0.9219	19.92	280110	0.9881	12.83	300006	1.1961	24.52	310018	1.1257	22.84	310067	1.3385	25.06
280013	1.7382	22.81	280058	1.1285	20.17	280111	1.3028	21.90	300007	1.1446	20.40	310019	1.6473	24.25*	310069	1.2386	23.76
280014	0.9200	15.96	280060	1.5681	19.50	280114	0.9367	15.72	300008	1.1612	20.93	310020	1.4225	24.31	310070	1.3761	27.69
280015	1.0018	17.64	280061	1.3988	17.70	280115	0.9545	16.88	300009	1.0464	18.19	310021	1.6597	23.61	310072	1.3532	21.85
280017	1.0449	14.21	280062	1.1403	14.59	280117	1.0304	17.87	300010	1.3190	19.46	310022	1.3046	21.41	310073	1.6573	28.85
280018	0.9921	15.13	280064	0.9605	16.39	280118	0.9357	16.92	300011	1.3302	22.50	310024	1.3477	24.32	310074	1.4056	23.87
280020	1.7888	20.08	280065	1.2545	19.22	280119	0.8719		300012	1.3253	24.79	310025	1.2381	18.76	310075	1.3357	23.38
280021	1.1400	17.24	280066	1.0204	11.70	280123	0.8405	13.83	300013	1.1165	19.29	310026	1.3365	23.63	310076	1.4753	30.10
280022	0.9370	18.44	280068	0.8544	9.49	280125	1.2273	16.22	300014	1.2247	20.55	310027	1.3219	22.09	310077	1.6035	25.23
280023	1.3771	26.74	280070	0.9519	18.80	290001	1.7178	22.90	300015	1.1975	20.88	310028	1.2719	23.49	310078	1.3589	23.89
280024	0.9485	15.18	280073	0.9819	17.42	290002	0.9215	17.84	300016	1.1982	23.78	310029	1.8571	23.94	310081	1.3168	22.21
280025	0.9383	15.67	280074	1.0434	18.35	290003	1.6796	22.95	300017	1.4335	21.87	310031	2.8403	26.51	310083	1.2103	23.94
280026	1.0401	16.77	280075	1.1198	15.92	290005	1.3125	19.51	300018	1.3143	21.69	310032	1.2791	24.12	310084	1.2859	27.04
280028	1.0585	17.37	280076	1.1016	15.21	290006	1.2307	22.32	300019	1.2071	21.29	310034	1.2926	23.36	310086	1.2463	24.33
280029	1.0970	25.16	280077	1.2267	19.63	290007	1.6281	29.82	300020	1.3598	22.23	310036	1.1781	20.26	310087	1.3346	20.70
280030	1.7561	26.00	280079	0.9470	11.35	290008	1.2008	20.66	300021	1.1372	18.76	310037	1.3747	27.75	310088	1.2268	22.45
280031	1.0339	13.87	280080	1.0743	15.90	290009	1.6408	22.71	300022	1.1054	18.51	310038	1.9781	28.46	310090	1.3844	23.91

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TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
310091	1.2517	23.00	320033	1.0638	26.26	330023	1.3016	24.27	330080	1.2842	25.95	330144	0.9522	14.39	330203	1.4111	20.78
310092	1.3584	20.63	320035	0.9774	24.63	330024	1.7844	34.32	330084	1.0907	18.01	330148	1.0299	16.94	330204	1.4201	23.30
310093	1.2391	22.44	320037	1.2031	17.03	330025	1.1211	16.21	330085	1.2368	20.69	330151	1.1139	16.23	330205	1.2435	20.58
310096	2.0482	25.16	320038	1.1836	16.87	330027	1.3863	35.44	330086	1.3292	31.59	330152	1.4515	30.60	330208	1.2195	26.21
310105	1.2274	25.59	320046	1.4747	18.46	330028	1.4173	28.26	330088	1.0439	25.99	330153	1.6740	18.33	330209	1.1902	24.06
310108	1.4130	22.68	320048	1.3028	20.04	330029	1.0092	18.84	330090	1.5195	19.51	330154	1.7674		330211	1.1966	19.69
310110	1.2397	21.84	320056	0.9389		330030	1.5314	18.37	330091	1.4009	19.10	330157	1.3658	22.45	330212	1.0327	21.77
310111	1.2775	21.11	320057	0.9771		330033	1.2412	18.75	330092	1.0031	12.95	330158	1.4573	25.94	330213	1.0949	20.71
310112	1.3142	23.67	320058	1.0242		330034		31.32	330094	1.2733	17.62	330159	1.2556	19.13	330214	1.8038	38.15
310113	1.2434	23.71	320059	1.0795		330036	1.2531	23.99	330095	1.2590	20.19	330160	1.4834	30.46	330215	1.1639	17.90
310115	1.2742	21.74	320060	0.9723		330037	1.1401	16.14	330096	1.1059	17.96	330162	1.3003	27.18	330218	1.1083	21.67
310116	1.3470	22.77	320061	1.2614		330038	1.0982	16.37	330097	1.1947	16.65	330163	1.2817	18.74	330219	1.5273	22.18
310118	1.3408	26.59	320062	0.8457		330041	1.2956	24.52	330100	1.0557	27.12	330164	1.3889	19.69	330221	1.4092	27.88
310119	1.7957	33.68	320063	1.2638	18.31	330043	1.2931	29.24	330101	1.7620	32.51	330166	1.0967	15.10	330222	1.2936	18.48
310120	1.1628	23.88	320065	1.1440	13.19	330044	1.2707	19.84	330102	1.3625	17.70	330167	1.7283	29.87	330223	1.0697	17.62
310528	1.4071		320067	0.9611	36.85	330045	1.3708	28.12	330103	1.2143	15.80	330169	1.4043	37.34	330224	1.2874	19.76
310529	1.4071		320068	0.8767	17.70	330046	1.4439	32.58	330104	1.3469	31.73	330171	1.2608	25.80	330225	1.1882	25.83
320001	1.5189	19.17	320069	0.9678	13.01	330047	1.2340	18.25	330106	1.6787	39.91	330175	1.1745	17.47	330226	1.3157	16.72
320002	1.3291	19.54	320070	0.9979		330048	1.2609	17.79	330107	1.2278	28.72	330177	0.9549	17.74	330229	1.2693	16.80
320003	1.1451	16.11	320074	1.1329	19.51	330049	1.1964	19.68	330108	1.2560	17.55	330179	0.8664	13.50	330230	1.2683	29.85
320004	1.2309	18.58	320079	1.2044	18.40	330053	1.2468	17.66	330111	1.0726	20.53	330180	1.2294	17.00	330231	1.0234	28.36
320005	1.3686	20.81	330001	1.1787	26.61	330055	1.6289	28.38	330114	0.9090	17.56	330181	1.3093	32.37	330232	1.2271	17.98
320006	1.4054	19.04	330002	1.3665	26.28	330056	1.3713	30.48	330115	1.1386	16.72	330182	2.5729	32.78*	330233	1.4766	32.79
320009	1.6991	18.32	330003	1.3553	17.37	330057	1.7160	18.70	330116	0.8466	16.53	330183	1.4643	20.09	330234	2.3667	35.75
320011	1.1645	20.22	330004	1.2760	21.83	330058	1.2882	17.41	330118		20.72	330184	1.3691	30.31	330235	1.1563	21.28
320012	1.0162	16.63	330005	1.6334	24.90	330059	1.5435	32.46	330119	1.6596	34.92	330185	1.2869	26.21	330236	1.4013	29.71
320013	1.2025	22.96	330006	1.3555	25.42	330061	1.2626	25.74	330121	1.0191	16.10	330188	1.2406	20.96	330238	1.2154	15.64
320014	1.0711	16.84	330007		19.07	330062	1.0915	19.99	330122	1.0256	20.86	330189	0.9157	15.13	330239	1.2083	17.52
320016	1.1680	21.02	330008	1.1472	19.45	330064	1.3542	33.20	330125	1.8707	16.09	330191	1.2920	18.50	330240	1.3457	23.38
320017	1.0879	18.64	330009	1.2474	30.66	330065	1.2488	20.01*	330126	1.2034	24.01	330193	1.4131	36.55	330241	2.0281	24.79
320018	1.4850	18.97	330010	1.3041	17.87	330066	1.3213	18.72	330127	1.3907	30.54	330194	1.8591	35.00	330242	1.3725	28.58
320019	1.4291	24.58	330011	1.2558	18.29	330067	1.3559	21.10	330128	1.2984	28.17	330195	1.6368	33.44	330245	1.6772	17.51
320021	1.7113	19.05	330012	1.2482	32.69	330072	1.3910	31.00	330132	1.1954	15.77	330196	1.3036	23.39	330246	1.3474	28.23
320022	1.1714	16.27	330013	2.0835	19.81	330073	1.1988	16.33	330133	1.4009	38.06	330197	1.0867	17.67	330247	0.9413	28.43
320023	0.9239	18.63	330014	1.3568	32.74	330074	1.2899	18.46	330135	1.1927	18.83	330198	1.4002	24.64	330249	1.1691	16.36
320030	1.1665	16.78	330016	1.0288	16.92	330075	1.0735	17.23	330136	1.3316	18.01	330199	1.3195	22.94	330250	1.3149	19.69
320031	0.9716	19.85	330019	1.3296	35.98	330078	1.4101	16.84	330140	1.7797	19.07	330201	1.6150	33.45*	330254	1.3228	16.35
320032	0.9893	19.25	330020	1.0404	16.37	330079	1.1665	16.96	330141	1.3350	26.72	330202	1.2994	43.79	330258	1.2266	29.74

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
330259	1.4440	25.68	330387	0.9061		340030	2.0506	21.18	340087	1.1029	17.47	340141	1.6896	21.50	350018	1.0477	15.87
330261	1.2036	25.82	330389	1.8456	30.47	340031	0.9217	14.73	340088	1.3517	21.53	340142	1.1644	17.19	350019	1.6646	22.51
330263	0.9771	20.75	330390	1.3632	31.08	340032	1.4561	19.60	340089	0.9792	13.86	340143	1.4585	21.46	350021	1.0506	13.29
330264	1.1710	23.22	330393	1.8344	26.59	340034	1.2442		340090	1.1480	17.21	340144	1.2422	21.13	350023	0.9937	16.37
330265	1.3028	18.55	330394	1.5311	19.26	340035	1.0676	20.68	340091	1.6245	20.66	340145	1.3102	20.25	350024	0.9655	15.51
330267	1.4366	24.52	330395	1.3433	32.84	340036	1.0915	18.26	340093	1.0273	16.72	340146	1.1826	16.64	350025	0.9338	17.21
330268	0.9345	13.14	330396	1.2143	26.26	340037	1.1047	16.93	340094	1.3767	19.07	340147	1.2064	19.64	350027	0.9560	16.01
330270	1.9596	34.74	330397	1.3009	32.83	340038	1.0927	17.57	340096	1.1847	17.83	340148	1.2816	18.61	350029	0.8521	12.00
330273	1.3019	23.20	330398		28.92	340039	1.2681	20.71	340097	1.1371	19.16	340151	1.1870	16.79	350030	1.0714	17.73
330275	1.9172	18.10	330399	1.2710	32.22	340040	1.7843	20.51	340098	1.5932	21.67	340153	1.8584	20.83	350033	0.9207	14.94
330276	1.2311	18.49	330400	0.8821		340041	1.2060	15.24	340099	1.0861	16.99	340155	1.4055	20.67*	350034	0.9218	18.84
330277	1.1123	18.34	340001	1.4099	15.48*	340042	1.2316	17.03	340101	1.0110	14.00	340156	0.8347		350035	0.9248	10.65
330279	1.3744	19.99	340002	1.6734	20.68	340044	1.0595	19.39	340104	0.8826	13.05	340158	1.0371	18.08	350038	1.0716	17.98
330285	1.8516	23.30	340003	1.0955	20.60	340045	0.9604	13.85	340105	1.4831	20.64	340159	1.1728	17.62	350039	0.9588	17.10
330286	1.2784	26.86	340004	1.4532	18.52	340047	1.8711	20.38	340106	1.1165	17.72	340160	1.0910	16.55	350041	1.1001	14.82
330290	1.7526	33.26	340005	1.0277	16.15	340049	0.7283	20.73	340107	1.2067	18.11	340162		14.35	350042	1.0451	19.25
330293	1.1727	16.87	340006	0.9684	16.67	340050	1.1208	20.25	340109	1.3127	18.78	340164	1.3481	21.39	350043	1.5489	17.03
330304	1.2306	26.84	340007	1.1562	17.36	340051	1.2485	16.57	340111	1.0645	16.35	340166	1.3030	20.05	350044	0.8822	10.34
330306	1.3142	27.41	340008	1.1447	20.88	340052	1.0014	23.31	340112	0.9920	14.32	340168	0.5101	15.34	350047	0.9607	13.91
330307	1.2306	21.19	340009		20.60	340053	1.5873	21.07	340113	1.8651	21.36	340171	1.1455	21.61	350049	1.1631	15.75
330314	1.3597	25.25	340010	1.3362	18.41	340054	1.1409	15.70	340114	1.5493	21.34	340173	1.2098	19.35	350050	0.8466	11.60
330316	1.3133	27.61	340011	1.1290	13.66	340055	1.2627	19.89	340115	1.5715	19.90	350001	0.9882	13.34	350051	0.9311	17.61
330327	0.8648	16.46	340012	1.2311	19.16	340060	1.0869	19.05	340116	1.8253	20.06	350002	1.8110	17.82	350053	1.0154	17.09
330331	1.3086	31.62	340013	1.2510	21.14	340061	1.7329	21.74	340119	1.2141	18.16	350003	1.2256	18.56	350055	1.0230	14.75
330332	1.2568	27.69	340014	1.5229	20.55	340063	1.0093	17.48	340120	1.0408	15.33	350004	1.9049	20.76	350056	0.9278	15.07
330333	1.2909		340015	1.2754	19.82	340064	1.1300	21.16	340121	1.0749	16.38	350005	1.0401	15.81	350058	0.9833	15.65
330336	1.2324	29.77	340016	1.1207	17.78	340065	1.2243	18.04	340123	1.1175	16.97	350006	1.5547	18.59	350060	0.8490	10.37
330338	1.1705	23.14	340017	1.2071	20.35	340067	0.9991	19.38	340124	1.0808	15.63	350007	0.8587	13.77	350061	1.0027	15.49
330339	0.8910	20.01	340018	1.0804	14.12	340068	1.1715	16.63	340125	1.4253	19.73	350008	1.1613	17.76	350063	0.9667	
330340	1.1929	28.86	340019	0.9785	15.15	340069	1.7761	21.12	340126	1.3013	18.83	350009	1.1136	19.53	350064	0.7555	
330350	1.6581	31.05	340020	1.1779	18.67	340070	1.2898	19.94	340127	1.1956	20.54	350010	1.0118	18.31	350069	1.2802	
330353	1.3482	32.30	340021	1.2520	19.99	340071	1.0832	17.14	340129	1.2476	20.48	350011	1.8866	18.31	360001	1.2935	16.77
330354	1.6409		340022	1.0739	17.90	340072	1.2082	17.04	340130	1.2840	19.91	350012	1.1412	11.47	360002	1.1402	18.13
330357	1.3536	38.13	340023	1.3875	18.19	340073	1.2988	22.21	340131	1.4394	19.86	350013	1.0380	16.64	360003	1.6873	
330372	1.2414	29.34	340024	1.1973	17.69	340075	1.1577	19.47	340132	1.3414	17.41	350014	0.9712	15.08	360006	1.9146	21.90
330381	1.2242	31.05	340025	1.1953	17.54	340080		23.28	340133	1.0261	16.60	350015	1.7387	16.88	360007	1.0265	18.39
330385	1.2649		340027	1.1839	18.21	340084	1.0709	17.68	340137	1.0783	34.86	350016		10.78	360008	1.3490	18.86
330386	1.1312	17.72	340028	1.5757	18.35	340085	1.1718	17.38	340138	1.1288	24.83	350017	1.2958	17.88	360009	1.5361	18.98

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
360010	1.2334	15.17	360055	1.3525	21.56	360098	1.5062	19.91	360150	1.3685	21.12	360213	1.2083	19.69	370032	1.5629	18.35
360011	1.3423	19.52	360056	1.4041	16.61	360099	1.0245	18.71	360151	1.4074	16.67	360218	1.2975	19.08	370033	1.0525	13.98
360012	1.3342	20.51	360057	1.0483	15.11	360100	1.2130	18.29	360152	1.5163	20.85	360230	1.4929	21.98	370034	1.2289	15.81
360013	1.1575	20.87	360058	1.1193	18.82	360101	1.3243	21.48	360153	1.1651	15.68	360231	1.1033	13.04	370035		25.56
360014	1.1008	21.00	360059	1.5947	19.06	360102	1.2553	19.46	360154	1.0086	14.51	360234	1.3213	36.08	370036	0.9960	12.53
360016	1.5836	16.64	360062	1.4230	20.87	360106	1.1940	19.11	360155	1.4647	22.60	360236	1.2715	17.61	370037	1.7645	16.78
360017	1.9251	21.81	360063	1.1702	18.75	360107	1.1811	19.80	360156	1.2202	16.78	360239	1.3395	20.28	370038	0.9615	13.46
360018	1.6721	22.56	360064	1.6012	20.51	360108	1.0338	18.15	360159	1.1602	20.40	360241	0.4317	24.60	370039	1.1425	15.52
360019	1.2060	18.79	360065	1.2487	20.23	360109	1.1111	20.44	360161	1.3892	19.23	360242	1.8217		370040	1.0073	15.19
360020	1.5186	25.81	360066	1.6090	22.67	360112	1.8536	22.69	360162	0.7891		360243		14.87	370041	0.9018	17.04
360024	1.2682	20.07	360067	1.0787	15.64	360113	1.2901	24.24	360163	1.8340	20.69	360245	0.6949	16.46	370042	0.8507	15.10
360025	1.3835	20.15	360068	1.8270	21.31	360114	1.0970	17.88	360165	1.1673	18.36	360247	0.4151		370043	0.9540	16.24
360026	1.3585	18.36	360069	1.1756	16.83	360115	1.3870	18.68	360166		18.73	360252	1.1998		370045	0.9814	10.36
360027	1.4749	21.12	360070	1.7350	17.47	360116	1.2625	19.25	360170	1.3600	24.15	370001	1.7264	19.57	370046	0.9928	20.54
360028	1.4691	17.36	360071	1.3047	17.52	360118	1.4264	19.53	360172	1.3346	18.64	370002	1.3068	14.87	370047	1.3957	16.87
360029	1.1472	18.76	360072	1.2218	18.01	360121	1.1630	30.53	360174	1.2905	20.06	370004	1.2174	19.80	370048	1.2000	18.48
360030	1.2350	17.59	360074	1.2811	21.16*	360123	1.3141	20.40	360175	1.2197	21.34	370005	0.8524	15.29	370049	1.2853	21.09
360031	1.2603	19.79	360075	1.3381	22.47	360125	1.2270	19.16	360176	1.1301	16.04	370006	1.1483	16.78	370051	0.9589	12.40
360032	1.1946	18.86	360076	1.3683	20.86	360126	1.2293	19.00	360177	1.1801	19.08	370007	1.0950	15.72	370054	1.2822	17.01
360034	1.2043	14.98	360077	1.5732	21.19	360127	1.1664	17.47	360178	1.2352	18.97	370008	1.4079	16.80	370056	1.6437	18.66
360035	1.6355	20.58	360078	1.2570	21.56	360128	1.2319	16.16	360179	1.4850	21.22	370011	1.0145	15.43	370057	1.0945	17.13
360036	1.2488	20.30	360079	1.9036	22.23	360129	0.9283	15.88	360180	2.1826	22.23*	370012	0.9599	11.91	370059	1.0654	18.46
360037	1.7944	23.08	360080	1.1484	17.61	360130	1.0412	16.93	360184		21.79	370013	1.8371	19.53	370060	1.0384	16.80
360038	1.6196	21.78	360081	1.3684	21.28	360131	1.2850	19.50	360185	1.2317	18.85	370014	1.1749	20.77	370063	1.2088	15.05
360039	1.3097	18.83	360082	1.2761	23.10	360132	1.3760	20.03	360186	1.0135	18.61	370015	1.0935	17.22	370064	0.8983	11.00
360040	1.2276	17.89	360084	1.5193	20.69	360133	1.5665	20.10*	360187	1.4773	18.71	370016	1.3381	19.61	370065	0.9824	17.06
360041	1.3560	19.78	360085	1.9661	22.00	360134	1.6855	20.68	360188	0.9369	17.38	370017		12.76	370071	1.0039	16.32
360042	1.1141	17.27	360086	1.5020	19.57	360136	1.0046	17.87	360189	1.0455	18.17	370018	1.3295	18.76	370072	0.8630	14.74
360044	1.2324	17.06	360087	1.5437	20.60	360137	1.7667	20.11	360192	1.3219	21.58	370019	1.3153	14.28	370076	1.2066	13.63
360045	1.4084	22.54	360088	1.3352	24.84	360140	0.9480	20.62	360194	1.1997	17.35	370020	1.2263	14.57	370078	1.5996	20.02
360046	1.1656	20.48	360089	1.2093	18.39	360141	1.6729	23.15	360195	1.1098	20.08	370021	0.8554	12.05	370079	0.9794	16.90
360047	1.1027	17.19	360090	1.2546	21.08	360142	1.0190	17.06	360197	1.1044	20.17	370022	1.2696	17.46	370080	0.9639	14.51
360048	1.8242	22.62	360091	1.2937	21.57	360143	1.3588	20.31	360200	0.9555	17.15	370023	1.2643	17.94	370082	0.8241	14.03
360049	1.2121	20.56	360092	1.1341	20.86	360144	1.3417	23.25	360203	1.0978	16.41	370025	1.3035	17.61	370083	0.9353	13.39
360050	1.1495	13.14	360093	1.0964	19.33	360145	1.7463	19.55	360204	1.0462	22.32	370026	1.5025	18.47	370084	1.0542	24.69
360051	1.6201	20.97	360094	1.3416	19.07	360147	1.2667	16.80	360210	1.1429	21.12	370028	1.9017	18.46	370085	0.9464	11.80
360052	1.6225	19.69*	360095	1.3125	20.55	360148	1.1127	19.79	360211	1.2930	20.20	370029	1.1722	16.56	370086	1.1221	15.67
360054	1.2007		360096	1.0795	18.38	360149		20.10	360212	1.3331	21.22	370030	1.1316	16.72	370089	1.2271	16.25

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
370091	1.6044	21.70	370170	1.0541		380021	1.2503	21.19	380083	1.1471	22.40	390037	1.4185	21.15	390080	1.3019	19.11
370092	1.0139	14.98	370171	0.9971		380022	1.1688	22.92	380084	1.2453	24.42	390039	1.1907	17.26	390081	1.2462	25.01
370093	1.8117	18.49	370172	0.8396		380023	1.1761	20.72	380087	1.2474	16.58	390040	1.0209	16.06	390083	1.1651	
370094	1.4127	18.10	370173	1.1247		380025	1.3346	26.40	380088	0.9247	24.74	390041	1.2732	20.03	390084	1.1987	16.59
370095	0.9763	12.64	370174	0.9543		380026	1.0945	20.70	380089	1.2394	19.53	390042	1.5063	22.88	390086	1.1480	18.59
370097	1.2818	23.54	370176	1.2074	16.06	380027	1.2669	20.98	380090	1.3238	29.26	390043	1.1749	17.33	390088	1.3842	23.80
370099	1.0947	15.47	370177	0.9524	11.37	380029	1.1922	19.64	380091	1.2535	27.86	390044	1.6322	20.34	390090	1.8116	21.65
370100	0.9115	14.22	370178	1.0189	10.66	380031	0.9315	24.67	390001	1.5417	19.33	390045	1.6031	18.66	390091	1.1333	18.17
370103	0.9543	19.40	370179	0.8885	18.46	380033	1.7553	25.24	390002	1.3557	20.92	390046	1.5702	20.80	390093	1.1630	17.97
370105	1.9099	21.76	370180	0.9075		380035	1.2499	23.10	390003	1.2310	16.88	390047	1.5521	19.19	390095	1.2468	16.33
370106	1.5203	18.67	370183	1.0814	10.31	380036		28.46	390004	1.3896	19.29*	390048	1.1545	19.22	390096	1.4929	19.13
370108	0.9726	12.38	370186	0.9477	13.67	380037	1.2582	22.27	390005	1.1046	17.71	390049	1.5575	20.92	390097	1.2575	24.17
370112	1.0891	15.36	370190	1.5098	14.13	380038	1.3126	26.31	390006	1.8361	20.28	390050	2.1143	22.95	390100	1.6304	20.62*
370113	1.1543	16.46	370192	1.3555	18.46	380039	1.2777	23.40	390007	1.1621	17.36	390051	2.1193	20.70	390101	1.2165	18.08
370114	1.5781	16.55	370196	0.8606		380040	1.2192	27.41	390008	1.1623	18.07	390052	1.1748	21.01	390102	1.3785	16.42
370121	1.0688	23.09	370198		21.31	380042	0.9475	21.58	390009	1.7844	20.50	390054	1.2301	17.82	390103	1.1339	18.55
370122	0.9493	15.36	370199	0.8639		380047	1.6760	23.15	390010	1.2242	17.59	390055	1.8787	23.77	390104	1.0108	16.05
370123	1.3885	19.46	370200	1.1197		380048	0.9881	17.75	390011	1.3623	18.24	390056	1.1528	17.84	390106	1.0782	16.67
370125	0.9138	15.90	370201	1.5239		380050	1.4244	20.47	390012	1.1580	20.78	390057	1.2898	20.18	390107	1.4339	19.48
370126	1.0242	25.10	370202	1.6312		380051	1.6019	22.51	390013	1.2035	19.41	390058	1.3431	19.88	390108	1.3803	20.88
370131	0.8213	17.84	370203	0.9571		380052	1.2343	19.44	390015	1.1147	13.13	390060		20.71	390109	1.1779	16.54
370133	1.0895	11.12	380001	1.2454	20.48	380056	1.1446	19.64	390016	1.2102	17.11	390061	1.4576	21.41	390110	1.6090	24.45
370138	0.9855	16.51	380002	1.2140	24.49	380060	1.4009	23.54	390017	1.1623		390062	1.1875	16.79	390111	1.9566	28.83
370139	0.9845	14.92	380003	1.1372	22.04	380061	1.5403	22.40	390018	1.2433	21.49	390063	1.8778	20.12	390112	1.2223	15.02
370140	1.0484	16.50	380004	1.7746	23.06	380062	1.0568	22.42	390019	1.0956	16.74	390065	1.2180	20.06	390113	1.2382	19.41
370141	1.2715	18.56	380005	1.1564	24.14	380063		20.41	390022	1.2626	21.66	390066	1.2689	20.00	390114	1.1908	19.68
370146	1.0376	13.04	380006	1.2218	21.43	380064	1.2399	20.40	390023	1.2740	22.66	390067	1.7230	21.06	390115	1.3884	23.13
370148	1.4798	21.23	380007	1.8133	24.88	380065	1.3760	29.90	390024	1.1950	25.28	390068	1.3359	18.38	390116	1.3141	22.01
370149	1.3531	16.29	380008	1.1193	20.81	380066	1.2342	22.84	390025	0.4914	15.62	390069	1.2272	19.76	390117	1.1927	17.96
370153	1.1109	18.06	380009	1.9155	23.82	380068		22.78	390026	1.2536	22.40	390070	1.3908	21.09	390118	1.2266	18.64
370154	0.9997	15.74	380010	1.0883	24.16	380069	0.9663	19.83	390027	1.6725	26.80	390071	1.0710	16.06	390119	1.3509	18.60
370156	1.0546	14.03	380011	1.1283	21.90	380070	1.2440	27.97	390028	1.8243	22.89	390072	1.0686	15.67	390121	1.3954	19.72
370158	0.9813	15.80	380013	1.1981	18.76	380071	1.2939	22.86	390029	2.0480	21.66	390073	1.6453	20.59	390122	1.0559	17.34
370159	1.2126	35.75	380014	1.6849	24.82	380072	0.9643	19.16	390030	1.3037	18.20	390074	1.2044	18.56	390123	1.2538	20.93
370163	0.9443	17.72	380017	1.8298	26.13	380075	1.3986	22.53	390031	1.1843	19.32	390075	0.8141	17.64	390125	1.2810	16.97
370165	1.1288	13.20	380018	1.8417	22.48	380078	0.9868	20.43	390032	1.2292	17.67	390076	1.2336	20.37	390126		20.74
370166	1.0969	17.29	380019	1.2490	22.52	380081	0.9945	21.77	390035	1.2915	19.92	390078	1.1636	19.40	390127	1.2380	21.81
370169	1.0537	12.64	380020	1.4433	20.31	380082	1.2817	22.26	390036	1.4804	20.06*	390079	1.7957	18.35	390128	1.2390	21.27

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
390130	1.1414	17.70	390184	1.1496	20.78	390246	1.1346	20.47	400013	1.2447	8.46	400122	1.0349	8.19	420039	1.1396	15.91
390131	1.3543	16.23	390185	1.1762	18.74	390247	1.0155	24.31	400014	1.3938	9.55	400123	1.2661	7.81	420043	1.1828	19.55
390132	1.3454	21.19	390189	1.1613	19.37	390249	0.9448	12.79	400015	1.5592	8.89	400124	2.9225	12.10	420048	1.2223	18.68
390133	1.7892	23.17*	390191	1.1886	16.46	390256	1.8684	21.09	400016	1.3398	13.29	400125	1.0767		420049	1.2086	17.82
390135	1.2544	21.45	390192	1.1512	16.71	390258	1.4919	21.98	400017	1.2238		410001	1.3880	23.40	420051	1.5733	19.54
390136	1.1034	17.01	390193	1.2810	17.13	390260	1.1989	18.22	400018	1.2832	10.51	410004	1.2965	22.64	420053	1.1080	17.15
390137	1.4923	17.09	390194	1.2385	21.28	390262	1.9292	18.30	400019	1.5231	10.43	410005	1.2923	23.48	420054	1.2667	18.36
390138	1.3158	19.45	390195	1.8209	23.96	390263	1.3520	18.74	400021	1.4409	10.72	410006	1.2576	23.65	420055	1.0334	21.55
390139	1.4902	24.10	390196	1.5086		390265	1.2960	20.69	400022	1.3550	9.99	410007	1.6077	22.27	420056	1.2203	15.10
390142	1.5730	26.57	390197	1.4697	19.26	390266	1.1655	17.21	400024	0.9633	8.09	410008	1.2095	23.12	420057	1.1423	15.98
390145	1.4010	20.49	390198	1.2564	15.98	390267	1.2438	21.59	400026	1.0177	5.64	410009	1.3252	24.66	420059	0.9951	15.89
390146	1.2706	19.06	390199	1.1973	17.17	390268	1.3339	21.44	400027		9.59	410010	1.1320	27.07	420061	1.1300	19.02
390147	1.2032	21.09	390200	0.9409	15.15	390270	1.3984	18.72	400028	1.1174	8.91	410011	1.2441	24.99	420062	1.1754	17.74
390150	1.1443	21.25	390201	1.2378	20.71	390272	0.5183		400031		8.27	410012	1.8150	24.68	420064	1.1821	
390151	1.2241	21.70	390203	1.3451	21.11	390277		17.82	400032	1.2050	10.59	410013	1.2765	24.46	420065	1.3485	19.91
390152	1.0777	20.34	390204	1.2783	20.27	390278	0.6647	18.63	400044	1.4631	11.97	420002	1.4889	19.58	420066	1.0367	15.19
390153	1.2252	23.34	390206		18.44	390279	1.0636	14.41	400048	1.1615	9.19	420004	1.8906	19.80	420067	1.2058	19.02
390154	1.2076	17.72	390209	1.0417	17.83	390281	1.3650		400061	1.7940	12.91	420005	1.0771	17.49	420068	1.3360	18.58
390156	1.4359	20.56*	390211	1.2277	18.01	390284	1.4412		400079	1.1999		420006	1.0719	18.62	420069	1.0419	17.14
390157	1.3608	19.74	390213	1.1661	19.22	390285	1.6668		400087	1.5057	9.51	420007	1.5943	18.44	420070	1.2721	15.43
390160	1.2339	21.43	390215	1.1889	20.77	390286	1.1152		400094	1.0905	8.92	420009	1.1750	18.80	420071	1.3375	19.49
390161	1.0720	16.69	390217	1.2195	19.27	390287	1.5408		400098	1.3009	9.34	420010	1.1495	17.12	420072	0.9270	13.86
390162	1.4942	21.42	390219	1.2829	18.96*	390288	1.3205		400102	1.1160	9.86	420011	1.1579	16.64	420073	1.2998	19.24
390163	1.2985	16.92	390220	1.1356	18.87	390289	1.2735		400103	1.4139	11.23	420014	1.0098	17.03	420074	0.9703	17.01
390164	2.1661	25.91	390222	1.2848	21.70	390290	1.9083		400104	1.2735	11.12	420015	1.3587	18.88	420075	0.9049	14.48
390166	1.1228	19.37	390223	1.7590	22.21*	390291	1.0064		400105	1.1909	9.32	420016	0.9117	15.62	420078	1.8707	20.57
390167		20.11	390224	0.8462	16.06	390292	1.7398		400106	1.2229	9.31	420018	1.6937	19.79	420079	1.4542	21.00
390168	1.4324	18.85	390225	1.2356	18.83	400001	1.2713	9.95	400109	1.4645	10.99	420019	1.1298	17.40	420080	1.4090	22.51
390169	1.4254	19.91	390226	1.7162	23.01	400002	1.6814	10.14	400110	1.2210	10.36	420020	1.1853	18.90	420082	1.5064	20.51
390170	1.6553	18.33	390228	1.3772	19.49	400003	1.3343	6.87	400111	1.1955	10.47	420023	1.4599	22.35	420083	1.3483	20.31
390173	1.1611	18.59	390231	1.5411	20.49	400004	1.2034	8.99	400112	1.0783	10.18	420026	1.8483	20.30	420085	1.4415	19.59
390174	1.6425	25.07*	390233	1.3671	20.75	400005	1.1684	9.56	400113	1.2079	8.52	420027	1.3037	18.92	420086	1.4438	26.48
390176	1.2014	17.84	390235	1.4513	21.34*	400006	1.1960	10.33	400114	1.0938	9.05	420030	1.2526	19.07	420087	1.7286	19.21
390178	1.3200	16.78	390236	1.1984	16.40	400007	1.1674	6.45	400115	1.0873	9.98	420031	0.8958	14.45	420088	1.0686	17.06
390179	1.2709	21.74	390237	1.5383	19.90	400009	1.0022	8.42	400117	1.1340	10.23	420033	1.1243	21.74	420089	1.1770	20.33
390180	1.4422	25.65	390238	1.3058	17.82	400010	0.8818	8.49	400118	1.2341	9.44	420036	1.2338	17.72	420091	1.2947	19.00
390181	1.0954	19.73	390244	0.9301	16.67	400011	1.0851	7.50	400120	1.3236	9.55	420037	1.2657	21.79	420093	0.9796	17.49
390183	1.1932	18.03	390245	1.3389	21.30	400012	1.2487	8.24	400121	0.9217	8.09	420038	1.2484	17.68	420095	2.5155	

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
420096	1.7514		430066	0.9008	14.40	440030	1.1751	16.49	440091	1.6362	19.71	440173	1.6396	18.69	450021	1.8814	21.55
430004	0.9609	18.79	430073	1.0143	16.39	440031	1.0663	15.53	440100	0.9807	14.04	440174	0.9259	17.33	450023	1.4841	16.17
430005	1.2812	16.48	430076	0.9123	13.65	440032	0.9951	13.99	440102	1.1416	14.54	440175	1.1195	19.26	450024	1.3907	17.45
430007	1.0407	14.22	430077	1.6719	18.33	440033	1.1005	14.70	440103		20.55	440176	1.3127	18.23	450025		16.85
430008	1.1208	18.12	430079	0.9190	14.41	440034	1.5809	19.55	440104	1.7547	23.12	440180	1.1305	22.35	450028	1.4881	18.94
430010	1.0575	19.27	430081	0.9496		440035	1.2507	19.06	440105	0.9667	16.78	440181	0.9166	16.80	450029	1.6984	17.00
430011	1.2700	17.11	430082	0.8197		440039	1.8372	18.57	440109	1.1160	16.70	440182	0.9912	17.90	450031	1.3727	22.47
430012	1.2865	17.39	430083	0.8671		440040	1.0520	16.48	440110	1.1731	12.62	440183	1.6053	22.77	450032	1.2407	17.39
430013	1.2140	18.41	430084	0.8903		440041	1.0032	14.79	440111	1.3903	23.33	440184	1.1685	17.22	450033	1.6070	19.88
430014	1.2991	16.94	430085	0.8145		440046	1.1755	18.34	440114	1.0945	14.67	440185	1.1912	17.98	450034	1.5605	18.27
430015	1.1562	21.74	430089	0.8934	17.90	440047	0.9188	16.66	440115	1.0341	17.45	440186	0.9946	19.57	450035	1.4463	19.66
430016	1.8956	19.70	430090	1.5851	21.52	440048	1.8112	19.46*	440120	1.6727	17.23	440187	1.1545	18.44	450037	1.5430	18.95
430018	0.9377	14.89	430091	1.8060	19.21	440049	1.6778	12.12	440125	1.5439	15.73	440189	1.5100		450039	1.5413	20.21*
430022	0.8661	13.77	430092	2.0606		440050	1.2316	20.50	440130	1.1552	18.18	440192	1.0452	19.28	450040	1.7134	16.94
430023	0.9045	12.32	430093	0.9802		440051	0.9195	13.21	440131	1.1323	15.71	440193	1.2660	19.37	450042	1.6929	20.49
430024	0.9625	15.49	440001	1.1930	15.17	440052	0.9792	16.76	440132	1.1083	16.89	440194	1.3426	20.08	450044	1.4881	23.89
430027	1.7844	19.26	440002	1.6591	19.40	440053	1.3276	18.58	440133	1.5549	21.57	440197	1.2797	22.18	450046	1.4707	16.73
430028	1.1337	19.48	440003	1.2569	18.50	440054	1.2203	13.99	440135	1.1874	19.78	440200	1.1776	18.30	450047	1.1163	13.46
430029	0.9468	17.07	440006	1.3368	19.65	440056	1.0523	15.98	440137	1.1338	14.97	440203	0.9624	18.47	450050	0.9150	14.98
430031	0.8712	13.33	440007	1.0197	12.62	440057	1.0726	13.06	440141	0.9927	13.80	440206		16.47	450051	1.6138	20.36
430033	0.9751	16.11	440008	1.0196	17.54	440058	1.1480	16.50	440142	1.0087	15.99	440210	1.0561	11.02	450052	1.0261	13.94
430034	0.9654	15.66	440009	1.1329	17.89	440059	1.4748	18.61	440143	1.0185	17.78	440211		15.03	450053	1.0551	17.05
430036	0.9604	14.40	440010	0.9371	20.90	440060	1.1176	18.63	440144	1.2759	17.78	440212		17.07	450054	1.6178	23.39
430037	0.9250	17.25	440011	1.3658	17.90	440061	1.1173	14.98	440145	0.9782	16.97	440213		19.58	450055	1.1126	15.13
430038	1.0131	13.72	440012	1.6411	16.03	440063	1.6311	19.36	440147	1.7122	21.59	440214	1.6187		450056	1.6203	21.00
430040	1.0512	13.88	440014	0.9859	16.12	440064	1.1067	17.77	440148	1.0657	19.26	440217	1.2148		450058	1.6096	17.60
430041	0.8894	13.32	440015	1.8127	18.60	440065	1.3182	18.72	440149	1.0301	17.02	450002	1.4960	21.57	450059	1.2338	15.23
430043	1.1877	14.02	440016	1.0277	15.74	440067	1.1752	14.74	440150	1.3189	20.23	450004	1.0878	16.85	450063	0.8737	14.83
430044	0.7894	19.42	440017	1.8014	19.67	440068	1.2451	19.48	440151	1.1401	17.45	450005	1.2002	13.48	450064	1.4426	17.41
430047	1.0491	18.79	440018	1.2742	17.14	440070	1.0142	13.79	440152	2.0595	20.49	450007	1.2265	17.07	450065	0.9949	22.60
430048	1.1085	18.62	440019	1.7608	20.22	440071	1.1950	17.20	440153	1.1112	16.93	450008	1.2228	17.16	450068	1.8929	23.02
430049	0.8842	15.59	440020	1.1148	19.75	440072	1.2842	17.75	440156	1.4817	31.20	450010	1.4716	16.53	450072	1.2215	19.15
430051	0.9210	17.29	440022		15.85	440073	1.2464	19.22	440157	1.0596	17.13	450011	1.5042	17.22	450073	1.1334	17.58
430054	0.9508	14.74	440023	1.0919	15.73	440078	1.0057	15.09	440159	1.2264	18.11	450014	1.1292	18.23	450076	1.7681	
430056	0.8955	12.20	440024	1.3011	18.57	440081	1.0953	18.89	440161	1.8362	21.95	450015	1.5990	17.54	450078	0.9236	11.83
430057	0.9851	16.85	440025	1.1421	16.14	440082	2.0079	19.62	440162	0.7243	14.97	450016	1.5700	18.13	450079	1.4697	17.69
430060	0.8973	9.05	440026		26.56	440083	1.0269	42.77	440166	1.6689	19.67	450018	1.4567	21.77	450080	1.1648	14.53
430064	1.0133	14.49	440029	1.2736	19.57	440084	1.1552	13.61	440168	1.0086	18.99	450020	0.9528	18.04	450081	0.9876	16.52

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
450082	0.9960	16.16	450146	0.8943	20.90	450213	1.7687	14.84	450307	0.6961	16.62	450411	0.9183	14.59	450545	1.1744	19.67
450083	1.7958	21.68	450147	1.3482	18.27	450214	1.3120	19.28	450309	1.0330	13.18	450417	0.9553	13.50	450547	1.0057	14.82
450085	1.1423	18.49	450148	1.1863	18.49	450217	0.9378	13.02	450315	0.9183	23.14	450418	1.4654	22.10	450551	1.0662	17.05
450087	1.4100	22.09	450149	1.5830	18.81	450219	0.9736	15.49	450320	1.2139	19.16	450419	1.1985	20.66	450558	1.8453	22.35
450090	1.1643	15.21	450150	0.9361	16.47	450221	1.0745	16.67	450321	0.8878	13.02	450422	1.0383	26.48	450563	1.2800	18.57
450092	1.1843	16.23	450151	1.1655	15.41	450222	1.5295	20.35	450322	0.6218	23.32	450423		22.83	450565	1.2368	16.38
450094	1.3057	22.14	450152	1.1794	18.29	450224	1.3260	26.64	450324	1.4635	18.06	450424	1.2331	18.88	450570	1.1060	19.17
450096	1.4316	17.97	450153	1.5855	19.54	450229	1.6656	16.55	450327	0.9713	11.85	450429	1.0777	14.19	450571	1.5416	16.83
450097	1.3604	19.38	450154	1.2060	13.92	450231	1.5949	19.10	450330	1.1591	19.03	450431	1.5180	19.91	450573	1.0078	15.78
450098	1.0430	20.60	450155	1.0641	11.69	450234	1.0237	16.45	450334	0.9096	12.85	450438	1.1740	19.73	450574	0.9157	14.86
450099	1.1801	19.44	450157	1.0359	15.83	450235	1.0433	15.36	450337	1.0009	17.46	450446	0.7064	13.10	450575	1.0415	19.41
450101	1.5377	17.19	450160	0.9635	17.74	450236	1.2054	16.52	450340	1.4004	16.76	450447	1.3487	18.15	450578	0.9355	15.74
450102	1.6869	17.86	450162	1.2420	21.17	450237	1.5863	20.88	450341	1.0090	19.30	450451	1.1711	18.91	450580	1.1929	15.90
450104	1.1446	16.72	450163	1.0163	17.58	450239	1.0093	17.54	450346	1.3165	16.62	450457	1.8455	26.17	450583	1.0284	15.85
450107	1.5559	23.53	450164	1.1251	17.02	450241	1.0053	12.68	450347	1.2273	17.22	450460	1.0059	15.43	450584	1.0554	14.26
450108	1.0361	15.79	450165	0.9970	13.79	450243	0.9962	11.96	450348	1.0832	13.95	450462	1.7608	19.31	450586	1.0130	14.45
450109	0.9101	13.84	450166	0.9848	11.48	450246	1.1557	16.55	450351	1.1985	17.56	450464	0.8967	13.29	450587	1.1749	17.14
450110		19.63	450169		13.24	450249	1.0124	12.20	450352	1.1554	15.59	450465	1.2051	15.65	450591	1.1231	17.90
450111	1.2657	19.41	450170	0.9179	14.47	450250	0.9090	10.29	450353	1.1249	16.90	450467	1.0074	10.62	450596	1.2398	21.99
450112	1.2205	16.16	450176	1.3096	16.21	450253	1.1342	12.27	450355	0.9593	12.92	450469	1.4645	19.80	450597	0.9200	17.32
450113	1.3520	17.49	450177	1.1283	14.79	450258	0.9538	16.34	450358	2.0646	21.38	450473	1.0003	20.34	450603	0.6767	11.65
450118		17.72	450178	0.9711	17.95	450264	0.9521	14.25	450362	1.0631	15.41	450475	1.1255	16.23	450604	1.3064	16.56
450119	1.2895	20.34	450181	1.0189	15.56	450269	1.0285	12.42	450369	1.0425	15.65	450484	1.5193	16.83	450605	1.1726	20.44
450121	1.4558	19.67	450184	1.4254	21.30	450270	1.1022	12.91	450370	1.1686	12.62	450488	1.3170	19.47	450609	0.8760	16.08
450123	1.1661	15.86	450185	0.9994	14.47	450271	1.2754	16.78	450371	1.1421	24.63	450489	0.9231	10.02	450610	1.5045	17.27
450124	1.7120	21.87	450187	1.2363	16.76	450272	1.2605	19.40	450372	1.2134	15.79	450497	1.0741	15.17	450614	0.9387	14.17
450126	1.3319	32.99	450188	0.9614	14.34	450276	1.0243	13.26	450373	1.0187	17.31	450498	0.9672	13.92	450615	1.1101	15.31
450128	1.2133	18.22	450191	1.0720	20.24	450278	0.9120	14.95	450374	0.9227	13.81	450508	1.4167	19.04	450617	1.3670	21.80
450130	1.3544	20.83	450192	1.1841	20.52	450280	1.5969	21.73	450378	1.3774	23.87	450514	1.0524	21.68	450620	1.0735	16.01
450131	1.2707	18.14	450193	1.9907	23.11	450283	1.0658	14.69	450379	1.4183	22.81	450517	0.9600	28.24	450623	1.1402	22.58
450132	1.5767	17.71	450194	1.3360	20.58	450288	1.1124	16.32	450381	0.9911	16.60	450518	1.4288	19.94	450626	1.0285	18.50
450133	1.5579	24.02	450196	1.4149	17.34	450289	1.4136	19.42	450388	1.7790	17.97	450523	1.4373	20.28	450628	0.9792	21.08
450135	1.6715	20.96	450200	1.4510	17.36	450292	1.2175	5.36	450389	1.3010	17.90	450530	1.2461	28.30	450630	1.4789	21.73
450137	1.5680	22.50	450201	1.0866	16.99	450293	0.9113	16.31	450393	1.1967	14.68	450534	0.9218	20.41	450631	1.7081	19.96
450140	0.9325	20.23	450203	1.0964	20.89	450296	1.1790	21.73	450395	0.9819	17.25	450535	1.2963	19.82	450632	0.9815	11.89
450143	1.0309	14.55	450209	1.7119	18.74	450299	1.4784	21.64	450399	0.8681	16.13	450537	1.2836	20.82	450633	1.5955	18.54
450144	1.0765	18.27	450210	1.0429	14.09	450303	0.8535	12.55	450400	1.3197	17.64	450539	1.1845	16.57	450634	1.7054	18.10
450145	0.8587	16.21	450211	1.3947	18.08	450306	1.0552	11.97	450403	1.2160	21.31	450544	1.1001	25.46	450638	1.5434	23.22

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
450639	1.4535	22.74	450702	1.3929	20.94	450775	1.2827	19.31	460007	1.3623	21.02	470004	1.0901	16.98	490033	1.1611	21.44
450641	0.9823	16.85	450704	1.1144	17.67	450776	0.9621	21.13	460008	1.3326	19.03	470005	1.2236	22.03	490037	1.2493	16.50
450643	1.2484	15.28	450705	0.8976	10.47	450777	0.9171	19.76	460009	1.8531	21.78	470006	1.2142	18.14	490038	1.1750	22.06
450644	1.5278	23.46	450706	1.2002	21.21	450779	1.3162	16.26	460010	2.0267	22.10	470008	1.2047	19.70	490040	1.4176	22.73
450646	1.4067	18.49	450709	1.2351	20.53	450780	1.6540	19.26	460011	1.4199	19.08	470010	1.1119	20.35	490041	1.3269	18.24
450647	1.8230	24.99	450711	1.6715	18.65	450785	0.8497	18.50	460013	1.3875	19.59	470011	1.1746	21.78	490042	1.2583	16.67
450648	1.0109	15.19	450712	0.5321	13.62	450788	1.5915	19.06	460014	1.1796		470012	1.2287	18.60	490043	1.3021	22.60
450649	0.9519	16.64	450713	1.4817	21.06	450794		18.22	460015	1.2695	20.84	470015	1.2640	20.58	490044	1.3680	18.39
450651	1.6788	22.80	450715	1.3773	22.21	450795	0.9434	16.65	460016	1.0803	18.66	470018	1.2088	21.70	490045	1.2492	20.74
450652		13.56	450716	1.2405	20.64	450796		16.54	460017	1.3617	17.95	470020	0.9267	21.33	490046	1.5443	18.48
450653	1.1007	18.42	450717	1.2506	20.77	450797		15.92	460018	0.9149	18.92	470023	1.3133	20.58	490047	1.0575	25.88
450654	0.9517	14.69	450718	1.1948	19.74	450798		9.66	460019	1.0442	16.62	470024	1.1433	20.88	490048	1.4965	18.83
450656	1.3437	17.42	450723	1.3958	19.76	450801	1.4413	16.61	460020	0.9010	17.38	490001	1.1856	22.06	490050	1.4056	23.10
450658	1.0274	16.26	450724	1.2345	20.38	450802	1.3907	19.92	460021	1.4514	21.12	490002	1.0447	16.63	490052	1.6530	16.89
450659	1.5156	21.64	450727	1.0718	13.65	450803	1.1881	17.10	460022	0.9548	20.59	490003	0.6857	19.17	490053	1.2444	15.72
450661	1.1545	19.78	450728	0.8812	17.83	450804	1.6092	18.91	460023	1.2893	22.42	490004	1.2554	19.25	490054	1.0026	15.75
450662	1.4591	18.33	450730	1.2159	22.12	450806	1.0901		460025	0.7321	21.01	490005	1.6128	20.67	490057	1.6660	19.96
450665	0.8576	15.36	450733	1.4100	17.35	450807	0.7885	11.72	460026	1.1345	20.17	490006	1.1819	16.17	490059	1.5972	21.25
450666	1.2980	20.59	450735		14.20	450808	1.9776	16.99	460027	0.9048	22.38	490007	2.1445	18.69	490060	1.0610	17.82
450668	1.6447	20.78	450742	1.2950	23.00	450809	1.5576	20.06	460029	1.0288	20.83	490009	1.8346	23.70	490063	1.7473	28.99
450669	1.2883	21.84	450743	1.5082	18.89	450810	0.8196		460030	1.1907	17.72	490010		22.96	490066	1.2752	19.28
450670	1.3667	16.94	450746	0.9165		450811	2.3313	19.11	460032	0.9642		490011	1.4315	17.97	490067	1.2439	17.42
450672	1.6502	21.68	450747	1.2546	19.20	450813	0.9759	15.92	460033	1.0248	19.62	490012	1.2096	16.29	490069	1.4470	14.45
450673	0.9922	14.16	450749	0.9838	16.34	450817	0.7497		460035	0.9162	16.27	490013	1.2819	17.34	490071	1.4402	21.90
450674	1.0414	22.39	450750	1.0004	14.75	450818	1.1935		460036	0.9335	24.10	490014	1.7745	25.89	490073	1.4367	20.91
450675	1.5238	22.56	450751	1.2101	22.05	450819	1.5223		460037	0.9614	19.16	490015	1.4511	19.68	490075	1.4050	18.50
450677	1.3365	22.99	450754	0.9924	16.19	450820	1.0098		460039	1.0265	25.10	490017	1.3972	18.65	490077	1.2582	21.44
450678	1.4631	23.40	450755	1.0440	17.99	450822	1.3206		460041	1.2947	21.11	490018	1.2388	19.02	490079	1.3006	17.72
450683	1.2553	20.55	450757	0.8813	13.87	450823	0.8929		460042	1.4016	18.27	490019	1.1702	19.76	490084	1.1482	16.95
450684	1.2358	19.75	450758	1.5865	22.64	450824	2.1452		460043	1.0320	24.56	490020	1.2444	18.77	490085	1.1526	17.78
450686	1.6694	15.61	450760	1.1227	17.76	450825	1.7366		460044	1.1802	21.55	490021	1.4211	19.70	490088	1.1466	17.26
450688	1.2922	19.80	450761	0.9095	13.77	450827	1.3679		460046		19.25	490022	1.5400	21.28	490089	1.0672	18.12
450690	1.3030	22.30	450763	1.0772	18.33	450828	1.1400		460047	1.6289	22.83	490023	1.1961	20.80	490090	1.1171	17.19
450694	1.1766	17.53	450766	2.0511	22.66	460001	1.7776	21.65	460049	2.0509	19.65	490024	1.6655	20.28	490091	1.2414	20.92
450696		25.05	450769	0.9131	14.64	460003	1.5139	20.12	460051	1.1512	19.49	490027	1.1283	16.56	490092	1.1993	17.41
450697	1.3828	19.22	450770	1.0388	16.59	460004	1.7379	18.65	460052	1.2179		490030		8.27	490093	1.4168	17.27
450698	0.9236	14.73	450771	1.8332	22.08	460005	1.5708	19.25	470001	1.3211	20.36	490031	1.0743	15.19	490094	1.0401	18.92
450700	0.9571	15.09	450774	1.4994	15.85	460006	1.2717	20.70	470003	1.8784	23.98	490032	1.7032	22.53	490097	1.2107	15.80

Average Hourly Wage based on data on file as of February 15, 2000. It does not reflect changes processed after that date.
ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
490098	1.1619	15.52	500015	1.3388	24.01	500068	1.0026	21.92	500139	1.4984	22.36	510060		17.83	520028	1.2946	22.03
490099	0.9143	18.11	500016	1.5172	24.52	500069	1.0966	21.36	500141	1.3708	23.88	510061	1.0311	13.89	520029	0.9182	19.61
490100		23.92	500019	1.4072	22.75	500071	1.2764	19.19	500143	0.5330	18.03	510062	1.1717	19.64	520030	1.6835	20.58
490101	1.2104	24.89	500021	1.4662	26.00	500072	1.1977	25.59	500146		21.60	510066		12.35	520031	1.0527	21.71
490104	0.7590	39.77	500023	1.1539	26.81	500073	0.9698	22.96	510001	1.8670	19.01	510067	1.1081	16.74	520032	1.2271	20.20
490105	0.6195	19.48	500024	1.7123	23.93	500074	1.0798	19.12	510002	1.2875	20.15	510068	1.2068	18.87	520033	1.1938	19.73
490106	0.8205	20.69	500025	1.8551	26.39	500077	1.2916	22.86	510005	1.0548	14.39	510070	1.3020	19.05	520034	1.1877	17.42
490107	1.3749	23.53	500026	1.4243	23.81	500079	1.2831	24.60	510006	1.2275	18.76	510071	1.3229	17.27	520035	1.2917	19.01
490108	0.9179	24.55	500027	1.6187	22.39	500080	0.8127	17.24	510007	1.5830	21.35	510072	1.0316	16.14	520037	1.6595	20.79
490109	0.8814	43.52	500028	1.0333	20.32	500084	1.1782	23.53	510008	1.2326	18.44	510077	1.1082	18.10	520038	1.2811	19.64
490110	1.3378	16.92	500029	0.9293	18.10	500085	0.9750	22.00	510012	0.9916	16.06	510080	1.0892	17.72	520039	0.9853	22.76
490111	1.1772	17.36	500030	1.4356	24.93	500086	1.2499	23.33	510013	1.0617	18.03	510081	1.1326	13.84	520040	1.5734	20.51
490112	1.6380	21.48	500031	1.2626	30.43	500088	1.3490	23.31	510015	0.9331	15.00	510082	1.1539	18.01	520041	1.1875	17.71
490113	1.2798	23.28	500033	1.3611	22.66	500089	1.0651	19.75	510018	1.0911	18.53	510084	0.9761		520042	1.0978	18.72
490114	1.0713	17.41	500036	1.3684	22.32	500090	0.9553	18.09	510020	1.0381	13.49	510085	1.2868	17.40	520044	1.4432	18.66
490115	1.1835	16.85	500037	1.1283	20.73	500092	1.0483	17.17	510022	1.8940	20.21	510086	1.0538		520045	1.6686	20.60
490116	1.1827	17.07	500039	1.4018	24.02	500094	0.8629	19.67	510023	1.2009	16.14	510088	1.0585		520047	0.9641	19.77
490117	1.1675	14.14	500041	1.2903	24.27	500096	1.0371	20.98	510024	1.5609	19.15	520002	1.2446	19.80	520048	1.4699	20.73
490118	1.7174	21.79	500042		22.91	500097	1.1124	20.30	510026	1.0625	13.89	520003	1.1470	17.12	520049	2.1110	20.42
490119	1.4774	17.91	500043	0.9855	22.03	500098	0.9611	16.56	510027	0.9781	17.55	520004	1.2166	20.57	520051	1.7733	21.74
490120	1.3380	19.31	500044	1.9958	23.47	500101	0.9913	19.75	510028	1.0360	20.50	520006	1.0031	22.32	520053	1.1632	17.45
490122	1.3994	24.00	500045	1.0519	21.03	500102	0.9753	20.99	510029	1.2643	17.79	520007	1.0609	16.45	520054	1.0276	16.04
490123	1.1397	17.96	500048	0.9209	23.64	500104	1.2042	22.82	510030	1.0272	17.58	520008	1.6068	22.82	520057	1.1291	19.21
490124	1.0762	21.36	500049	1.4087	24.86	500106	0.9099	19.03	510031	1.4214	31.62	520009	1.6634	18.66	520058	1.1246	19.73
490126	1.3068	19.13	500050	1.3901	22.09	500107	1.1275	18.12	510033	1.2891	16.44	520010	1.0997	22.77	520059	1.3217	21.20
490127	1.0278	16.17	500051	1.7224	24.92	500108	1.7558	26.43	510035	1.1875	16.75	520011	1.1660	20.84	520060	1.4629	18.35
490129	1.0921	70.69	500052	1.3449		500110	1.1461	21.63	510036	0.9419	14.42	520013	1.3438	15.83	520062	1.2311	19.42
490130	1.2502	16.53	500053	1.3078	24.04	500118	1.1260	23.84	510038	1.0712	15.92	520014	1.1234	17.23	520063	1.1835	19.72
490132	1.1041	19.11	500054	1.9647	28.67	500119	1.2955	22.48	510039	1.4126	17.00	520015	1.1646	18.71	520064	1.5643	22.81
500001	1.5630	22.39	500055	1.0899	23.94	500122	1.2366	22.87	510043	0.8981	14.27	520016	1.1835	18.32	520066	1.4377	23.81
500002	1.4632	21.89	500057	1.2634	18.32	500123	1.0661	20.51	510046	1.2032	17.49	520017	1.1188	20.03	520068	0.9323	19.48
500003	1.4120	28.85	500058	1.4557	24.82	500124	1.3291	23.38	510047	1.1603		520018	1.0709	20.18	520069	1.1929	20.55
500005	1.8140	22.48	500059	1.0927	23.65	500125	1.0770	15.91	510048	1.1370	21.04	520019	1.1935	20.02	520070	1.5322	18.68
500007	1.3788	26.17	500060	1.4548	25.20	500127	1.0838		510050	1.7222	17.01	520021	1.4890	21.38	520071	1.2015	19.17
500008	1.8285	25.37	500061	0.9435	21.72	500129	1.5989	26.11	510053	1.0166	16.53	520024	1.0043	14.08	520074	1.0144	21.03
500011	1.3586	23.89	500062	1.0828	18.84	500132	1.0101	15.67	510055	1.2904	23.80	520025	1.0627	18.43	520075	1.4649	20.29
500012	1.5651	21.02	500064	1.5966	25.70	500134	0.6380	17.75	510058	1.2883	18.58	520026	1.1073	21.63	520076	1.1466	18.01
500014	1.5484	24.43	500065	1.2588	21.94	500138	4.4489		510059	2.2171	16.77	520027	1.2727	19.95	520077	0.9197	17.92

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

TABLE 3C: HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1999
HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2001 WAGE INDEX

PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE	PROV.	CASE MIX INDEX	AVG. HOUR. WAGE
520078	1.5782	21.35	520134	1.1381	18.36	530012	1.6523	19.07									
520082		17.76	520135	0.8966	15.92	530014	1.4436	18.33									
520083	1.6498	23.92	520136	1.4618	19.95	530015	1.2294	22.89									
520084	1.1004	20.86	520138	1.8041	21.26	530016	1.2655	18.77									
520087	1.6939	20.48	520139	1.2597	21.06	530017	0.9021	16.52									
520088	1.2653	21.10	520140	1.6432	21.66	530018	1.2153	18.90									
520089	1.4636	21.62	520142	0.8531	22.95	530019	0.9189	19.65									
520090	1.3780	18.96	520144	1.0474	18.75	530022	1.1474	18.75									
520091	1.3127	21.61	520145	0.9007	18.40	530023	0.8667	20.69									
520092	1.1118	17.82	520146	1.0503	18.01	530025	1.4917	21.46									
520094	0.7713	20.53	520148	1.1135	17.41	530026	0.9944	18.10									
520095	1.2760	20.54	520149	0.9075	14.45	530027	0.8937	18.04									
520096	1.4155	19.73	520151	1.0428	17.38	530029	0.9222	20.22									
520097	1.2960	20.12	520152	1.1007	20.40	530031	0.7912	19.18									
520098	1.8137	22.48	520153	0.9397	16.73	530032	1.0391	21.19									
520100	1.2287	18.54	520154	1.1326	18.60												
520101	1.1324	19.65	520156	1.1396	21.58												
520102	1.1668	20.30	520157	1.0554	18.12												
520103	1.3028	19.56	520159	0.9117	18.98												
520107	1.2267	20.82	520160	1.7786	19.42												
520109	1.0392	19.42	520161	0.9866	20.37												
520110	1.2277	20.50	520170	1.2569	21.62												
520111	0.9743	17.85	520171	0.9402	18.19												
520112	1.1347	19.21	520173	1.1319	21.37												
520113	1.3008	21.31	520177	1.6377	22.29												
520114	1.0857	17.84	520178	1.0532	19.94												
520115	1.1995	18.55	520188	2.3936	13.91												
520116	1.1297	20.34	520189	1.0866													
520117	1.0176	18.85	530002	1.1379	19.42												
520118	0.8951	15.80	530003	0.8570	18.11												
520120		25.88	530004	0.9967	15.19												
520121	0.9684	20.63	530005	1.2070	13.46												
520122	0.9672	16.97	530006	1.1178	18.73												
520123	1.0245	17.40	530007	0.9956	20.19												
520124	1.0387	17.77	530008	1.1846	19.18												
520130	1.0843	16.31	530009	0.9534	22.99												
520131	0.9925	19.00	530010	1.2257	22.07												
520132	1.1750	15.68	530011	1.1642	18.74												

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ASTERISK DENOTES TEACHING PHYSICIAN COSTS REMOVED BASED ON COSTS REPORTED ON WORKSHEET A, COL. 1, LINE 23 OF FY 1997 COST REPORT.

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

Urban area (constituent counties)	Wage index	GAF
0040 Abilene, TX	0.8318	0.8815
Taylor, TX		
0060 Aguadilla, PR	0.4826	0.6072
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	1.0557	1.0378
Portage, OH		
Summit, OH		
0120 Albany, GA	1.1854	1.1235
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8563	0.8992
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9365	0.9561
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8262	0.8774
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9849	0.9896
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9262	0.9489
Blair, PA		
0320 Amarillo, TX Potter, TX	0.8663	0.9064
Randall, TX		
0380 Anchorage, AK	1.2967	1.1947
Anchorage, AK		
0440 Ann Arbor, MI	1.1283	1.0862
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8331	0.8825
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.9101	0.9375
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4540	0.5823
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9527	0.9674
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9829	0.9883
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	0.9945	0.9962
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.1220	1.0820
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.8170	0.8707
Lee, AL		
0600 Augusta-Aiken, GA–SC	0.9226	0.9463
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9436	0.9610
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	0.9966	0.9977
Kern, CA		
0720 [1] Baltimore, MD	0.9485	0.9644
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9613	0.9733
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3938	1.2553
Barnstable, MA		
0760 Baton Rouge, LA	0.8964	0.9278
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8361	0.8846
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1491	1.0998
Whatcom, WA		
0870 [2] Benton Harbor, MI	0.9133	0.9398
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1727	1.1153
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9577	0.9708
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8282	0.8789
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8723	0.9107
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.8574	0.9000
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8016	0.8595
Burleigh, ND		
Morton, ND		
1020 Bloomington-Normal, IL	0.8854	0.9200
Monroe, IN		
1040 Bloomington-Normal, IL	0.9294	0.9511
McLean, IL		
1080 Boise City, ID	0.9133	0.9398
Ada, ID		
Canyon, ID		
1123 [1 2] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (MA Hospitals)	1.1348	1.0905
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH Hospitals)	1.1239	1.0833
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.9798	0.9861
Boulder, CO		
1145 Brazoria, TX	0.8751	0.9127
Brazoria, TX		
1150 Bremerton, WA	1.1069	1.0720
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8794	0.9158

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

Urban area (constituent counties)	Wage index	GAF
Cameron, TX		
1260 Bryan-College Station, TX	0.8306	0.8806
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9566	0.9701
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9624	0.9741
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4591	0.5868
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 [2] Canton-Massillon, OH	0.8778	0.9146
Carroll, OH		
Stark, OH		
1350 [2] Casper, WY	0.9046	0.9336
Natrona, WY		
1360 Cedar Rapids, IA	0.8396	0.8872
Linn, IA		
1400 Champaign-Urbana, IL	0.9353	0.9552
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9094	0.9370
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9324	0.9532
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC–SC	0.9307	0.9520
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0744	1.0504
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	1.0083	1.0057
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.9046	0.9336
Laramie, WY		
1600 [1] Chicago, IL	1.1027	1.0692
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0684	1.0464
Butte, CA		
1640 1Cincinnati, OH–KY–IN	0.9330	0.9536
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
1660 Clarksville-Hopkinsville, TN–KY	0.8393	0.8869
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9649	0.9758
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9770	0.9842
El Paso, CO		
1740 Columbia, MO	0.8600	0.9019
Boone, MO		
1760 Columbia, SC	0.9641	0.9753
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.8607	0.9024
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9741	0.9822
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8496	0.8944
Nueces, TX		
San Patricio, TX		
1890 Corvallis, OR	1.1439	1.0964
Benton, OR		
1900 [2] Cumberland, MD–WV (MD Hospitals)	0.8717	0.9103
Allegany, MD		
Mineral, WV		
1900 Cumberland, MD–WV (WV Hospital)	0.8437	0.8901
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9220	0.9459
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8527	0.8966
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.9021	0.9319
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9519	0.9668
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.9179	0.9430
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8627	0.9038
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.8601	0.9019
Macon, IL		
2080 [1] Denver, CO	1.0032	1.0022
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.9211	0.9453
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0057	1.0039
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.8105	0.8660
Dale, AL		
Houston, AL		
2190 Dover, DE	1.1032	1.0696
Kent, DE		
2200 Dubuque, IA	0.8928	0.9253
Dubuque, IA		
2240 Duluth-Superior, MN–WI	1.0201	1.0137
St. Louis, MN		
Douglas, WI		

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

Urban area (constituent counties)	Wage index	GAF
2281 Dutchess County, NY Dutchess, NY	0.9599	0.9724
2290 [2] Eau Claire, WI Chippewa, WI Eau Claire, WI	0.9073	0.9356
2320 El Paso, TX El Paso, TX	0.9215	0.9456
2330 Elkhart-Goshen, IN Elkhart, IN	0.9549	0.9689
2335 Elmira, NY Chemung, NY	0.8645	0.9051
2340 Enid, OK Garfield, OK	0.8781	0.9148
2360 Erie, PA Erie, PA	0.9021	0.9319
2400 Eugene-Springfield, OR Lane, OR	1.1026	1.0692
2440 [2] Evansville-Henderson, IN–KY (IN Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8807	0.9167
2440 Evansville-Henderson, IN–KY (KY Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8018	0.8596
2520 Fargo-Moorhead, ND–MN Clay, MN Cass, ND	0.8830	0.9183
2560 Fayetteville, NC Cumberland, NC	0.8638	0.9046
2580 Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.7999	0.8582
2620 Flagstaff, AZ–UT Coconino, AZ Kane, UT	1.0844	1.0571
2640 Flint, MI Genesee, MI	1.1189	1.0800
2650 Florence, AL Colbert, AL Lauderdale, AL	0.7621	0.8302
2655 Florence, SC Florence, SC	0.8838	0.9189
2670 Fort Collins-Loveland, CO Larimer, CO	1.1005	1.0678
2680 [1] Ft. Lauderdale, FL Broward, FL	1.0228	1.0156
2700 Fort Myers-Cape Coral, FL Lee, FL	0.9112	0.9383
2710 Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	0.9672	0.9774
2720 Fort Smith, AR–OK Crawford, AR Sebastian, AR Sequoyah, OK	0.8858	0.9203
2750 Fort Walton Beach, FL Okaloosa, FL	0.9351	0.9551
2760 [2] Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.8807	0.9167
2800 [1] Forth Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9442	0.9614
2840 Fresno, CA Fresno, CA Madera, CA	1.0184	1.0126
2880 Gadsden, AL Etowah, AL	0.8491	0.8940
2900 Gainesville, FL Alachua, FL	1.0286	1.0195
2920 Galveston-Texas City, TX Galveston, TX	1.0284	1.0194
2960 Gary, IN Lake, IN Porter, IN	0.9454	0.9623
2975 [2] Glens Falls, NY Warren, NY Washington, NY	0.8558	0.8989
2980 [2] Goldsboro, NC Wayne, NC	0.8553	0.8985
2985 Grand Forks, ND–MN Polk, MN Grand Forks, ND	1.0207	1.0141
2995 Grand Junction, CO Mesa, CO	0.9601	0.9725
3000 [1] Grand Rapids-Muskegon-Holland, MI Allegan, MI Kent, MI Muskegon, MI Ottawa, MI	1.0256	1.0175
3040 Great Falls, MT Cascade, MT	0.9447	0.9618
3060 Greeley, CO Weld, CO	0.9908	0.9937
3080 Green Bay, WI Brown, WI	0.9359	0.9556
3120 [1] Greensboro-Winston-Salem-High Point, NC Alamance, NC Davidson, NC Davie, NC Forsyth, NC Guilford, NC Randolph, NC Stokes, NC Yadkin, NC	0.9187	0.9436
3150 Greenville, NC Pitt, NC	0.9454	0.9623
3160 Greenville-Spartanburg-Anderson, SC Anderson, SC Cherokee, SC Greenville, SC Pickens, SC Spartanburg, SC	0.9160	0.9417
3180 Hagerstown, MD Washington, MD	0.9647	0.9757
3200 Hamilton-Middletown, OH Butler, OH	0.8892	0.9227
3240 Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	0.9467	0.9632
3283 [1 2] Hartford, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.1798	1.1199
3285 [2] Hattiesburg, MS Forrest, MS Lamar, MS	0.7608	0.8293
3290 Hickory-Morganton-Lenoir, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.8989	0.9296
3320 Honolulu, HI Honolulu, HI	1.1905	1.1268
3350 Houma, LA Lafourche, LA Terrebonne, LA	0.8218	0.8742
3360 [1] Houston, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	0.9661	0.9767
3400 Huntington-Ashland, WV–KY–OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9961	0.9973
3440 Huntsville, AL Limestone, AL Madison, AL	0.9089	0.9367
3480 [1] Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN	0.9314	0.9525

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

Urban area (constituent counties)	Wage index	GAF
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9749	0.9827
Johnson, IA		
3520 [2] Jackson, MI	0.9133	0.9398
Jackson, MI		
3560 Jackson, MS	0.8890	0.9226
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8939	0.9261
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.8995	0.9300
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8553	0.8985
Onslow, NC		
3610 [2] Jamestown, NY	0.8558	0.8989
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9856	0.9901
Rock, WI		
3640 Jersey City, NJ	1.0985	1.0664
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8412	0.8883
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA	0.8686	0.9080
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.8587	0.9009
Craighead, AR		
3710 Joplin, MO	0.7924	0.8527
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0247	1.0168
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.8954	0.9271
Kankakee, IL		
3760 [1] Kansas City, KS–MO	0.9629	0.9744
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9703	0.9796
Kenosha, WI		
3810 Killeen-Temple, TX	1.0321	1.0219
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8422	0.8890
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9190	0.9438
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.9442	0.9614
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8852	0.9199
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.9091	0.9368
Clinton, IN		
Tippecanoe, IN		
3960 [2] Lake Charles, LA	0.7921	0.8525
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8904	0.9236
Polk, FL		
4000 Lancaster, PA	0.9274	0.9497
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9873	0.9913
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.7637	0.8314
Webb, TX		
4100 Las Cruces, NM	0.8744	0.9122
Dona Ana, NM		
4120 [1] Las Vegas, NV–AZ	1.0876	1.0592
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8272	0.8782
Douglas, KS		
4200 Lawton, OK	0.9156	0.9414
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9064	0.9349
Androscoggin, ME		
4280 Lexington, KY	0.8921	0.9248
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9634	0.9748
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9808	0.9868
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8959	0.9275
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8816	0.9173
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.1955	1.1301
Los Angeles, CA		
4520 Louisville, KY–IN	0.9395	0.9582
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8828	0.9182
Lubbock, TX		
4640 Lynchburg, VA	0.9218	0.9458
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.9046	0.9336
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0354	1.0241
Dane, WI		
4800 [2] Mansfield, OH	0.8778	0.9146
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4617	0.5891
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8403	0.8877
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0438	1.0298
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9713	0.9803
Brevard, Fl		

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

Urban area (constituent counties)	Wage index	GAF
4920 [1 2] Memphis, TN–AR–MS (TN Hospitals)	0.7980	0.8568
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4920 [1 2] Memphis, TN–AR–MS (AR Hospitals)	0.7538	0.8240
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4920 [1 2] Memphis, TN–AR–MS (MS Hospitals)	0.7608	0.8293
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 [2] Merced, CA	0.9966	0.9977
Merced, CA		
5000 [1] Miami, FL	1.0148	1.0101
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.0342	1.0233
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9803	0.9865
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN–WI	1.1118	1.0753
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9462	0.9628
Missoula, MT		
5160 Mobile, AL	0.8205	0.8733
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0481	1.0327
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1552	1.1038
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8467	0.8923
Ouachita, LA		
5240 [2] Montgomery, AL	0.7610	0.8294
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	1.0734	1.0497
Delaware, IN		
5330 Myrtle Beach, SC	0.8658	0.9060
Horry, SC		
5345 Naples, FL	0.9396	0.9582
Collier, FL		
5360 [1] Nashville, TN	0.9201	0.9446
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3089	1.2024
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2135	1.1417
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.1984	1.1319
New London, CT		
5560 [1] New Orleans, LA	0.9283	0.9503
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.4445	1.2864
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.0717	1.0486
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.0946	1.0639
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA–NC	0.8429	0.8896
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City, VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5051	1.3231
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.8904	0.9236
Marion, FL		
5800 Odessa-Midland, TX	0.9168	0.9422
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8910	0.9240
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0787	1.0532
Thurston, WA		
5920 Omaha, NE–IA	0.9707	0.9798
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1560	1.1044
Orange, CA		
5960 [1] Orlando, FL	0.9959	0.9972
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 [2] Owensboro, KY	0.8017	0.8595
Daviess, KY		
6015 Panama City, FL	0.9129	0.9395
Bay, FL		
6020 [2] Parkersburg-Marietta, WV–OH (WV Hospitals)	0.8321	0.8817
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV–OH (OH Hospitals)	0.8778	0.9146
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8904	0.9236
Escambia, FL		
Santa Rosa, FL		

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

Urban area (constituent counties)	Wage index	GAF
6120 Peoria-Pekin, IL	0.8687	0.9081
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA–NJ	1.0660	1.0447
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9532	0.9677
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7866	0.8484
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9818	0.9875
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.1348	1.0905
Berkshire, MA		
6340 Pocatello, ID	1.0819	1.0554
Bannock, ID		
6360 Ponce, PR	0.4347	0.5652
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9779	0.9848
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR–WA	1.0928	1.0627
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0955	1.0645
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9972	0.9981
Utah, UT		
6560 [2] Pueblo, CO	0.9179	0.9430
Pueblo, CO		
6580 Punta Gorda, FL	0.9565	0.9700
Charlotte, FL		
6600 Racine, WI	0.9298	0.9514
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9749	0.9827
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8463	0.8920
Pennington, SD		
6680 Reading, PA	0.9203	0.9447
Berks, PA		
6690 Redding, CA	1.1795	1.1197
Shasta, CA		
6720 Reno, NV	1.0508	1.0345
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.1564	1.1046
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9679	0.9779
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.1159	1.0780
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.9543	0.9685
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1361	1.0913
Olmsted, MN		
6840 [1] Rochester, NY	0.8846	0.9195
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8904	0.9236
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8875	0.9215
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.2003	1.1332
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9475	0.9637
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	1.0164	1.0112
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.9245	0.9477
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO–IL	0.9114	0.9384
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 [2] Salem, OR	1.0300	1.0204
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4649	1.2988
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9661	0.9767
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7747	0.8396
Tom Green, TX		
7240 [1] San Antonio, TX	0.8087	0.8647
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1901	1.1266
San Diego, CA		
7360 [1] San Francisco, CA	1.4433	1.2857
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4376	1.2822
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4691	0.5955
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		

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

Urban area (constituent counties)	Wage index	GAF
Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Luguillo, PR Manati, PR Morovis, PR Naguabo, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.0755	1.0511
7480 Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0728	1.0493
7485 Santa Cruz-Watsonville, CA Santa Cruz, CA	1.4736	1.3041
7490 Santa Fe, NM Los Alamos, NM Santa Fe, NM	0.9383	0.9573
7500 Santa Rosa, CA Sonoma, CA	1.3182	1.2083
7510 Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9670	0.9773
7520 Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.8689	0.9083
7560 [2] Scranton-Wilkes-Barre-Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8686	0.9080
7600 [1] Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.1134	1.0763
7610 [2] Sharon, PA Mercer, PA	0.8686	0.9080
7620 [2] Sheboygan, WI Sheboygan, WI	0.9073	0.9356
7640 Sherman-Denison, TX Grayson, TX	0.8619	0.9032
7680 Shreveport-Bossier City, LA Bossier, LA Caddo, LA Webster, LA	0.8853	0.9200
7720 Sioux City, IA–NE Woodbury, IA Dakota, NE	0.8571	0.8998
7760 Sioux Falls, SD Lincoln, SD Minnehaha, SD	0.8890	0.9226
7800 South Bend, IN St. Joseph, IN	1.0233	1.0159
7840 Spokane, WA Spokane, WA	1.1979	1.1316
7880 Springfield, IL Menard, IL Sangamon, IL	0.8744	0.9122
7920 Springfield, MO Christian, MO Greene, MO Webster, MO	0.8357	0.8843
8003 [2] Springfield, MA Hampden, MA Hampshire, MA	1.1348	1.0905
8050 State College, PA Centre, PA	0.9114	0.9384
8080 [2] Steubenville-Weirton, OH–WV (OH Hospitals) Jefferson, OH Brooke, WV Hancock, WV	0.8778	0.9146
8080 Steubenville-Weirton, OH–WV (WV Hospitals) Jefferson, OH Brooke, WV Hancock, WV	0.8658	0.9060
8120 Stockton-Lodi, CA San Joaquin, CA	1.0711	1.0482
8140 [2] Sumter, SC Sumter, SC	0.8445	0.8907
8160 Syracuse, NY Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	0.9662	0.9767
8200 Tacoma, WA Pierce, WA	1.1658	1.1108
8240 [2] Tallahassee, FL Gadsden, FL Leon, FL	0.8904	0.9236
8280 [1] Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.9111	0.9382
8320 [2] Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8807	0.9167
8360 Texarkana, AR-Texarkana, TX Miller, AR Bowie, TX	0.7962	0.8555
8400 Toledo, OH Fulton, OH Lucas, OH Wood, OH	0.9705	0.9797
8440 Topeka, KS Shawnee, KS	0.9134	0.9399
8480 Trenton, NJ Mercer, NJ	0.9919	0.9944
8520 Tucson, AZ Pima, AZ	0.8826	0.9180
8560 Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8698	0.9089
8600 Tuscaloosa, AL Tuscaloosa, AL	0.8081	0.8642
8640 Tyler, TX Smith, TX	0.9270	0.9494
8680 [2] Utica-Rome, NY Herkimer, NY Oneida, NY	0.8558	0.8989
8720 Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.2672	1.1761
8735 Ventura, CA Ventura, CA	1.0586	1.0398
8750 Victoria, TX Victoria, TX	0.8133	0.8680
8760 Vineland-Millville-Bridgeton, NJ Cumberland, NJ	1.0462	1.0314
8780 [2] Visalia-Tulare-Porterville, CA Tulare, CA	0.9966	0.9977
8800 Waco, TX McLennan, TX	0.8402	0.8876
8840 [1] Washington, DC–MD–VA–WV District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Clarke, VA Culpeper, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier, VA Fredericksburg City, VA King George, VA Loudoun, VA Manassas City, VA Manassas Park City, VA Prince William, VA Spotsylvania, VA Stafford, VA	1.0832	1.0563

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

Urban area (constituent counties)	Wage index	GAF
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.8932	0.9256
Black Hawk, IA		
8940 Wausau, WI	0.9511	0.9663
Marathon, WI		
8960 [1] West Palm Beach-Boca Raton, FL	0.9658	0.9765
Palm Beach, FL		
9000 [2] Wheeling, WV–OH (WV Hospitals)	0.8321	0.8817
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV–OH (OH Hospitals)	0.8778	0.9146
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9574	0.9706
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7668	0.8337
Archer, TX		
Wichita, TX		
9140 [2] Williamsport, PA	0.8686	0.9080
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1281	1.0860
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9474	0.9637
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0763	1.0516
Yakima, WA		
9270 Yolo, CA	1.0261	1.0178
Yolo, CA		
9280 York, PA	0.9427	0.9604
York, PA		
9320 Youngstown-Warren, OH	0.9604	0.9727
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0820	1.0555
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9605	0.9728
Yuma, AZ		

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

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

Nonurban Area	Wage Index	GAF
Alabama	0.7610	0.8294
Alaska	1.2681	1.1766
Arizona	0.8400	0.8875
Arkansas	0.7538	0.8240
California	0.9966	0.9977
Colorado	0.9179	0.9430
Connecticut	1.1798	1.1199
Delaware	0.9349	0.9549
Florida	0.8904	0.9236
Georgia	0.8510	0.8954
Hawaii	1.1438	1.0964
Idaho	0.8831	0.9184
Illinois	0.8320	0.8817
Indiana	0.8807	0.9167
Iowa	0.8196	0.8726
Kansas	0.7710	0.8369
Kentucky	0.8017	0.8595
Louisiana	0.7921	0.8525
Maine	0.8813	0.9171
Maryland	0.8717	0.9103
Massachusetts	1.1348	1.0905
Michigan	0.9133	0.9398
Minnesota	0.9116	0.9386
Mississippi	0.7608	0.8293
Missouri	0.7766	0.8410
Montana	0.9017	0.9316
Nebraska	0.8265	0.8777
Nevada	0.9354	0.9553
New Hampshire	0.9995	0.9997
New Jersey [1]	0.0000	.....
New Mexico	0.8425	0.8893
New York	0.8558	0.8989
North Carolina	0.8553	0.8985
North Dakota	0.7698	0.8360
Ohio	0.8778	0.9146
Oklahoma	0.7622	0.8303
Oregon	1.0300	1.0204
Pennsylvania	0.8686	0.9080
Puerto Rico	0.4232	0.5550
Rhode Island [1]	0.0000	.....
South Carolina	0.8445	0.8907
South Dakota	0.7786	0.8425
Tennessee	0.7980	0.8568
Texas	0.7523	0.8229
Utah	0.9182	0.9432
Vermont	0.9538	0.9681
Virginia	0.8361	0.8846
Washington	1.0763	1.0516
West Virginia	0.8321	0.8817
Wisconsin	0.9073	0.9356
Wyoming	0.9046	0.9336

[1] All counties within the State are classified as urban.

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

Area	Wage index	GAF
Abilene, TX	0.8318	0.8815
Akron, OH	1.0181	1.0124
Albany, GA	1.0783	1.0530
Alexandria, LA	0.8262	0.8774
Amarillo, TX	0.8663	0.9064

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

Area	Wage index	GAF
Anchorage, AK	1.2967	1.1947
Ann Arbor, MI	1.1177	1.0792
Atlanta, GA	0.9945	0.9962
Atlantic-Cape May, NJ	1.0998	1.0673
Augusta-Aiken, GA–SC	0.9226	0.9463
Baltimore, MD	0.9485	0.9644
Barnstable-Yarmouth, MA	1.3694	1.2402
Baton Rouge, LA	0.8856	0.9202
Benton Harbor, MI	0.9133	0.9398
Bergen-Passaic, NJ	1.1727	1.1153
Billings, MT	0.9577	0.9708
Binghamton, NY	0.8723	0.9107
Birmingham, AL	0.8574	0.9000
Bismarck, ND	0.8016	0.8595
Bloomington, IN	0.9294	0.9511
Boise City, ID	0.9133	0.9398
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH, RI, and VT Hospitals)	1.1239	1.0833
Bryan-College Station, TX	0.8306	0.8806
Burlington, VT (VT Hospitals)	0.9538	0.9681
Burlington, VT (NY Hospital)	0.9238	0.9472
Casper, WY	0.9046	0.9336
Champaign-Urbana, IL	0.9353	0.9552
Charleston-North Charleston, SC	0.9094	0.9370
Charleston, WV	0.9003	0.9306
Charlotte-Gastonia-Rock Hill, NC–SC	0.9307	0.9520
Chattanooga, TN–GA	0.9795	0.9859
Chicago, IL	1.0902	1.0609
Cincinnati, OH–KY–IN	0.9330	0.9536
Clarksville-Hopkinsville, TN–KY	0.8393	0.8869
Cleveland-Lorain-Elyria, OH	0.9649	0.9758
Columbia, MO	0.8600	0.9019
Columbia, SC	0.9517	0.9667
Columbus, OH	0.9741	0.9822
Dallas, TX	0.9220	0.9459
Danville, VA	0.8361	0.8846
Davenport-Moline—Rock Island, IA–IL	0.9021	0.9319
Dayton-Springfield, OH	0.9519	0.9668
Denver, CO	1.0032	1.0022
Des Moines, IA	0.9087	0.9365
Dothan, AL	0.8105	0.8660
Dover, DE	0.9349	0.9549
Duluth-Superior, MN–WI	1.0201	1.0137
Eau Claire, WI	0.9073	0.9356
Erie, PA	0.9021	0.9319
Eugene-Springfield, OR	1.1026	1.0692
Fargo-Moorhead, ND–MN (ND and SD Hospitals)	0.8597	0.9017
Fayetteville, NC	0.8553	0.8985
Flagstaff, AZ–UT	1.0678	1.0459
Flint, MI	1.1189	1.0800
Florence, AL	0.7621	0.8302
Florence, SC	0.8838	0.9189

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

Area	Wage index	GAF
Fort Collins-Loveland, CO	1.1005	1.0678
Ft. Lauderdale, FL	1.0228	1.0156
Fort Pierce-Port St. Lucie, FL	0.9672	0.9774
Fort Smith, AR–OK	0.8634	0.9043
Fort Wayne, IN	0.8807	0.9167
Forth Worth-Arlington, TX	0.9442	0.9614
Gadsden, AL	0.8491	0.8940
Grand Forks, ND–MN	1.0042	1.0029
Grand Junction, CO	0.9601	0.9725
Grand Rapids-Muskegon-Holland, MI	1.0150	1.0102
Great Falls, MT	0.9447	0.9618
Greeley, CO	0.9642	0.9753
Green Bay, WI	0.9359	0.9556
Greensboro-Winston-Salem-High Point, NC	0.9187	0.9436
Greenville, NC	0.9244	0.9476
Greenville-Spartanburg-Anderson, SC	0.9160	0.9417
Harrisburg-Lebanon-Carlisle, PA	0.9360	0.9557
Hartford, CT (MA Hospital)	1.1530	1.1024
Hattiesburg, MS	0.7608	0.8293
Hickory-Morganton-Lenoir, NC	0.8766	0.9138
Honolulu, HI	1.1905	1.1268
Houston, TX	0.9661	0.9767
Huntington-Ashland, WV–KY–OH	0.9721	0.9808
Huntsville, AL	0.8882	0.9220
Indianapolis, IN	0.9314	0.9525
Jackson, MS	0.8776	0.9145
Jackson, TN	0.8939	0.9261
Jacksonville, FL	0.8995	0.9300
Jersey City, NJ	1.0985	1.0664
Johnson City-Kingsport-Bristol, TN–VA	0.8412	0.8883
Joplin, MO	0.7924	0.8527
Kalamazoo-Battlecreek, MI	1.0144	1.0098
Kansas City, KS–MO	0.9629	0.9744
Knoxville, TN	0.8422	0.8890
Kokomo, IN	0.9190	0.9438
Lafayette, LA	0.8852	0.9199
Lansing-East Lansing, MI	0.9873	0.9913
Las Cruces, NM	0.8623	0.9035
Las Vegas, NV–AZ	1.0876	1.0592
Lexington, KY	0.8769	0.9140
Lima, OH	0.9497	0.9653
Lincoln, NE	0.9808	0.9868
Little Rock-North Little Rock, AR	0.8841	0.9191
Longview-Marshall, TX	0.8403	0.8877
Los Angeles-Long Beach, CA	1.1955	1.1301
Louisville, KY–IN	0.9395	0.9582
Lynchburg, VA	0.9090	0.9368
Macon, GA	0.9046	0.9336
Madison, WI	1.0354	1.0241
Mansfield, OH	0.8778	0.9146
Memphis, TN–AR–MS (AR Hospital)	0.7538	0.8240
Memphis, TN–AR–MS (MS Hospital)	0.7608	0.8293
Milwaukee-Waukesha, WI	0.9803	0.9865
Minneapolis-St. Paul, MN–WI	1.1118	1.0753
Missoula, MT	0.9462	0.9628
Mobile, AL	0.8205	0.8733
Monmouth-Ocean, NJ	1.1552	1.1038
Montgomery, AL	0.7610	0.8294
Myrtle Beach, SC (NC Hospital)	0.8553	0.8985
Nashville, TN	0.9078	0.9359
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2135	1.1417
New London-Norwich, CT	1.1861	1.1240
New Orleans, LA	0.9283	0.9503
New York, NY	1.4445	1.2864
Newburgh, NY–PA	0.9919	0.9944
Norfolk-Virginia Beach-Newport News, VA–NC (NC Hospital)	0.8553	0.8985
Oakland, CA	1.5051	1.3231
Ocala, FL	0.8904	0.9236
Odessa-Midland, TX	0.9058	0.9345
Oklahoma City, OK	0.8910	0.9240
Omaha, NE–IA	0.9707	0.9798
Orange County, CA	1.1560	1.1044
Orlando, FL	0.9856	0.9901
Peoria-Pekin, IL	0.8687	0.9081
Pine Bluff, AR	0.7762	0.8407
Pittsburgh, PA	0.9713	0.9803
Pittsfield, MA (VT Hospital)	1.0032	1.0022
Pocatello, ID	0.9265	0.9491
Portland, ME	0.9622	0.9740
Portland-Vancouver, ORWA	1.0928	1.0627
Provo-Orem, UT	0.9972	0.9981
Raleigh-Durham-Chapel Hill, NC	0.9749	0.9827
Rapid City, SD	0.8463	0.8920
Redding, CA	1.1795	1.1197
Reno, NV	1.0508	1.0345
Richland-Kennewick-Pasco, WA	1.1267	1.0851
Roanoke, VA	0.9543	0.9685
Rochester, MN	1.1361	1.0913
Rockford, IL	0.8904	0.9236
Sacramento, CA	1.2003	1.1332
Saginaw-Bay City-Midland, MI	0.9475	0.9637
St. Cloud, MN	1.0164	1.0112
St. Joseph, MO	0.9036	0.9329
St. Louis, MO–IL	0.9114	0.9384
Salinas, CA	1.4649	1.2988
Salt Lake City-Ogden, UT	0.9661	0.9767
San Diego, CA	1.1901	1.1266
Santa Cruz-Watsonville, CA	1.2834	1.1863
Santa Fe, NM	0.9383	0.9573
Santa Rosa, CA	1.2832	1.1862
Seattle-Bellevue-Everett, WA	1.1134	1.0763
Sherman-Denison, TX	0.8619	0.9032
Sioux City, IA–NE	0.8571	0.8998
South Bend, IN	1.0233	1.0159
Spokane, WA	1.1608	1.1075
Springfield, IL	0.8744	0.9122
Springfield, MO	0.8089	0.8648
Syracuse, NY	0.9662	0.9767
Tampa-St. Petersburg-Clearwater, FL	0.9111	0.9382
Texarkana, AR-Texarkana, TX	0.7962	0.8555
Toledo, OH	0.9705	0.9797
Topeka, KS	0.9134	0.9399
Tucson, AZ	0.8826	0.9180
Tulsa, OK	0.8698	0.9089
Tuscaloosa, AL	0.8081	0.8642
Tyler, TX	0.9077	0.9358
Victoria, TX	0.8133	0.8680
Washington, DC–MD–VA–WV	1.0832	1.0563
Waterloo-Cedar Falls, IA	0.8932	0.9256
Wausau, WI	0.9511	0.9663
Wichita, KS	0.9290	0.9508
Rural Alabama	0.7610	0.8294
Rural Florida	0.8904	0.9236
Rural Illinois	0.8320	0.8817
Rural Louisiana	0.7921	0.8525
Rural Michigan	0.9133	0.9398
Rural Minnesota	0.9116	0.9386
Rural Missouri	0.7766	0.8410
Rural Montana	0.9017	0.9316
Rural Oregon	1.0300	1.0204
Rural Texas (OK Hospital)	0.7622	0.8303
Rural Washington	1.0763	1.0516
Rural West Virginia	0.8321	0.8817
Rural Wisconsin	0.9073	0.9356
Rural Wyoming	0.8905	0.9237

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	18.0486
Aguadilla, PR	10.4725
Akron, OH	22.9067
Albany, GA	25.7222
Albany-Schenectady-Troy, NY	18.5809
Albuquerque, NM	20.3203
Alexandria, LA	17.8813
Allentown-Bethlehem-Easton, PA	21.3707
Altoona, PA	20.0974
Amarillo, TX	18.7968
Anchorage, AK	27.9780
Ann Arbor, MI	24.4830
Anniston, AL	18.0781
Appleton-Oshkosh-Neenah, WI	19.7485
Arecibo, PR	9.8505

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Asheville, NC	20.6721
Athens, GA	21.3273
Atlanta, GA	21.5792
Atlantic-Cape May, NJ	24.3464
Auburn-Opelika, AL	17.7284
Augusta-Aiken, GA–SC	20.0184
Austin-San Marcos, TX	20.4753
Bakersfield, CA	21.1738
Baltimore, MD	20.4985
Bangor, ME	20.8595
Barnstable-Yarmouth, MA	30.2448
Baton Rouge, LA	19.4498
Beaumont-Port Arthur, TX	18.1415
Bellingham, WA	24.9338
Benton Harbor, MI	19.0728
Bergen-Passaic, NJ	25.6998
Billings, MT	20.6821
Biloxi-Gulfport-Pascagoula, MS	17.9703
Binghamton, NY	18.9273
Birmingham, AL	18.5525
Bismarck, ND	17.1607
Bloomington,IN	19.2118
Bloomington-Normal, IL	20.0254
Boise City, ID	19.7312
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	24.3877
Boulder-Longmont, CO	21.2598
Brazoria, TX	18.9889
Bremerton, WA	24.0180
Brownsville-Harlingen-San Benito, TX	19.0812
Bryan-College Station, TX	17.9622
Buffalo-Niagara Falls, NY	20.7580
Burlington, VT	23.6135
Caguas, PR	9.9614
Canton-Massillon, OH	18.8702
Casper, WY	19.0746
Cedar Rapids, IA	18.2191
Champaign-Urbana, IL	20.1555
Charleston-North Charleston, SC	19.7335
Charleston, WV	20.2316
Charlotte-Gastonia-Rock Hill, NC–SC	20.1566
Charlottesville, VA	23.3140
Chattanooga, TN–GA	21.8793
Cheyenne, WY	18.3270
Chicago, IL	23.9273
Chico-Paradise, CA	23.1834
Cincinnati, OH–KY–IN	20.2453
Clarksville-Hopkinsville, TN–KY	17.9692
Cleveland-Lorain-Elyria, OH	20.9457
Colorado Springs, CO	21.1998
Columbia, MO	18.6606
Columbia, SC	20.9200
Columbus, GA-AL	18.6769
Columbus, OH	21.1363
Corpus Christi, TX	18.4356
Corvallis, OR	24.8210
Cumberland, MD-WV	18.3080
Dallas, TX	20.0063
Danville, VA	18.5023
Davenport-Moline-Rock Island, IA–IL	19.5749
Dayton-Springfield, OH	20.6558
Daytona Beach, FL	20.0411
Decatur, AL	18.7206
Decatur, IL	18.6640
Denver, CO	21.7676
Des Moines, IA	19.9873
Detroit, MI	21.8228
Dothan, AL	17.4329
Dover, DE	23.9388
Dubuque, IA	19.3729
Duluth-Superior, MN–WI	22.0638
Dutchess County, NY	22.3565
Eau Claire, WI	17.5107
El Paso, TX	19.9962
Elkhart-Goshen, IN	20.7202
Elmira, NY	18.7582
Enid, OK	19.0534
Erie, PA	19.5749
Eugene-Springfield, OR	23.9117
Evansville, Henderson, IN–KY	17.3973
Fargo-Moorhead, ND-MN	19.1596
Fayetteville, NC	18.7438
Fayetteville-Springdale-Rogers, AR	17.3575
Flagstaff, AZ–UT	23.5301
Flint, MI	24.1126
Florence, AL	16.4548
Florence, SC	19.1780
Fort Collins-Loveland, CO	23.3920
Fort Lauderdale, FL	22.1262
Fort Myers-Cape Coral, FL	19.7718
Fort Pierce-Port St. Lucie, FL	20.7352
Fort Smith, AR-OK	19.2209
Fort Walton Beach, FL	20.2902
Fort Wayne, IN	18.9774
Fort Worth-Arlington, TX	20.4871
Fresno, CA	22.0987
Gadsden, AL	18.4245
Gainesville, FL	22.3195
Galveston-Texas City, TX	22.3151
Gary, IN	20.4033
Glens Falls, NY	18.2226
Goldsboro, NC	18.4077
Grand Forks, ND–MN	22.1477
Grand Junction, CO	20.0924
Grand Rapids-Muskegon-Holland, MI	22.2552
Great Falls, MT	19.9908
Greeley, CO	21.4997
Green Bay, WI	20.3069
Greensboro-Winston-Salem-High Point, NC	19.9482
Greenville, NC	20.5145
Greenville-Spartanburg-Anderson, SC	19.8759
Hagerstown, MD	20.9333
Hamilton-Middletown, OH	19.2938
Harrisburg-Lebanon-Carlisle, PA	20.5425
Hartford, CT	24.8641
Hattiesburg, MS	16.4489
Hickory-Morganton-Lenoir, NC	19.9965
Honolulu, HI	25.7981
Houma, LA	17.8310
Houston, TX	20.9625
Huntington-Ashland, WV–KY–OH	21.6140
Huntsville, AL	19.7211
Indianapolis, IN	20.2095
Iowa City, IA	21.1537
Jackson, MI	19.4234
Jackson, MS	19.2901
Jackson, TN	19.3964
Jacksonville, FL	19.5189
Jacksonville, NC	17.0264
Jamestown, NY	17.1320
Janesville-Beloit, WI	21.3868
Jersey City, NJ	23.7469
Johnson City-Kingsport-Bristol, TN–VA	18.0944
Johnstown, PA	20.7614
Jonesboro, AR	18.6323
Joplin, MO	17.0944
Kalamazoo-Battlecreek, MI	22.2348
Kankakee, IL	19.4290
Kansas City, KS–MO	20.8941
Kenosha, WI	21.0547
Killeen-Temple, TX	22.3946
Knoxville, TN	18.1724
Kokomo, IN	19.8136
La Crosse, WI–MN	20.4875
Lafayette, LA	19.1482
Lafayette, IN	19.7271
Lake Charles, LA	16.2042
Lakeland-Winter Haven, FL	20.7380
Lancaster, PA	20.1227
Lansing-East Lansing, MI	21.4235
Laredo, TX	16.5720
Las Cruces, NM	18.9734
Las Vegas, NV-AZ	23.6000
Lawrence, KS	17.9498
Lawton, OK	19.8665
Lewiston-Auburn, ME	19.6684
Lexington, KY	19.3574
Lima, OH	20.9055
Lincoln, NE	21.1236
Little Rock-North Little Rock, AR	19.4396
Longview-Marshall, TX	19.1300
Los Angeles-Long Beach, CA	25.8459
Louisville, KY–IN	20.3861
Lubbock, TX	19.1566
Lynchburg, VA	20.0013
Macon, GA	19.6297
Madison, WI	22.4673
Mansfield, OH	19.0435
Mayaguez, PR	10.0185
McAllen-Edinburg-Mission, TX	18.2331
Medford-Ashland, OR	22.6499
Melbourne-Titusville-Palm Bay, FL	21.0752
Memphis, TN–AR–MS	15.8781
Merced, CA	21.1426
Miami, FL	22.0202
Middlesex-Somerset-Hunterdon, NJ	24.8629
Milwaukee-Waukesha, WI	21.2711
Minneapolis-St. Paul, MN–WI	24.1246
Missoula, MT	20.4135
Mobile, AL	17.8029
Modesto, CA	22.7416
Monmouth-Ocean, NJ	24.6814
Monroe, LA	18.3733
Montgomery, AL	16.4427
Muncie, IN	23.2904
Myrtle Beach, SC	18.7864
Naples, FL	20.3889
Nashville, TN	19.9647
Nassau-Suffolk, NY	30.5221
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	26.9488
New London-Norwich, CT	26.0037
New Orleans, LA	20.1432
New York, NY	31.3439
Newark, NJ	25.6220
Newburgh, NY-PA	23.7525
Norfolk-Virginia Beach-Newport News, VA–NC	18.2637

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Oakland, CA	32.6592
Ocala, FL	19.2230
Odessa-Midland, TX	19.8941
Oklahoma City, OK	19.3346
Olympia, WA	23.4064
Omaha, NE-IA	21.0639
Orange County, CA	25.1808
Orlando, FL	21.6103
Owensboro, KY	16.7178
Panama City, FL	19.8085
Parkersburg-Marietta, WV–OH	17.5453
Pensacola, FL	17.8738
Peoria-Pekin, IL	18.7922
Philadelphia, PA–NJ	23.1316
Phoenix-Mesa, AZ	20.6836
Pine Bluff, AR	17.0672
Pittsburgh, PA	21.3039
Pittsfield, MA	22.6239
Pocatello, ID	23.4749
Ponce, PR	9.4317
Portland, ME	21.2189
Portland-Vancouver, OR–WA	23.7092
Providence-Warwick, RI	23.7714
Provo-Orem, UT	21.5911
Pueblo, CO	18.5332
Punta Gorda, FL	20.7540
Racine, WI	20.1753
Raleigh-Durham-Chapel Hill, NC	21.1552
Rapid City, SD	18.3452
Reading, PA	19.9691
Redding, CA	25.5947
Reno, NV	22.8021
Richland-Kennewick-Pasco, WA	25.0933
Richmond-Petersburg, VA	21.0026
Riverside-San Bernardino, CA	24.4131
Roanoke, VA	20.7061
Rochester, MN	24.6529
Rochester, NY	19.1942
Rockford, IL	19.3204
Rocky Mount, NC	19.2567
Sacramento, CA	26.0102
Saginaw-Bay City-Midland, MI	20.5596
St. Cloud, MN	22.0551
St. Joseph, MO	20.0604
St. Louis, MO–IL	19.7758
Salem, OR	22.3396
Salinas, CA	31.7057
Salt Lake City-Ogden, UT	20.9541
San Angelo, TX	16.8092
San Antonio, TX	17.5486
San Diego, CA	25.8245
San Francisco, CA	31.2006
San Jose, CA	31.3127
San Juan-Bayamon, PR	10.1790
San Luis Obispo-Atascadero-Paso Robles, CA	23.3363
Santa Barbara-Santa Maria-Lompoc, CA	23.2791
Santa Cruz-Watsonville, CA	31.9763
Santa Fe, NM	20.3593
Santa Rosa, CA	28.6042

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Sarasota-Bradenton, FL	20.9819
Savannah, GA	18.8537
Scranton-Wilkes Barre-Hazleton, PA	18.1723
Seattle-Bellevue-Everett, WA	24.0236
Sharon, PA	17.3633
Sheboygan, WI	18.3680
Sherman-Denison, TX	18.3921
Shreveport-Bossier City, LA	19.2092
Sioux City, IA-NE	18.5977
Sioux Falls, SD	19.2902
South Bend, IN	22.2041
Spokane, WA	25.9937
Springfield, IL	18.9742
Springfield, MO	18.1326
Springfield, MA	23.4382
State College, PA	19.7770
Steubenville-Weirton, OH–WV	18.7875
Stockton-Lodi, CA	23.2417
Sumter, SC	15.4277
Syracuse, NY	20.8181
Tacoma, WA	25.2962
Tallahassee, FL	18.6152
Tampa-St. Petersburg-Clearwater, FL	19.5050
Terre Haute, IN	15.3117
Texarkana, AR-Texarkana, TX	17.0551
Toledo, OH	21.4500
Topeka, KS	19.8204
Trenton, NJ	21.5233
Tucson, AZ	19.0859
Tulsa, OK	18.8729
Tuscaloosa, AL	17.5354
Tyler, TX	20.1140
Utica-Rome, NY	18.2490
Vallejo-Fairfield-Napa, CA	28.7082
Ventura, CA	24.1637
Victoria, TX	17.6229
Vineland-Millville-Bridgeton, NJ	22.7012
Visalia-Tulare-Porterville, CA	21.2165
Waco, TX	18.2321
Washington, DC–MD–VA–WV	23.5031
Waterloo-Cedar Falls, IA	18.4528
Wausau, WI	20.5783
West Palm Beach-Boca Raton, FL	21.1018
Wheeling, OH-WV	16.9649
Wichita, KS	20.7737
Wichita Falls, TX	16.6396
Williamsport, PA	18.2295
Wilmington-Newark, DE–MD	24.4776
Wilmington, NC	20.5573
Yakima, WA	21.7819
Yolo, CA	22.2646
York, PA	20.4558
Youngstown-Warren, OH	20.8393
Yuba City, CA	23.4776
Yuma, AZ	20.8420

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	16.4226
Alaska	27.5158
Arizona	18.2279
Arkansas	16.3570
California	21.6246
Colorado	19.9177
Connecticut	25.5994
Delaware	20.2855
Florida	19.2234
Georgia	18.4650
Hawaii	24.8190
Idaho	19.1619
Illinois	18.0540
Indiana	19.1101
Iowa	17.7834
Kansas	16.7288
Kentucky	17.3951
Louisiana	17.1441
Maine	19.1234
Maryland	18.9146
Massachusetts	24.6234
Michigan	19.7353
Minnesota	19.7808
Mississippi	16.5082
Missouri	16.8219
Montana	19.5658
Nebraska	17.9331
Nevada	20.2962
New Hampshire	21.6890
New Jersey [1]	.....
New Mexico	18.2818
New York	18.5706
North Carolina	18.5592
North Dakota	16.7027
Ohio	19.0464
Oklahoma	16.5386
Oregon	22.3491
Pennsylvania	18.8470
Puerto Rico	9.1823
Rhode Island [1]	.....
South Carolina	18.3244
South Dakota	16.8938
Tennessee	17.3149
Texas	16.3108
Utah	19.9234
Vermont	20.3374
Virginia	18.1413
Washington	23.3538
West Virginia	18.0536
Wisconsin	19.6848
Wyoming	19.6292

[1] All counties within the State are classified as urban.

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclass. hospitals	GAF—reclass. hospitals
Aguadilla, PR	1.0507	1.0344		
Arecibo, PR	0.9883	0.9920		
Caguas, PR	0.9995	0.9997		
Mayaguez, PR	1.0052	1.0036		
Ponce, PR	0.9463	0.9629		
San Juan-Bayamon, PR	1.0213	1.0145		
Rural Puerto Rico	0.9213	0.9454		

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.1023	6.3	9.1
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.1157	7.3	9.7
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9575	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.2879	4.8	7.3
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.4334	2.3	3.3
6	01	SURG	CARPAL TUNNEL RELEASE	.8265	2.2	3.2
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.5918	6.9	10.3
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.3987	2.1	3.0
9	01	MED	SPINAL DISORDERS & INJURIES	1.3176	4.8	6.7
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2276	4.9	6.7
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8343	3.1	4.2
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8916	4.5	6.1
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7675	4.1	5.1
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.2205	4.8	6.2
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7486	2.9	3.6
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1670	4.6	6.1
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6563	2.7	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9616	4.3	5.6
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6975	2.9	3.7
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7645	7.9	10.5
21	01	MED	VIRAL MENINGITIS	1.5003	5.2	6.9
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0084	3.8	5.0
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8021	3.2	4.2
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9925	3.7	5.0
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.6045	2.6	3.3
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6453	2.4	3.2
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.2871	3.2	5.1
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 17 ≥ W CC	1.3124	4.5	6.3
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 17 ≥ W/O CC	.7037	2.8	3.7
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA < 1 HR AGE 0–17	.3311	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8655	3.1	4.2
32	01	MED	CONCUSSION AGE >17 W/O CC	.5374	2.1	2.7
33	01	MED	*CONCUSSION AGE 0–17	.2080	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0108	3.8	5.2
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6051	2.7	3.4
36	02	SURG	RETINAL PROCEDURES	.6636	1.2	1.4
37	02	SURG	ORBITAL PROCEDURES	1.0020	2.6	3.7
38	02	SURG	PRIMARY IRIS PROCEDURES	.4832	1.8	2.5
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5803	1.5	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8625	2.3	3.6
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3370	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6472	1.6	2.2
43	02	MED	HYPHEMA	.5008	2.6	3.3
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6293	4.0	5.0
45	02	MED	NEUROLOGICAL EYE DISORDERS	.7031	2.7	3.3
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7767	3.5	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4921	2.5	3.3
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2968	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.8368	3.5	5.0
50	03	SURG	SIALOADENECTOMY	.8531	1.6	2.0
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.7986	1.8	2.6
52	03	SURG	CLEFT LIP & PALATE REPAIR	.8428	1.6	2.1
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2137	2.3	3.7

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
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4812	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.9049	1.9	2.9
56	03	SURG	RHINOPLASTY	.9487	2.1	3.1
57	03	SURG	T & A PROC, EXCEPT TONSILLECTOMY & /OR ADENOIDECTOMY ONLY, AGE >17.	1.0775	2.6	4.0
58	03	SURG	*T & A PROC, EXCEPT TONSILLECTOMY & /OR ADENOIDECTOMY ONLY, AGE 0–17.	.2733	1.5	1.5
59	03	SURG	TONSILLECTOMY & /OR ADENOIDECTOMY ONLY, AGE >17	.6824	1.8	2.4
60	03	SURG	*TONSILLECTOMY & /OR ADENOIDECTOMY ONLY, AGE 0–17 ...	.2081	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2708	2.8	4.9
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2946	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3393	3.0	4.3
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2285	4.2	6.5
65	03	MED	DYSEQUILIBRIUM	.5383	2.3	2.9
66	03	MED	EPISTAXIS	.5580	2.5	3.2
67	03	MED	EPIGLOTTITIS	.8088	2.8	3.5
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6744	3.4	4.2
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5114	2.7	3.3
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.4666	2.4	2.9
71	03	MED	LARYNGOTRACHEITIS	.7730	3.0	3.9
72	03	MED	NASAL TRAUMA & DEFORMITY	.6409	2.6	3.3
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17 ...	.7763	3.3	4.3
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	.3348	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1338	7.8	10.0
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7905	8.4	11.3
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1793	3.4	4.9
78	04	MED	PULMONARY EMBOLISM	1.3703	6.0	7.0
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6471	6.6	8.5
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9168	4.6	5.7
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5162	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3810	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	.9752	4.4	5.6
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5492	2.8	3.4
85	04	MED	PLEURAL EFFUSION W CC	1.2201	4.9	6.4
86	04	MED	PLEURAL EFFUSION W/O CC	.6990	2.9	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3746	4.8	6.3
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9314	4.2	5.2
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0638	5.0	6.0
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6540	3.6	4.2
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.6702	2.8	3.3
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1852	5.0	6.3
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7211	3.3	4.0
94	04	MED	PNEUMOTHORAX W CC	1.1694	4.8	6.3
95	04	MED	PNEUMOTHORAX W/O CC	.6072	3.0	3.7
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7873	3.9	4.7
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5871	3.1	3.7
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.9098	3.0	4.7
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.7104	2.5	3.2
100 ...	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5415	1.8	2.2
101 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8535	3.3	4.4
102 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5522	2.1	2.7
103 ...	PRE	SURG	HEART TRANSPLANT	17.3527	28.8	48.6
104 ...	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	7.2014	8.9	11.7
105 ...	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	5.6515	7.4	9.3
106 ...	05	SURG	CORONARY BYPASS W PTCA	7.5379	9.4	11.2
107 ...	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3870	9.2	10.4
108 ...	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.6650	8.0	10.6
109 ...	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0244	6.8	7.7
110 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1440	7.1	9.5
111 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2427	4.7	5.5
112 ...	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.8729	2.6	3.8
113 ...	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7595	9.7	12.7
114 ...	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5650	6.0	8.3

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
115 ...	05	SURG	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR PR.	3.4763	6.0	8.4
116 ...	05	SURG	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	2.4225	2.6	3.7
117 ...	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.2983	2.6	4.1
118 ...	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.4952	1.9	2.8
119 ...	05	SURG	VEIN LIGATION & STRIPPING	1.2627	2.9	4.8
120 ...	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0394	4.9	8.1
121 ...	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6191	5.5	6.7
122 ...	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0872	3.3	4.0
123 ...	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5531	2.8	4.6
124 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4152	3.3	4.4
125 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0624	2.2	2.8
126 ...	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5352	9.2	12.0
127 ...	05	MED	HEART FAILURE & SHOCK	1.0135	4.2	5.4
128 ...	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7644	5.0	5.8
129 ...	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0936	1.8	2.8
130 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9474	4.7	5.9
131 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5891	3.6	4.4
132 ...	05	MED	ATHEROSCLEROSIS W CC	.6703	2.4	3.1
133 ...	05	MED	ATHEROSCLEROSIS W/O CC	.5656	1.9	2.4
134 ...	05	MED	HYPERTENSION	.5921	2.6	3.3
135 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.9085	3.3	4.5
136 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.6074	2.3	2.9
137 ...	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8170	3.3	3.3
138 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8288	3.1	4.0
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5139	2.0	2.5
140 ...	05	MED	ANGINA PECTORIS	.5737	2.2	2.7
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7225	2.9	3.7
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5556	2.2	2.7
143 ...	05	MED	CHEST PAIN	.5403	1.8	2.2
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1676	3.8	5.4
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6308	2.2	2.8
146 ...	06	SURG	RECTAL RESECTION W CC	2.7439	8.9	10.2
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.6272	6.0	6.6
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4317	10.1	12.1
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5645	6.1	6.6
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8508	9.1	11.2
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3404	4.8	5.9
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9422	6.8	8.2
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.2045	4.9	5.5
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1504	10.1	13.3
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3691	3.3	4.3
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8413	6.0	6.0
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2381	3.9	5.5
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6630	2.1	2.6
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3341	3.8	5.0
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7828	2.2	2.7
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1022	2.9	4.2
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6236	1.6	2.0
163 ...	06	SURG	*HERNIA PROCEDURES AGE 0–17	.8701	2.1	2.1
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3776	7.1	8.4
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2823	4.3	4.9
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4813	4.0	5.1
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8936	2.3	2.7
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.2069	3.2	4.6
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.7475	1.9	2.4
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8739	7.7	11.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1951	3.6	4.8
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.3502	5.1	7.0
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7641	2.8	3.9
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9981	3.9	4.8
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5495	2.5	2.9
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.1057	4.1	5.3
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8997	3.7	4.6
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6593	2.6	3.1
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.0583	4.7	6.0
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9426	4.2	5.4
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5309	2.8	3.4
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7922	3.4	4.4
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5713	2.4	3.0
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.5137	2.5	3.3
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8624	3.3	4.5
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3207	2.9	2.9
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7687	2.9	3.8
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1005	4.1	5.6
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5799	2.4	3.1
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.9912	4.1	6.0
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3818	10.5	14.1
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7866	5.3	6.6
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.3954	10.3	12.6
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6141	5.6	6.8
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.9025	8.3	9.9
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6543	4.9	5.7
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4551	7.2	8.7
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2323	3.9	4.5
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3610	7.2	9.7
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.1765	7.0	10.8
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.4002	10.2	13.9
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3035	4.9	6.5
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3284	5.0	6.7
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2030	4.5	5.9
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC ...	1.2072	4.7	6.3
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6759	3.0	3.9
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1037	4.0	5.2
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6532	2.3	2.9
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.0902	4.6	5.2
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8074	6.0	6.9
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2663	4.6	5.0
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	.8449	11.1	11.1
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7751	6.4	8.7
214 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
215 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
216 ...	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1983	7.1	9.8
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.9142	8.9	13.1
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.5309	4.2	5.4
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0219	2.7	3.2
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5828	5.3	5.3
221 ...	08	SURG	NO LONGER VALID	.0000	.0	.0

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
222 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
223 ...	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.9560	2.0	2.6
224 ...	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	.7986	1.7	2.0
225 ...	08	SURG	FOOT PROCEDURES	1.0864	3.3	4.7
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4749	4.3	6.3
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8025	2.1	2.7
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.0648	2.4	3.6
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.7157	1.8	2.4
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.2592	3.4	5.1
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.3813	3.2	4.8
232 ...	08	SURG	ARTHROSCOPY	1.0833	2.3	3.6
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0825	5.3	7.7
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2661	2.7	3.6
235 ...	08	MED	FRACTURES OF FEMUR	.7584	3.8	5.2
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7218	4.0	5.0
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5668	3.0	3.7
238 ...	08	MED	OSTEOMYELITIS	1.3520	6.4	8.6
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	.9749	4.9	6.2
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2671	4.9	6.6
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6166	3.1	3.9
242 ...	08	MED	SEPTIC ARTHRITIS	1.0690	5.1	6.6
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7261	3.7	4.7
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7170	3.7	4.8
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4842	2.8	3.6
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5572	3.0	3.6
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5698	2.6	3.4
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7854	3.7	4.7
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6919	2.6	3.8
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6912	3.3	4.3
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4993	2.4	3.0
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	.2531	1.8	1.8
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7239	3.7	4.7
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4403	2.6	3.2
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2947	2.9	2.9
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7950	3.8	5.1
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9100	2.3	2.8
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7223	1.8	2.0
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.9083	1.8	2.8
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6521	1.3	1.4
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9307	1.7	2.2
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8768	2.7	3.8
263 ...	09	SURG	SKIN GRAFT & /OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.1112	8.9	12.1
264 ...	09	SURG	SKIN GRAFT & /OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1515	5.4	7.2
265 ...	09	SURG	SKIN GRAFT & /OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5284	4.2	6.6
266 ...	09	SURG	SKIN GRAFT & /OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8726	2.4	3.3
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	1.0827	3.1	5.2
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1382	2.4	3.7
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7023	5.8	8.3
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7657	2.3	3.3

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
271 ...	09	MED	SKIN ULCERS	1.0093	5.5	7.1
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	1.0005	4.8	6.4
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6162	3.2	4.2
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.2100	4.9	7.0
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5316	2.4	3.3
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6919	3.6	4.7
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8398	4.7	5.7
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5526	3.6	4.3
279 ...	09	MED	*CELLULITIS AGE 0–17	.6626	4.2	4.2
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6769	3.2	4.2
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4720	2.4	3.1
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2563	2.2	2.2
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.6924	3.5	4.6
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4348	2.5	3.2
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	1.9923	7.7	10.4
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.1300	4.9	6.2
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8336	7.8	10.5
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1764	4.6	5.7
289 ...	10	SURG	PARATHYROID PROCEDURES	.9892	2.0	3.1
290 ...	10	SURG	THYROID PROCEDURES	.9207	1.8	2.4
291 ...	10	SURG	THYROGLOSSAL PROCEDURES	.5503	1.4	1.6
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4548	6.9	10.0
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2190	3.5	4.9
294 ...	10	MED	DIABETES AGE >35	.7596	3.6	4.7
295 ...	10	MED	DIABETES AGE 0–35	.7555	2.9	3.9
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8594	4.0	5.2
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5170	2.8	3.5
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.5309	2.5	3.2
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.9442	4.0	5.6
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.0836	4.7	6.1
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.6108	2.9	3.7
302 ...	11	SURG	KIDNEY TRANSPLANT	3.4495	7.9	9.4
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.4639	7.0	8.5
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3371	6.4	8.9
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1844	3.1	3.8
306 ...	11	SURG	PROSTATECTOMY W CC	1.2483	3.7	5.5
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6424	1.9	2.3
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6345	4.2	6.4
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9332	2.0	2.5
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1174	3.0	4.4
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6165	1.6	1.9
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0197	3.0	4.5
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6464	1.7	2.1
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4939	2.3	2.3
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0511	4.2	7.5
316 ...	11	MED	RENAL FAILURE	1.3444	4.9	6.7
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.7439	2.1	3.2
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1316	4.3	6.0
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6045	2.1	2.9
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8625	4.3	5.4
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5686	3.2	3.8
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.4946	3.3	4.1
323 ...	11	MED	URINARY STONES W CC, & /OR ESW LITHOTRIPSY	.7992	2.4	3.2
324 ...	11	MED	URINARY STONES W/O CC	.4502	1.6	1.9
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6468	3.0	3.9
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4302	2.1	2.7
327 ...	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3533	3.1	3.1
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7487	2.8	3.9
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.5283	1.7	2.0
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3182	1.6	1.6
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0226	4.1	5.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.5994	2.5	3.3
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.8248	3.5	5.1
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5582	4.2	4.9
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1706	3.2	3.4
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8873	2.7	3.5
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6147	1.9	2.2
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.1903	3.5	5.3
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0710	3.0	4.5
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2828	2.4	2.4
341 ...	12	SURG	PENIS PROCEDURES	1.1668	2.1	3.2
342 ...	12	SURG	CIRCUMCISION AGE >17	.8214	2.5	3.1
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1537	1.7	1.7
344 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.1489	1.6	2.3
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8813	2.6	3.8
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9783	4.3	5.8
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5905	2.4	3.4
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7170	3.2	4.2
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4420	2.0	2.6
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6987	3.6	4.4
351 ...	12	MED	*STERILIZATION, MALE	.2358	1.3	1.3
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6875	2.8	3.9
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9232	5.3	6.7
354 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5267	4.9	5.9
355 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9265	3.1	3.3
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7838	2.1	2.4
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3601	6.9	8.5
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2247	3.7	4.4
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8582	2.6	2.8
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8859	2.4	3.0
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.2248	2.2	3.5
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3013	1.4	1.4
363 ...	13	SURG	D & C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.8178	2.6	3.5
364 ...	13	SURG	D & C, CONIZATION EXCEPT FOR MALIGNANCY	.7559	2.6	3.6
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8502	5.0	7.3
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2498	4.8	6.8
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5675	2.4	3.2
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1249	5.0	6.7
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5721	2.4	3.2
370 ...	14	SURG	CESAREAN SECTION W CC	1.0631	4.4	5.7
371 ...	14	SURG	CESAREAN SECTION W/O CC	.7157	3.3	3.7
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.6069	2.7	3.5
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4172	2.0	2.3
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION & /OR D & C	.7698	2.7	3.5
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL & /OR D & C.	.6841	4.4	4.4
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5314	2.6	3.5
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.8870	2.6	3.9
378 ...	14	MED	ECTOPIC PREGNANCY	.7543	2.1	2.3
379 ...	14	MED	THREATENED ABORTION	.3981	2.0	3.1
380 ...	14	MED	ABORTION W/O D & C	.4867	1.8	2.2
381 ...	14	SURG	ABORTION W D & C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.5323	1.5	2.0
382 ...	14	MED	FALSE LABOR	.1845	1.2	1.3
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.5082	2.7	3.9
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3232	1.7	2.3
385 ...	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3729	1.8	1.8

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
386	15	MED	*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5275	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.0922	13.3	13.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8657	8.6	8.6
389	15	MED	*FULL TERM NEONATE W MAJOR PROBLEMS	1.8357	4.7	4.7
390	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	.8865	2.9	3.7
391	15	MED	*NORMAL NEWBORN	.1523	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.1818	7.1	9.5
393	16	SURG	*SPLENECTOMY AGE 0–17	1.3449	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.5946	4.1	6.7
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8262	3.3	4.5
396	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	1.2128	2.4	3.7
397	16	MED	COAGULATION DISORDERS	1.2290	3.8	5.2
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2765	4.7	6.0
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6899	2.8	3.6
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6272	5.8	9.1
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.7311	7.8	11.2
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1002	2.8	3.9
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7607	5.7	8.1
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8495	3.1	4.2
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	1.9067	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.8109	7.5	10.3
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.3138	3.6	4.4
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.9991	4.7	7.7
409	17	MED	RADIOTHERAPY	1.1226	4.4	5.9
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.9493	2.9	3.7
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3288	2.0	2.3
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4877	2.0	2.7
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3665	5.3	7.3
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7522	3.0	4.1
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5919	10.3	14.2
416	18	MED	SEPTICEMIA AGE >17	1.5287	5.5	7.4
417	18	MED	SEPTICEMIA AGE 0–17	1.2437	3.9	6.3
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0076	4.8	6.2
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8724	3.7	4.8
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6053	2.9	3.6
421	18	MED	VIRAL ILLNESS AGE >17	.6760	3.1	3.9
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.7893	2.8	5.1
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.7317	5.9	8.2
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.2742	8.7	13.5
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION.	.7022	3.0	4.1
426	19	MED	DEPRESSIVE NEUROSES	.5303	3.3	4.6
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5673	3.3	5.0
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7360	4.4	7.1
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8567	4.9	6.6
430	19	MED	PSYCHOSES	.7659	5.9	8.3
431	19	MED	CHILDHOOD MENTAL DISORDERS	.6434	4.7	6.6
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.6488	3.2	4.8
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2829	2.2	3.0
434	20	MED	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7239	3.9	5.1
435	20	MED	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4167	3.5	4.3
436	20	MED	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.7433	10.3	12.9
437	20	MED	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.6576	7.6	9.0
438	.....		NO LONGER VALID	.0000	.0	.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7255	5.3	8.2
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9063	5.8	8.9

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9443	2.2	3.2
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.3391	5.4	8.2
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9979	2.5	3.4
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7225	3.2	4.2
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.5054	2.4	3.0
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2955	2.4	2.4
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.5160	1.9	2.5
448 ...	21	MED	*ALLERGIC REACTIONS AGE 0–17	.0972	2.9	2.9
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8073	2.6	3.7
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4409	1.6	2.1
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2625	2.1	2.1
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0135	3.5	5.0
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4998	2.2	2.8
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8586	3.2	4.6
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4661	2.0	2.6
456 ...			NO LONGER VALID	.0000	.0	.0
457 ...			NO LONGER VALID	.0000	.0	.0
458 ...			NO LONGER VALID	.0000	.0	.0
459 ...			NO LONGER VALID	.0000	.0	.0
460 ...			NO LONGER VALID	.0000	.0	.0
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.2045	2.4	4.6
462 ...	23	MED	REHABILITATION	1.2426	9.3	11.7
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.6922	3.3	4.3
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.4771	2.4	3.1
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5777	2.1	3.4
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6777	2.2	3.9
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.5112	2.3	4.1
468 ...			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6423	9.2	13.0
469 ...			**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470 ...			**UNGROUPABLE	.0000	.0	.0
471 ...	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.1978	5.0	5.7
472 ...			NO LONGER VALID	.0000	.0	.0
473 ...	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5861	7.6	13.1
474 ...			NO LONGER VALID	.0000	.0	.0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6949	8.1	11.3
476 ...		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2633	8.4	11.6
477 ...		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8270	5.4	8.2
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3372	5.0	7.3
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4333	2.8	3.6
480 ...	PRE	SURG	LIVER TRANSPLANT	9.5064	14.6	19.2
481 ...	PRE	SURG	BONE MARROW TRANSPLANT	8.7719	24.1	27.1
482 ...	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.5738	9.9	12.8
483 ...	PRE	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	15.8415	33.4	40.7
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.6100	9.0	13.3
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.0519	7.6	9.4
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.9156	8.1	12.2
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0199	5.5	7.7
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.5503	11.6	17.0
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.7496	6.0	8.6
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9715	3.7	5.1
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6661	2.9	3.5
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.2524	10.9	16.1
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8180	4.3	5.7
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0374	2.0	2.5
495 ...	PRE	SURG	LUNG TRANSPLANT	8.5947	13.1	20.3
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.5796	7.8	10.0
497 ...	08	SURG	SPINAL FUSION W CC	2.9469	4.9	6.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
498 ...	08	SURG	SPINAL FUSION W/O CC	1.9077	2.8	3.4
499 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4590	3.6	4.8
500 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9811	2.2	2.7
501 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6350	8.4	10.6
502 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4327	4.9	6.0
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2151	3.1	4.0
504 ...	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	12.4664	23.9	30.1
505 ...	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0389	2.5	4.7
506 ...	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.4971	13.0	17.6
507 ...	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8438	6.6	9.2
508 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.3119	5.1	7.2
509 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8154	4.1	6.2
510 ...	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.4130	5.2	7.9
511 ...	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.6568	3.1	4.5

*MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
**DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.
NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
007.5	Cyclosporiasis	N	6	182, 183, 184
082.40	Unspecified ehrlichiosis	N	18	423
082.41	Ehrlichiosis Chafiensis (E. Chafiensis)	N	18	423
082.49	Other ehrlichiosis	N	18	423
285.21	Anemia in end-stage renal disease	N	16	395, 396
285.22	Anemia in neoplastic disease	N	16	395, 396
285.29	Anemia of other chronic illness	N	16	395, 396
294.10	Dementia in conditions classified elsewhere without behavioral disturbance	N	19	429
294.11	Dementia in conditions classified elsewhere with behavioral disturbance	N	19	429
372.81	Conjunctivochalasis	N	2	46, 47, 48
372.89	Other disorders of conjunctiva	N	2	46, 47, 48
477.1	Allergic rhinitis, due to food	N	3	68, 69, 70
493.02	Extrinsic asthma, with acute exacerbation	Y	4	96, 97, 98
493.12	Intrinsic asthma, with acute exacerbation	Y	4	96, 97, 98
493.22	Chronic obstructive asthma, with acute exacerbation	Y	4	88
493.92	Unspecified asthma, with acute exacerbation	Y	4	96, 97, 98
494.0	Bronchiectasis without acute exacerbation	N	4	88
494.1	Bronchiectasis with acute exacerbation	Y	4	88
558.3	Allergic gastroenteritis and colitis	N	6	182, 183, 184
600.0	Hypertrophy (benign) of prostate	N	12	348, 349
600.1	Nodular prostate	N	12	348, 349
600.2	Benign localized hyperplasia of prostate	N	12	348, 349
600.3	Cyst of prostate	N	12	348, 349
600.9	Unspecified hyperplasia of prostate	N	12	348, 349
645.10	Post term pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.11	Post term pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.13	Post term pregnancy, antepartum condition or complication	N	14	383, 384
645.20	Prolonged pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.21	Prolonged pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.23	Prolonged pregnancy, antepartum condition or complication	N	14	383, 384
692.75	Disseminated superficial actinic porokeratosis (DSAP)	N	9	283, 284
707.10	Unspecified ulcer of lower limb	Y	9	263, 264, 271
707.11	Ulcer of thigh	Y	9	263, 264, 271
707.12	Ulcer of calf	Y	9	263, 264, 271
707.13	Ulcer of ankle	Y	9	263, 264, 271
707.14	Ulcer of heel and midfoot	Y	9	263, 264, 271
707.15	Ulcer of other part of foot	Y	9	263, 264, 271
707.19	Ulcer of other part of lower limb	Y	9	263, 264, 271

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
727.83	Plica syndrome	N	8	248
781.91	Loss of height	N	1	34, 35
781.92	Abnormal posture	N	1	34, 35
781.99	Other symptoms involving nervous and musculoskeletal systems	N	1	34, 35
783.21	Loss of weight	N	10	296, 297, 298
783.22	Underweight	N	10	296, 297, 298
783.40	Unspecified lack of normal physiological development	N	10	296, 297, 298
783.41	Failure to thrive	N	10	296, 297, 298
783.42	Delayed milestones	N	10	296, 297, 298
783.43	Short stature	N	10	296, 297, 298
783.7	Adult failure to thrive	N	10	296, 297, 298
790.01	Precipitous drop in hematocrit	N	16	395, 396
790.09	Other abnormality of red blood cells	N	16	395, 396
792.5	Cloudy (hemodialysis) (peritoneal) dialysis effluent	N	23	463, 464
995.7	Other adverse food reactions, not elsewhere classified	N	21	454, 455
996.87	Complications of transplanted organ, intestine	Y	21	452, 453
V15.01	Allergy to peanuts	N	23	467
V15.02	Allergy to milk products	N	23	467
V15.03	Allergy to eggs	N	23	467
V15.04	Allergy to seafood	N	23	467
V15.05	Allergy to other foods	N	23	467
V15.06	Allergy to insects	N	23	467
V15.07	Allergy to latex	N	23	467
V15.08	Allergy to radiographic dye	N	23	467
V15.09	Other allergy, other than to medicinal agents	N	23	467
V21.30	Unspecified low birth weight status	N	23	467
V21.31	Low birth weight status, less than 500 grams	N	23	467
V21.32	Low birth weight status, 500–999 grams	N	23	467
V21.33	Low birth weight status, 1000–1499 grams	N	23	467
V21.34	Low birth weight status, 1500–1999 grams	N	23	467
V21.35	Low birth weight status, 2000–2500 grams	N	23	467
V26.21	Fertility testing	N	23	467
V26.22	Aftercare following sterilization reversal	N	23	467
V26.29	Other investigation and testing	N	23	467
V42.84	Organ or tissue replaced by transplant, intestines	Y	23	467
V45.74	Acquired absence of organ, other parts of urinary tract	N	23	467
V45.75	Acquired absence of organ, stomach	N	23	467
V45.76	Acquired absence of organ, lung	N	23	467
V45.77	Acquired absence of organ, genital organs	N	23	467
V45.78	Acquired absence of organ, eye	N	23	467
V45.79	Other acquired absence of organ	N	23	467
V49.81	Postmenopausal status (age-related) (natural)	N	23	467
V49.89	Other specified conditions influencing health status	N	23	467
V56.31	Encounter for adequacy testing for hemodialysis	N	11	317
V56.32	Encounter for adequacy testing for peritoneal dialysis	N	11	317
V58.83	Encounter for therapeutic drug monitoring	N	23	465, 466
V67.00	Follow-up examination, following unspecified surgery	N	23	465, 466
V67.01	Following surgery, follow-up vaginal pap smear	N	23	465, 466
V67.09	Follow-up examination, following other surgery	N	23	465, 466
V71.81	Observation for suspected abuse and neglect	N	23	467
V71.89	Observation for other specified suspected conditions	N	23	467
V76.46	Special screening for malignant neoplasms, ovary	N	23	467
V76.47	Special screening for malignant neoplasms, Vagina	N	23	467
V76.50	Special screening for malignant neoplasms, unspecified intestine	N	23	467
V76.51	Special screening for malignant neoplasms, colon	N	23	467
V76.52	Special screening for malignant neoplasms, small intestine	N	23	467
V76.81	Special screening for malignant neoplasms, nervous system	N	23	467
V76.89	Special screening for other malignant neoplasm	N	23	467
V77.91	Screening for lipoid disorders	N	23	467
V77.99	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders.	N	23	467
V82.81	Special screening for osteoporosis	N	23	467
V82.89	Special screening for other specified conditions	N	23	467

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
39.71	Endovascular implantation of graph in abdominal aorta	Y	5	110, 111
			11	315
			21	442, 443
			24	486
39.79	Other endovascular graft repair of aneurysm	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443
			24	486
41.07	Autologous hematopoietic stem cell transplant with purging	Y	PRE	481
41.08	Allogeneic hematopoietic stem cell transplant with purging	Y	PRE	481
41.09	Autologous bone marrow transplant with purging	Y	PRE	481
46.97	Transplant of intestine	Y	6	148, 149
			7	201
			17	400, 406, 407
			21	442, 443
			24	486
60.96	Transurethral destruction of prostate tissue by microwave thermotherapy	Y	11	306, 307
			12	336, 337
			UNR	476
60.97	Other transurethral destruction of prostate tissue by other thermotherapy	Y	11	306, 307
			12	336, 337
			UNR	476
99.75	Administration of neuroprotective agent	N		

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
294.1	Dementia in conditions classified elsewhere	N	19	429
372.8	Other disorders of conjunctiva	N	2	46, 47, 48
494	Bronchiectasis	Y	4	88
600	Hyperplasia of prostate	N	12	348, 349
645.00	Prolonged pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.01	Prolonged pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.03	Prolonged pregnancy, antepartum condition or complication	N	14	383, 384
707.1	Ulcer of lower limb, except decubitus	Y	9	263, 264, 271
781.9	Other symptoms involving nervous and musculoskeletal systems	N	1	34, 35
783.2	Abnormal loss of weight	N	10	296, 297, 298
783.4	Lack of expected normal physiological development	N	10	296, 297, 298
790.0	Abnormality of red blood cells	N	16	395, 396
V15.0	Allergy, other than to medicinal agents	N	23	467
V26.2	Investigation and testing	N	23	467
V49.8	Other specified problems influencing health status	N	23	467
V67.0	Follow-up examination following surgery	N	23	465, 466
V71.8	Observation for other specified suspected conditions	N	23	467
V76.8	Special screening for malignant neoplasms, other neoplasm	N	23	467
V77.9	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders.	N	23	467
V82.8	Special screening for other specified conditions	N	23	467

TABLE 6D.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
564.1	Irritable bowel syndrome	N	6	182, 183, 184
V26.3	Genetic counseling and testing	N	23	467
V76.49	Special screening for malignant, other sites	N	23	467

TABLE 6E.—REVISED PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
41.01	Autologous bone marrow transplant without purging	Y	PRE	481
41.04	Autologous hematopoietic stem cell transplant without purging	Y	PRE	481
41.05	Allogeneic hematopoietic stem cell transplant without purging	Y	PRE	481
86.59	Closure of skin and subcutaneous tissue other sites	N		

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*0075	2818	70713	49312	01170	4870	01152	4829
00841	2824	70714	49322	01171	4950	01153	4830
00842	28260	70715	49392	01172	4951	01154	4831
00843	28261	70719	*49391	01173	4952	01155	4838
00844	28262	*4871	49302	01174	4953	01156	4841
00845	28263	4941	49312	01175	4954	01160	4843
00846	28269	*49300	49322	01176	4955	01161	4845
00847	2830	49302	49392	01180	4956	01162	4846
00849	28310	49312	*49392	01181	4957	01163	4847
*01790	28311	49322	49301	01182	4958	01164	4848
4941	28319	49392	49302	01183	4959	01165	485
*01791	2832	*49301	49311	01184	496	01166	486
4941	2839	49302	49312	01185	5060	01170	4870
*01792	2840	49312	49320	01186	5061	01171	4941
4941	2848	49322	49321	01190	5070	01172	4950
*01793	2849	49392	49322	01191	5071	01173	4951
4941	2850	*49302	49391	01192	5078	01174	4952
*01794	2851	49301	49392	01193	5080	01175	4953
4941	*29410	49302	*4940	01194	5081	01176	4954
*01795	2910	49311	01100	01195	515	01180	4955
4941	2911	49312	01101	01196	5160	01181	4956
*01796	2912	49320	01102	01200	5161	01182	4957
4941	2913	49321	01103	01201	5162	01183	4958
*28521	2914	49322	01104	01202	5163	01184	4959
2800	29181	49391	01105	01203	5168	01185	496
2814	29189	49392	01106	01204	5169	01186	5060
2818	2919	*49310	01110	01205	5171	01190	5061
2824	2920	49302	01111	01206	5172	01191	5070
28260	29211	49312	01112	01210	5178	01192	5071
28261	29212	49322	01113	01211	74861	01193	5078
28262	2922	49392	01114	01212	*4941	01194	5080
28263	29281	*49311	01115	01213	01100	01195	5081
28269	29282	49302	01116	01214	01101	01196	515
2830	29283	49312	01120	01215	01102	01200	5160
28310	29284	49322	01121	01216	01103	01201	5161
28311	29289	49392	01122	0310	01104	01202	5162
28319	2929	*49312	01123	11505	01105	01203	5163
2832	29381	49301	01124	11515	01106	01204	5168
2839	29382	49302	01125	1304	01110	01205	5169
2840	29383	49311	01126	1363	01111	01206	5171
2848	29384	49312	01130	481	01112	01210	5172
2849	*29411	49320	01131	4820	01113	01211	5178
2850	2910	49321	01132	4821	01114	01212	74861
2851	2911	49322	01133	4822	01115	01213	*496
*28522	2912	49391	01134	48230	01116	01214	4941
2800	2913	49392	01135	48231	01120	01215	*5061
2814	2914	*49320	01136	48232	01121	01216	4941
2818	29181	49302	01140	48239	01122	0310	*5064
2824	29189	49312	01141	48240	01123	11505	4941
28260	2919	49322	01142	48241	01124	11515	*5069
28261	2920	49392	01143	48249	01125	1304	4941
28262	29211	*49321	01144	48281	01126	1363	*5178
28263	29212	49302	01145	48282	01130	481	49302
28269	2922	49312	01146	48283	01131	4820	49312
2830	29281	49322	01150	48284	01132	4821	49322
28310	29282	49392	01151	48289	01133	4822	49392
28311	29283	*49322	01152	4829	01134	48230	*51889
28319	29284	49301	01153	4830	01135	48231	49302
2832	29289	49302	01154	4831	01136	48232	49312
2839	2929	49311	01155	4838	01140	48239	49322
2840	29381	49312	01156	4841	01141	48240	49392
2848	29382	49320	01160	4843	01142	48241	*5198
2849	29383	49321	01161	4845	01143	48249	49302
2850	29384	49322	01162	4846	01144	48281	49312
2851	*44023	49391	01163	4847	01145	48282	49322
*28529	70710	49392	01164	4848	01146	48283	49392
2800	70711	*49390	01165	485	01150	48284	*5199
2814	70712	49302	01166	486	01151	48289	49302

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

49312	*70712	V421
49322	70710	V426
49392	70711	V427
*5583	70712	V4281
00841	70713	V4282
00842	70714	V4283
00843	70715	V4289
00844	70719	V432
00845	*70713	*99689
00846	70710	V4284
00847	70711	*99791
00849	70712	99687
*6000	70713	*99799
5960	70714	99687
5996	70715	*V4284
6010	70719	V4284
6012	*70714	*V4289
6013	70710	V4284
6021	70711	*V429
78820	70712	V4284
78829	70713	
*6001	70714	
5960	70715	
5996	70719	
6010	*70715	
6012	70710	
6013	70711	
6021	70712	
78820	70713	
78829	70714	
*6002	70715	
5960	70719	
5996	*70719	
6010	70710	
6012	70711	
6013	70712	
6021	70713	
78820	70714	
78829	70715	
*6003	70719	
5960	*7078	
5996	70710	
6010	70711	
6012	70712	
6013	70713	
6021	70714	
78820	70715	
78829	70719	
*6009	*7079	
5960	70710	
5996	70711	
6010	70712	
6012	70713	
6013	70714	
6021	70715	
78820	70719	
78829	*7098	
*70710	70710	
70710	70711	
70711	70712	
70712	70713	
70713	70714	
70714	70715	
70715	70719	
70719	*74861	
*70711	4941	
70710	*99680	
70711	99687	
70712	V4284	
70713	*99687	
70714	99680	
70715	99687	
70719	V420	

TABLE 6G.—DELECTIONS TO THE CC EXCLUSIONS LIST

CCs that are deleted from the list are in Table 6G—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*01790	01135	48231	6021
494	01136	48232	78820
*01791	01140	48239	78829
494	01141	48240	*7071
*01792	01142	48241	7071
494	01143	48249	*7078
*01793	01144	48281	7071
494	01145	48282	*7079
*01794	01146	48283	7071
494	01150	48284	*7098
01795	01151	48289	7071
494	01152	4829	*74861
*01796	01153	4830	494
494	01154	4831	
*2941	01155	4838	
2910	01156	4841	
2911	01160	4843	
2912	01161	4845	
2913	01162	4846	
2914	01163	4847	
29181	01164	4848	
29189	01165	485	
2919	01166	486	
2920	01170	4870	
29211	01171	494	
29212	01172	4950	
2922	01173	4951	
29281	01174	4952	
29282	01175	4953	
29283	01176	4954	
29284	01180	4955	
29289	01181	4956	
2929	01182	4957	
29381	01183	4958	
29382	01184	4959	
29383	01185	496	
29384	01186	5060	
*44023	01190	5061	
7071	01191	5070	
*4871	01192	5071	
494	01193	5078	
*494	01194	5080	
01100	01195	5081	
01101	01196	515	
01102	01200	5160	
01103	01201	5161	
01104	01202	5162	
01105	01203	5163	
01106	01204	5168	
01110	01205	5169	
01111	01206	5171	
01112	01210	5172	
01113	01211	5178	
01114	01212	74861	
01115	01213	*496	
01116	01214	494	
01120	01215	*5061	
01121	01216	494	
01122	0310	*5064	
01123	11505	494	
01124	11515	*5069	
01125	1304	494	
01126	1363	*600	
01130	481	5960	
01131	4820	5996	
01132	4821	6010	
01133	4822	6012	
01134	48230	6013	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35069	9.0962	2	4	6	12	19
2	7064	9.6692	3	5	7	12	19
4	6022	7.3316	1	2	5	9	16
5	95151	3.2852	1	1	2	3	7
6	340	3.2412	1	1	2	4	7
7	12054	10.2745	2	4	7	13	21
8	3662	3.0145	1	1	2	4	7
9	1623	6.4898	1	3	5	8	12
10	18297	6.5874	2	3	5	8	13
11	3300	4.1488	1	2	3	5	8
12	44849	6.0417	2	3	4	7	11
13	6185	5.0928	2	3	4	6	9
14	330036	5.9583	2	3	5	7	11
15	139608	3.6293	1	2	3	5	7
16	11101	6.1222	2	3	5	7	12
17	3437	3.3750	1	2	3	4	6
18	25899	5.5415	2	3	4	7	10
19	7951	3.7393	1	2	3	5	7
20	5735	10.2382	3	5	8	13	20
21	1356	6.8754	2	3	5	9	13
22	2501	4.9384	2	2	4	6	9
23	8311	4.2224	1	2	3	5	8
24	52472	5.0144	1	2	4	6	10
25	24380	3.3056	1	2	3	4	6
26	20	3.2000	1	1	2	3	7
27	3567	5.0962	1	1	3	6	11
28	10686	6.2281	1	3	5	8	13
29	3910	3.7133	1	2	3	5	7
31	3209	4.2312	1	2	3	5	8
32	1545	2.7398	1	1	2	3	5
34	19531	5.1937	1	2	4	6	10
35	5177	3.4199	1	2	3	4	6
36	4223	1.3640	1	1	1	1	2
37	1476	3.6917	1	1	3	5	8
38	115	2.5304	1	1	1	3	5
39	1152	1.9106	1	1	1	2	4
40	1755	3.5801	1	1	2	4	8
41	1	4.0000	4	4	4	4	4
42	2698	2.2279	1	1	1	3	5
43	83	3.3012	1	2	3	4	7
44	1226	4.9625	2	3	4	6	9
45	2490	3.2743	1	2	3	4	6
46	2940	4.5871	1	2	4	6	9
47	1183	3.2975	1	1	3	4	6
49	2228	4.9677	1	2	4	6	9
50	2569	1.9844	1	1	1	2	3
51	264	2.5606	1	1	1	3	6
52	196	2.1276	1	1	1	2	5
53	2569	3.6734	1	1	2	4	8
54	4	1.5000	1	1	1	1	3
55	1560	2.8865	1	1	1	3	6
56	526	3.0646	1	1	2	4	6
57	579	3.9862	1	1	2	4	8
59	111	2.4414	1	1	2	2	5
60	2	1.0000	1	1	1	1	1
61	208	4.8894	1	1	2	6	13
62	2	3.5000	2	2	5	5	5
63	3168	4.2601	1	2	3	5	9
64	3162	6.4756	1	2	4	8	14
65	31728	2.8963	1	1	2	4	5
66	6938	3.1721	1	1	3	4	6
67	477	3.5241	1	2	3	4	7
68	13401	4.1595	1	2	3	5	8
69	4228	3.2774	1	2	3	4	6
70	33	2.9091	1	2	3	4	5
71	105	3.8667	1	2	3	6	7
72	812	3.3017	1	2	3	4	6
73	6402	4.3380	1	2	3	5	8
75	39147	9.9967	3	5	8	12	20
76	39851	11.2556	3	5	9	14	21

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
77	2375	4.8880	1	2	4	7	10
78	30492	6.9444	3	5	6	8	11
79	183121	8.4551	3	4	7	11	16
80	8291	5.6652	2	3	5	7	10
81	5	9.2000	2	2	10	10	19
82	63683	6.9428	2	3	5	9	14
83	6462	5.5305	2	3	4	7	10
84	1494	3.3681	1	2	3	4	6
85	20066	6.3638	2	3	5	8	12
86	1923	3.7889	1	2	3	5	7
87	62959	6.2450	1	3	5	8	12
88	403808	5.2212	2	3	4	7	9
89	524107	6.0245	2	3	5	7	11
90	51271	4.2271	2	3	4	5	7
91	49	3.3061	1	2	3	4	5
92	13763	6.2465	2	3	5	8	12
93	1543	3.9942	1	2	3	5	7
94	12332	6.3027	2	3	5	8	12
95	1561	3.6887	1	2	3	5	7
96	64893	4.7277	2	3	4	6	8
97	31521	3.6879	1	2	3	5	7
98	18	4.6667	1	1	3	6	7
99	18166	3.2204	1	1	2	4	6
100	7230	2.2047	1	1	2	3	4
101	19700	4.4248	1	2	3	5	8
102	4970	2.7360	1	1	2	3	5
103	442	48.6041	9	12	29	64	112
104	33069	11.6306	3	6	10	15	22
105	29348	9.2675	4	5	7	11	17
106	3800	11.2111	5	7	9	13	20
107	90499	10.3531	5	7	9	12	17
108	5234	10.5728	3	5	8	13	20
109	61584	7.7338	4	5	6	9	13
110	54902	9.4567	2	5	8	11	18
111	7109	5.4788	2	4	5	7	8
112	60796	3.7594	1	1	3	5	8
113	44201	12.0562	3	6	9	15	24
114	8478	8.2536	2	4	7	10	16
115	14032	8.4152	1	4	7	11	16
116	308071	3.7287	1	1	3	5	8
117	3404	4.0523	1	1	2	5	9
118	6649	2.8117	1	1	1	3	6
119	1445	4.8374	1	1	3	6	12
120	36651	8.1192	1	2	5	10	18
121	163449	6.4387	2	3	5	8	12
122	80682	3.8317	1	2	3	5	7
123	40870	4.5742	1	1	3	6	11
124	134743	4.3708	1	2	3	6	8
125	74923	2.7862	1	1	2	4	5
126	5131	11.6936	3	6	9	14	22
127	680654	5.3354	2	3	4	7	10
128	11526	5.8044	3	4	5	7	9
129	4173	2.8447	1	1	1	3	7
130	89048	5.8037	2	3	5	7	10
131	26830	4.3785	1	3	4	6	7
132	152932	3.0474	1	1	2	4	6
133	7573	2.3956	1	1	2	3	4
134	32813	3.2987	1	2	3	4	6
135	7100	4.4668	1	2	3	5	9
136	1170	2.9120	1	1	2	4	6
138	191436	4.0071	1	2	3	5	8
139	77194	2.5069	1	1	2	3	5
140	76478	2.7136	1	1	2	3	5
141	85791	3.7068	1	2	3	5	7
142	42652	2.6766	1	1	2	3	5
143	185700	2.1667	1	1	2	3	4
144	78800	5.3171	1	2	4	7	11
145	6884	2.8117	1	1	2	4	6
146	11215	10.1815	5	7	9	12	17
147	2418	6.6208	3	5	6	8	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
148	134272	12.1101	5	7	10	14	22
149	17551	6.6488	4	5	6	8	10
150	20300	11.1450	4	7	9	14	20
151	4479	5.9272	2	3	5	8	10
152	4441	8.1743	3	5	7	10	14
153	1914	5.4713	3	4	5	7	8
154	29346	13.2615	4	7	10	16	25
155	6052	4.3354	1	2	3	6	8
156	2	28.0000	28	28	28	28	28
157	8196	5.4926	1	2	4	7	11
158	4393	2.6271	1	1	2	3	5
159	16421	5.0258	1	2	4	6	10
160	10974	2.7204	1	1	2	4	5
161	11483	4.1695	1	2	3	5	9
162	7018	1.9577	1	1	1	2	4
163	8	2.7500	1	1	3	3	3
164	4720	8.4019	4	5	7	10	15
165	1942	4.8553	2	3	5	6	8
166	3307	5.0889	2	3	4	6	9
167	2896	2.7099	1	2	2	3	5
168	1511	4.5963	1	2	3	6	9
169	802	2.4214	1	1	2	3	5
170	11287	11.1669	2	5	8	14	23
171	1125	4.7911	1	2	4	6	9
172	30485	6.9710	2	3	5	9	14
173	2492	3.8435	1	1	3	5	8
174	236408	4.8222	2	3	4	6	9
175	28026	2.9414	1	2	3	4	5
176	15607	5.2668	2	3	4	6	10
177	9489	4.5521	2	2	4	6	8
178	3568	3.1373	1	2	3	4	6
179	12177	6.0139	2	3	5	7	11
180	85083	5.3978	2	3	4	7	10
181	24320	3.4134	1	2	3	4	6
182	232501	4.3626	1	2	3	5	8
183	78432	2.9618	1	1	2	4	6
184	98	3.2449	1	2	2	4	5
185	4300	4.4963	1	2	3	6	9
186	2	4.5000	2	2	7	7	7
187	722	3.8130	1	2	3	5	8
188	74594	5.5723	1	2	4	7	11
189	11097	3.1388	1	1	2	4	6
190	69	6.0290	2	3	4	6	11
191	9367	14.0878	4	7	10	18	28
192	974	6.5842	2	4	6	8	11
193	5669	12.5490	5	7	10	15	23
194	755	6.7497	2	4	6	8	12
195	4869	9.9029	4	6	8	12	17
196	1190	5.6832	2	4	5	7	9
197	20225	8.7363	3	5	7	11	16
198	6079	4.4996	2	3	4	6	8
199	1724	9.6456	3	4	8	12	19
200	1071	10.7404	2	4	8	14	22
201	1465	13.8314	3	6	11	18	27
202	25595	6.5031	2	3	5	8	13
203	28958	6.6940	2	3	5	9	13
204	54818	5.8581	2	3	4	7	11
205	22519	6.2964	2	3	5	8	12
206	1778	3.8335	1	2	3	5	7
207	30768	5.1176	1	2	4	6	10
208	9616	2.8974	1	1	2	4	6
209	342301	5.1232	3	3	4	6	8
210	126555	6.8082	3	4	6	8	11
211	31227	4.9152	3	4	4	6	7
212	7	3.0000	2	2	2	3	4
213	8882	8.7299	2	4	7	11	17
216	5822	9.7583	2	4	7	12	19
217	17573	13.0833	3	5	9	16	28
218	21344	5.3594	2	3	4	6	10
219	19125	3.2444	1	2	3	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	2	2.5000	1	1	4	4	4
223	17434	2.5812	1	1	2	3	5
224	7953	2.0448	1	1	2	3	4
225	5575	4.7146	1	2	3	6	10
226	4985	6.2828	1	2	4	8	13
227	4416	2.6594	1	1	2	3	5
228	2437	3.5568	1	1	2	4	8
229	1080	2.3944	1	1	2	3	5
230	2102	5.1237	1	2	3	6	10
231	10618	4.8282	1	2	3	6	10
232	565	3.5894	1	1	2	4	9
233	4542	7.6797	2	3	5	9	16
234	2666	3.5709	1	2	3	4	7
235	5334	5.1245	1	2	4	6	10
236	38564	4.8516	1	3	4	6	9
237	1576	3.7386	1	2	3	5	7
238	7594	8.4664	3	4	6	10	16
239	51719	6.2172	2	3	5	8	12
240	11850	6.5754	2	3	5	8	13
241	2953	3.9401	1	2	3	5	7
242	2477	6.5268	2	3	5	8	12
243	84831	4.7022	1	3	4	6	9
244	11891	4.7802	1	2	4	6	9
245	4929	3.7206	1	2	3	4	7
246	1342	3.6461	1	2	3	4	7
247	15047	3.4443	1	1	3	4	7
248	9336	4.7321	1	2	4	6	9
249	10719	3.7768	1	1	3	5	8
250	3509	4.2485	1	2	3	5	8
251	2351	2.9872	1	1	3	4	5
252	1	2.0000	2	2	2	2	2
253	18878	4.6841	1	3	4	6	9
254	10341	3.2080	1	2	3	4	6
255	1	1.0000	1	1	1	1	1
256	5803	5.1260	1	2	4	6	10
257	16795	2.8263	1	2	2	3	5
258	15710	2.0006	1	1	2	2	3
259	3717	2.7896	1	1	1	3	6
260	4780	1.4749	1	1	1	2	2
261	1730	2.1624	1	1	1	2	4
262	673	3.8098	1	1	3	5	7
263	24527	11.5534	3	5	8	14	23
264	3877	6.9010	2	3	5	8	14
265	3868	6.6099	1	2	4	8	14
266	2527	3.3174	1	1	2	4	7
267	255	5.2353	1	1	3	6	12
268	896	3.6953	1	1	2	4	8
269	8856	8.2516	2	3	6	10	16
270	2734	3.2579	1	1	2	4	7
271	21090	7.1019	2	4	6	8	13
272	5465	6.3420	2	3	5	8	12
273	1341	4.2118	1	2	3	5	8
274	2368	6.9548	2	3	5	9	14
275	224	3.3125	1	1	2	4	7
276	1076	4.6515	1	2	4	6	9
277	83707	5.7178	2	3	5	7	10
278	28524	4.3359	2	3	4	5	7
279	4	4.0000	2	2	4	5	5
280	15047	4.1980	1	2	3	5	8
281	6682	3.0805	1	1	3	4	6
283	5322	4.5569	1	2	3	6	9
284	1852	3.1960	1	1	2	4	6
285	6125	10.4263	3	5	8	13	20
286	1995	6.2000	2	3	5	7	11
287	5974	10.5387	3	5	8	13	20
288	2252	5.7234	2	3	4	6	9
289	4326	3.1248	1	1	2	3	7
290	8214	2.4329	1	1	2	2	4
291	57	1.6316	1	1	1	2	2
292	4945	9.9610	2	4	7	13	21

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
293	321	4.9346	1	2	4	7	10
294	83924	4.7128	1	2	4	6	9
295	3464	3.8467	1	2	3	5	7
296	232274	5.2398	2	3	4	6	10
297	40842	3.4744	1	2	3	4	6
298	106	3.1887	1	2	2	4	6
299	1052	5.5542	1	2	4	6	11
300	15582	6.1317	2	3	5	8	12
301	3101	3.7004	1	2	3	5	7
302	7525	9.4141	4	5	7	11	16
303	19405	8.4850	4	5	7	10	15
304	11967	8.8979	2	4	7	11	18
305	2852	3.8443	1	2	3	5	7
306	7925	5.4829	1	2	3	7	12
307	2226	2.2668	1	1	2	3	4
308	7673	6.3836	1	2	4	8	14
309	3947	2.4880	1	1	2	3	5
310	23701	4.3591	1	2	3	5	9
311	8200	1.8902	1	1	1	2	3
312	1570	4.5166	1	1	3	6	10
313	633	2.1153	1	1	1	3	4
314	2	1.0000	1	1	1	1	1
315	28524	7.4721	1	1	5	10	17
316	96406	6.6791	2	3	5	8	13
317	1230	3.2114	1	1	2	3	6
318	5544	5.9975	1	3	4	7	12
319	460	2.8630	1	1	2	4	6
320	181708	5.3834	2	3	4	7	10
321	28174	3.8452	1	2	3	5	7
322	69	4.0580	1	2	3	5	7
323	16353	3.2183	1	1	2	4	7
324	7365	1.8789	1	1	1	2	3
325	7788	3.8947	1	2	3	5	7
326	2414	2.6582	1	1	2	3	5
327	7	9.2857	1	1	2	4	13
328	718	3.9053	1	1	3	5	8
329	104	2.0481	1	1	1	3	4
331	43233	5.5300	1	2	4	7	11
332	4795	3.2715	1	1	2	4	7
333	296	5.0507	1	2	3	6	10
334	12132	4.8938	2	3	4	6	8
335	11393	3.4104	2	3	3	4	5
336	40525	3.5229	1	2	3	4	7
337	30540	2.1759	1	1	2	3	3
338	1641	5.2956	1	2	3	7	12
339	1503	4.5269	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3836	3.2018	1	1	2	3	7
342	775	3.1174	1	2	2	4	6
344	3934	2.2567	1	1	1	2	4
345	1272	3.7673	1	1	2	5	8
346	4622	5.8090	1	3	4	7	11
347	396	3.3712	1	1	2	4	7
348	3105	4.2029	1	2	3	5	8
349	589	2.6027	1	1	2	3	5
350	6157	4.3937	2	2	4	5	8
352	646	3.8498	1	2	3	5	8
353	2631	6.7081	3	3	5	8	13
354	8209	5.8725	3	3	4	7	10
355	5698	3.3243	2	3	3	4	5
356	25961	2.4179	1	1	2	3	4
357	5767	8.4947	3	4	7	10	16
358	21628	4.3926	2	3	3	5	7
359	29103	2.8141	2	2	3	3	4
360	16133	2.9634	1	2	2	3	5
361	420	3.4524	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3079	3.4784	1	2	2	3	7
364	1611	3.5847	1	1	2	5	7
365	1917	7.3005	2	3	5	9	16

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
366	4226	6.7283	1	3	5	8	14
367	472	3.1462	1	1	2	4	7
368	2861	6.7113	2	3	5	8	13
369	2832	3.1963	1	1	2	4	6
370	1141	5.7160	3	3	4	5	9
371	1174	3.6567	2	3	3	4	5
372	916	3.4509	2	2	2	3	5
373	3916	2.2829	1	2	2	2	3
374	125	3.4880	2	2	2	3	5
375	6	2.6667	2	2	2	3	3
376	254	3.4803	1	2	2	4	7
377	53	3.8679	1	1	2	5	8
378	151	2.3444	1	1	2	3	4
379	355	3.1127	1	1	2	3	7
380	74	2.1622	1	1	2	2	4
381	176	1.9545	1	1	1	2	3
382	39	1.3077	1	1	1	1	2
383	1545	3.8913	1	1	3	5	8
384	123	2.3415	1	1	1	2	4
389	8	5.8750	3	3	4	8	10
390	19	3.7368	1	1	3	5	7
392	2508	9.4769	3	4	7	12	19
393	1	8.0000	8	8	8	8	8
394	1724	6.6810	1	2	4	8	15
395	80464	4.5303	1	2	3	6	9
396	17	3.7059	1	1	2	5	6
397	18071	5.2277	1	2	4	7	10
398	18051	5.9638	2	3	5	7	11
399	1614	3.5520	1	2	3	4	7
400	6845	9.0488	1	3	6	12	20
401	5827	11.1903	2	5	8	14	23
402	1483	3.9400	1	1	3	5	8
403	33277	8.0524	2	3	6	10	17
404	4491	4.2224	1	2	3	6	9
406	2546	10.2859	3	4	7	13	21
407	695	4.4086	1	2	4	6	8
408	2246	7.7061	1	2	5	10	18
409	3281	5.9113	2	3	4	6	11
410	40863	3.7201	1	2	3	5	6
411	13	2.3077	1	1	2	4	4
412	29	2.7241	1	1	2	3	6
413	6149	7.2477	2	3	6	9	14
414	712	4.0941	1	2	3	5	9
415	39856	14.1713	4	6	11	18	28
416	195783	7.3483	2	4	6	9	14
417	32	6.1875	1	2	4	7	13
418	22097	6.1239	2	3	5	7	11
419	15859	4.8212	2	2	4	6	9
420	3091	3.5642	1	2	3	4	6
421	12242	3.8638	1	2	3	5	7
422	96	5.2708	1	2	2	5	7
423	8073	8.1416	2	3	6	10	17
424	1354	13.3936	2	5	9	16	28
425	15006	4.0716	1	2	3	5	8
426	4313	4.5613	1	2	3	6	9
427	1660	5.0283	1	2	3	6	10
428	839	7.1025	1	2	4	8	15
429	27480	6.4737	2	3	5	8	12
430	58011	8.2066	2	3	6	10	16
431	295	6.5864	2	3	5	8	13
432	389	4.7506	1	2	3	5	9
433	5781	3.0073	1	1	2	4	6
434	21835	5.0844	1	2	4	6	9
435	14486	4.2925	1	2	4	5	8
436	3499	12.8337	4	7	11	17	25
437	9750	8.9544	3	5	8	11	15
439	1287	8.1756	1	3	5	10	17
440	5017	8.8433	2	3	6	10	19
441	579	3.2383	1	1	2	4	7
442	15896	8.2292	1	3	6	10	17

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
443	3547	3.3941	1	1	2	4	7
444	5150	4.2252	1	2	3	5	8
445	2223	3.0031	1	1	2	4	5
447	4854	2.5117	1	1	2	3	5
448	1	4.0000	4	4	4	4	4
449	26543	3.6722	1	1	3	4	7
450	6363	2.0525	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	21656	4.9536	1	2	3	6	10
453	4464	2.8156	1	1	2	3	5
454	4930	4.5554	1	2	3	6	9
455	1070	2.6262	1	1	2	3	5
461	3356	4.5584	1	1	2	5	11
462	12630	11.5264	4	6	9	15	21
463	18895	4.2653	1	2	3	5	8
464	5456	3.0770	1	1	2	4	6
465	227	3.3612	1	1	2	3	7
466	1719	3.8674	1	1	2	4	8
467	1301	4.0638	1	1	2	4	7
468	58386	12.9325	3	6	10	17	26
471	11423	5.7339	3	4	5	6	9
473	7615	12.8411	2	3	7	19	32
475	109114	11.1765	2	5	9	15	22
476	4448	11.6369	2	5	10	15	21
477	25690	8.1425	1	3	6	10	17
478	111192	7.3159	1	3	5	9	15
479	22375	3.6220	1	2	3	5	7
480	460	19.1848	7	9	14	23	38
481	229	27.1485	16	19	23	32	43
482	6119	12.7756	4	7	10	15	24
483	43070	38.8321	14	21	32	49	70
484	323	13.3065	2	5	10	18	28
485	2932	9.3905	4	5	7	11	17
486	2012	12.1511	1	5	9	16	24
487	3491	7.5408	1	3	6	10	15
488	767	16.9465	4	7	12	21	34
489	14253	8.5597	2	3	6	10	18
490	5283	5.1333	1	2	4	6	10
491	11332	3.4896	2	2	3	4	6
492	2667	16.1234	4	5	9	26	34
493	54030	5.7170	1	3	5	7	11
494	27254	2.4838	1	1	2	3	5
495	145	20.2552	6	8	12	18	33
496	1270	9.9843	4	5	7	12	18
497	22593	6.2173	2	3	5	7	11
498	19133	3.4179	1	2	3	4	6
499	30738	4.7687	1	2	4	6	9
500	42090	2.6897	1	1	2	3	5
501	1943	10.5713	4	5	8	13	20
502	612	5.9379	2	3	5	7	10
503	5563	3.9730	1	2	3	5	7
504	122	30.0984	10	15	25	40	60
505	153	4.7190	1	1	2	6	12
506	962	17.6258	4	8	14	24	37
507	280	9.1857	2	4	7	13	18
508	637	7.1350	2	3	5	9	15
509	165	6.1333	1	2	4	8	12
510	1653	7.8506	2	3	5	9	17
511	594	4.4646	1	1	3	6	10
	10930692						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35069	9.0962	2	4	6	12	19

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
2	7064	9.6692	3	5	7	12	19
4	6022	7.3316	1	2	5	9	16
5	95151	3.2852	1	1	2	3	7
6	340	3.2412	1	1	2	4	7
7	12054	10.2745	2	4	7	13	21
8	3662	3.0145	1	1	2	4	7
9	1623	6.4898	1	3	5	8	12
10	18297	6.5874	2	3	5	8	13
11	3300	4.1488	1	2	3	5	8
12	44849	6.0417	2	3	4	7	11
13	6185	5.0928	2	3	4	6	9
14	362463	6.0528	2	3	5	7	11
15	139608	3.6293	1	2	3	5	7
16	11101	6.1222	2	3	5	7	12
17	3437	3.3750	1	2	3	4	6
18	25899	5.5415	2	3	4	7	10
19	7951	3.7393	1	2	3	5	7
20	5735	10.2382	3	5	8	13	20
21	1356	6.8754	2	3	5	9	13
22	2501	4.9384	2	2	4	6	9
23	8311	4.2224	1	2	3	5	8
24	52472	5.0144	1	2	4	6	10
25	24380	3.3056	1	2	3	4	6
26	20	3.2000	1	1	2	3	7
27	3567	5.0962	1	1	3	6	11
28	10685	6.2270	1	3	5	8	13
29	3910	3.7133	1	2	3	5	7
31	3209	4.2312	1	2	3	5	8
32	1545	2.7398	1	1	2	3	5
34	19531	5.1937	1	2	4	6	10
35	5177	3.4199	1	2	3	4	6
36	4223	1.3640	1	1	1	1	2
37	1476	3.6917	1	1	3	5	8
38	115	2.5304	1	1	1	3	5
39	1152	1.9106	1	1	1	2	4
40	1755	3.5801	1	1	2	4	8
41	1	4.0000	4	4	4	4	4
42	2698	2.2279	1	1	1	3	5
43	83	3.3012	1	2	3	4	7
44	1226	4.9625	2	3	4	6	9
45	2490	3.2743	1	2	3	4	6
46	2940	4.5871	1	2	4	6	9
47	1183	3.2975	1	1	3	4	6
49	2228	4.9677	1	2	4	6	9
50	2569	1.9844	1	1	1	2	3
51	264	2.5606	1	1	1	3	6
52	196	2.1276	1	1	1	2	5
53	2569	3.6734	1	1	2	4	8
54	4	1.5000	1	1	1	1	3
55	1560	2.8865	1	1	1	3	6
56	526	3.0646	1	1	2	4	6
57	579	3.9862	1	1	2	4	8
59	111	2.4414	1	1	2	2	5
60	2	1.0000	1	1	1	1	1
61	208	4.8894	1	1	2	6	13
62	2	3.5000	2	2	5	5	5
63	3168	4.2601	1	2	3	5	9
64	3162	6.4756	1	2	4	8	14
65	31728	2.8963	1	1	2	4	5
66	6938	3.1721	1	1	3	4	6
67	477	3.5241	1	2	3	4	7
68	13401	4.1595	1	2	3	5	8
69	4228	3.2774	1	2	3	4	6
70	33	2.9091	1	2	3	4	5
71	105	3.8667	1	2	3	6	7
72	812	3.3017	1	2	3	4	6
73	6402	4.3380	1	2	3	5	8
75	39147	9.9967	3	5	8	12	20
76	39851	11.2556	3	5	9	14	21
77	2375	4.8880	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
78	30492	6.9444	3	5	6	8	11
79	183121	8.4551	3	4	7	11	16
80	8291	5.6652	2	3	5	7	10
81	5	9.2000	2	2	10	10	19
82	63683	6.9428	2	3	5	9	14
83	6462	5.5305	2	3	4	7	10
84	1494	3.3681	1	2	3	4	6
85	20066	6.3638	2	3	5	8	12
86	1923	3.7889	1	2	3	5	7
87	62959	6.2450	1	3	5	8	12
88	403808	5.2212	2	3	4	7	9
89	524106	6.0245	2	3	5	7	11
90	51271	4.2271	2	3	4	5	7
91	49	3.3061	1	2	3	4	5
92	13763	6.2465	2	3	5	8	12
93	1543	3.9942	1	2	3	5	7
94	12332	6.3027	2	3	5	8	12
95	1561	3.6887	1	2	3	5	7
96	64893	4.7277	2	3	4	6	8
97	31521	3.6879	1	2	3	5	7
98	18	4.6667	1	1	3	6	7
99	18166	3.2204	1	1	2	4	6
100	7230	2.2047	1	1	2	3	4
101	19700	4.4248	1	2	3	5	8
102	4970	2.7360	1	1	2	3	5
103	442	48.6041	9	12	29	64	112
104	33352	11.6423	3	6	10	15	22
105	29488	9.2812	4	5	7	11	17
106	3785	11.2201	5	7	9	13	20
107	90361	10.3492	5	7	9	12	17
108	5213	10.5580	3	5	8	13	20
109	61526	7.7320	4	5	6	9	13
110	54724	9.4413	2	5	8	11	18
111	7102	5.4816	2	4	5	7	8
112	60794	3.7592	1	1	3	5	8
113	49775	12.1191	4	6	9	15	24
114	8478	8.2536	2	4	7	10	16
115	14032	8.4152	1	4	7	11	16
116	308070	3.7287	1	1	3	5	8
117	3404	4.0523	1	1	2	5	9
118	6649	2.8117	1	1	1	3	6
119	1445	4.8374	1	1	3	6	12
120	36650	8.1194	1	2	5	10	18
121	163449	6.4387	2	3	5	8	12
122	80682	3.8317	1	2	3	5	7
123	40869	4.5742	1	1	3	6	11
124	134743	4.3708	1	2	3	6	8
125	74923	2.7862	1	1	2	4	5
126	5131	11.6936	3	6	9	14	22
127	680654	5.3354	2	3	4	7	10
128	11526	5.8044	3	4	5	7	9
129	4173	2.8447	1	1	1	3	7
130	89048	5.8037	2	3	5	7	10
131	26830	4.3785	1	3	4	6	7
132	152932	3.0474	1	1	2	4	6
133	7573	2.3956	1	1	2	3	4
134	32813	3.2987	1	2	3	4	6
135	7100	4.4668	1	2	3	5	9
136	1170	2.9120	1	1	2	4	6
138	191436	4.0071	1	2	3	5	8
139	77194	2.5069	1	1	2	3	5
140	76478	2.7136	1	1	2	3	5
141	85791	3.7068	1	2	3	5	7
142	42652	2.6766	1	1	2	3	5
143	185700	2.1667	1	1	2	3	4
144	78800	5.3171	1	2	4	7	11
145	6884	2.8117	1	1	2	4	6
146	11215	10.1815	5	7	9	12	17
147	2418	6.6208	3	5	6	8	10
148	134272	12.1101	5	7	10	14	22

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
149	17551	6.6488	4	5	6	8	10
150	20300	11.1450	4	7	9	14	20
151	4479	5.9272	2	3	5	8	10
152	4441	8.1743	3	5	7	10	14
153	1914	5.4713	3	4	5	7	8
154	29346	13.2615	4	7	10	16	25
155	6052	4.3354	1	2	3	6	8
156	2	28.0000	28	28	28	28	28
157	8196	5.4926	1	2	4	7	11
158	4393	2.6271	1	1	2	3	5
159	16421	5.0258	1	2	4	6	10
160	10974	2.7204	1	1	2	4	5
161	11483	4.1695	1	2	3	5	9
162	7018	1.9577	1	1	1	2	4
163	8	2.7500	1	1	3	3	3
164	4720	8.4019	4	5	7	10	15
165	1942	4.8553	2	3	5	6	8
166	3307	5.0889	2	3	4	6	9
167	2896	2.7099	1	2	2	3	5
168	1511	4.5963	1	2	3	6	9
169	802	2.4214	1	1	2	3	5
170	11287	11.1669	2	5	8	14	23
171	1125	4.7911	1	2	4	6	9
172	30485	6.9710	2	3	5	9	14
173	2492	3.8435	1	1	3	5	8
174	236408	4.8222	2	3	4	6	9
175	28026	2.9414	1	2	3	4	5
176	15607	5.2668	2	3	4	6	10
177	9489	4.5521	2	2	4	6	8
178	3568	3.1373	1	2	3	4	6
179	12177	6.0139	2	3	5	7	11
180	85083	5.3978	2	3	4	7	10
181	24320	3.4134	1	2	3	4	6
182	232501	4.3626	1	2	3	5	8
183	78432	2.9618	1	1	2	4	6
184	98	3.2449	1	2	2	4	5
185	4300	4.4963	1	2	3	6	9
186	2	4.5000	2	2	7	7	7
187	722	3.8130	1	2	3	5	8
188	74594	5.5723	1	2	4	7	11
189	11097	3.1388	1	1	2	4	6
190	69	6.0290	2	3	4	6	11
191	9367	14.0878	4	7	10	18	28
192	974	6.5842	2	4	6	8	11
193	5669	12.5490	5	7	10	15	23
194	755	6.7497	2	4	6	8	12
195	4869	9.9029	4	6	8	12	17
196	1190	5.6832	2	4	5	7	9
197	20225	8.7363	3	5	7	11	16
198	6079	4.4996	2	3	4	6	8
199	1724	9.6456	3	4	8	12	19
200	1071	10.7404	2	4	8	14	22
201	1465	13.8314	3	6	11	18	27
202	25595	6.5031	2	3	5	8	13
203	28958	6.6940	2	3	5	9	13
204	54818	5.8581	2	3	4	7	11
205	22519	6.2964	2	3	5	8	12
206	1778	3.8335	1	2	3	5	7
207	30768	5.1176	1	2	4	6	10
208	9616	2.8974	1	1	2	4	6
209	394168	5.1231	3	3	4	6	8
210	146423	6.8039	3	4	6	8	11
211	35938	4.9292	3	4	4	6	7
212	7	3.0000	2	2	2	3	4
213	8882	8.7299	2	4	7	11	17
216	5822	9.7583	2	4	7	12	19
217	17573	13.0833	3	5	9	16	28
218	21344	5.3594	2	3	4	6	10
219	19125	3.2444	1	2	3	4	5
220	2	2.5000	1	1	4	4	4

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
223	17434	2.5812	1	1	2	3	5
224	7953	2.0448	1	1	2	3	4
225	5575	4.7146	1	2	3	6	10
226	4985	6.2828	1	2	4	8	13
227	4416	2.6594	1	1	2	3	5
228	2437	3.5568	1	1	2	4	8
229	1080	2.3944	1	1	2	3	5
230	2102	5.1237	1	2	3	6	10
231	10618	4.8282	1	2	3	6	10
232	565	3.5894	1	1	2	4	9
233	4542	7.6797	2	3	5	9	16
234	2666	3.5709	1	2	3	4	7
235	5334	5.1245	1	2	4	6	10
236	43318	4.8912	2	3	4	6	9
237	1576	3.7386	1	2	3	5	7
238	7594	8.4664	3	4	6	10	16
239	51719	6.2172	2	3	5	8	12
240	11850	6.5754	2	3	5	8	13
241	2953	3.9401	1	2	3	5	7
242	2477	6.5268	2	3	5	8	12
243	84831	4.7022	1	3	4	6	9
244	11891	4.7802	1	2	4	6	9
245	4929	3.7206	1	2	3	4	7
246	1342	3.6461	1	2	3	4	7
247	15047	3.4443	1	1	3	4	7
248	9336	4.7321	1	2	4	6	9
249	10719	3.7768	1	1	3	5	8
250	3509	4.2485	1	2	3	5	8
251	2351	2.9872	1	1	3	4	5
252	1	2.0000	2	2	2	2	2
253	18878	4.6841	1	3	4	6	9
254	10341	3.2080	1	2	3	4	6
255	1	1.0000	1	1	1	1	1
256	5803	5.1260	1	2	4	6	10
257	16795	2.8263	1	2	2	3	5
258	15710	2.0006	1	1	2	2	3
259	3717	2.7896	1	1	1	3	6
260	4780	1.4749	1	1	1	2	2
261	1730	2.1624	1	1	1	2	4
262	673	3.8098	1	1	3	5	7
263	27219	11.5858	3	5	8	14	23
264	4261	6.9681	2	3	5	8	14
265	3868	6.6099	1	2	4	8	14
266	2527	3.3174	1	1	2	4	7
267	255	5.2353	1	1	3	6	12
268	896	3.6953	1	1	2	4	8
269	8856	8.2516	2	3	6	10	16
270	2734	3.2579	1	1	2	4	7
271	21090	7.1019	2	4	6	8	13
272	5465	6.3420	2	3	5	8	12
273	1341	4.2118	1	2	3	5	8
274	2368	6.9548	2	3	5	9	14
275	224	3.3125	1	1	2	4	7
276	1076	4.6515	1	2	4	6	9
277	83707	5.7178	2	3	5	7	10
278	28524	4.3359	2	3	4	5	7
279	4	4.0000	2	2	4	5	5
280	15047	4.1980	1	2	3	5	8
281	6682	3.0805	1	1	3	4	6
283	5322	4.5569	1	2	3	6	9
284	1852	3.1960	1	1	2	4	6
285	6125	10.4263	3	5	8	13	20
286	1995	6.2000	2	3	5	7	11
287	5974	10.5387	3	5	8	13	20
288	2252	5.7234	2	3	4	6	9
289	4326	3.1248	1	1	2	3	7
290	8214	2.4329	1	1	2	2	4
291	57	1.6316	1	1	1	2	2
292	4945	9.9610	2	4	7	13	21
293	321	4.9346	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	83924	4.7128	1	2	4	6	9
295	3464	3.8467	1	2	3	5	7
296	232274	5.2398	2	3	4	6	10
297	40842	3.4744	1	2	3	4	6
298	106	3.1887	1	2	2	4	6
299	1052	5.5542	1	2	4	6	11
300	15582	6.1317	2	3	5	8	12
301	3101	3.7004	1	2	3	5	7
302	7525	9.4141	4	5	7	11	16
303	19405	8.4850	4	5	7	10	15
304	11967	8.8979	2	4	7	11	18
305	2852	3.8443	1	2	3	5	7
306	7925	5.4829	1	2	3	7	12
307	2226	2.2668	1	1	2	3	4
308	7673	6.3836	1	2	4	8	14
309	3947	2.4880	1	1	2	3	5
310	23701	4.3591	1	2	3	5	9
311	8200	1.8902	1	1	1	2	3
312	1570	4.5166	1	1	3	6	10
313	633	2.1153	1	1	1	3	4
314	2	1.0000	1	1	1	1	1
315	28524	7.4721	1	1	5	10	17
316	96405	6.6791	2	3	5	8	13
317	1230	3.2114	1	1	2	3	6
318	5544	5.9975	1	3	4	7	12
319	460	2.8630	1	1	2	4	6
320	181708	5.3834	2	3	4	7	10
321	28174	3.8452	1	2	3	5	7
322	69	4.0580	1	2	3	5	7
323	16353	3.2183	1	1	2	4	7
324	7365	1.8789	1	1	1	2	3
325	7788	3.8947	1	2	3	5	7
326	2414	2.6582	1	1	2	3	5
327	7	9.2857	1	1	2	4	13
328	718	3.9053	1	1	3	5	8
329	104	2.0481	1	1	1	3	4
331	43233	5.5300	1	2	4	7	11
332	4795	3.2715	1	1	2	4	7
333	296	5.0507	1	2	3	6	10
334	12132	4.8938	2	3	4	6	8
335	11393	3.4104	2	3	3	4	5
336	40525	3.5229	1	2	3	4	7
337	30540	2.1759	1	1	2	3	3
338	1641	5.2956	1	2	3	7	12
339	1503	4.5269	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3836	3.2018	1	1	2	3	7
342	775	3.1174	1	2	2	4	6
344	3934	2.2567	1	1	1	2	4
345	1272	3.7673	1	1	2	5	8
346	4622	5.8090	1	3	4	7	11
347	396	3.3712	1	1	2	4	7
348	3105	4.2029	1	2	3	5	8
349	589	2.6027	1	1	2	3	5
350	6157	4.3937	2	2	4	5	8
352	646	3.8498	1	2	3	5	8
353	2631	6.7081	3	3	5	8	13
354	8209	5.8725	3	3	4	7	10
355	5698	3.3243	2	3	3	4	5
356	25961	2.4179	1	1	2	3	4
357	5767	8.4947	3	4	7	10	16
358	21628	4.3926	2	3	3	5	7
359	29103	2.8141	2	2	3	3	4
360	16133	2.9634	1	2	2	3	5
361	420	3.4524	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3079	3.4784	1	2	2	3	7
364	1611	3.5847	1	1	2	5	7
365	1917	7.3005	2	3	5	9	16
366	4226	6.7283	1	3	5	8	14

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
367	472	3.1462	1	1	2	4	7
368	2861	6.7113	2	3	5	8	13
369	2832	3.1963	1	1	2	4	6
370	1141	5.7160	3	3	4	5	9
371	1174	3.6567	2	3	3	4	5
372	916	3.4509	2	2	2	3	5
373	3916	2.2829	1	2	2	2	3
374	125	3.4880	2	2	2	3	5
375	6	2.6667	2	2	2	3	3
376	254	3.4803	1	2	2	4	7
377	53	3.8679	1	1	2	5	8
378	151	2.3444	1	1	2	3	4
379	355	3.1127	1	1	2	3	7
380	74	2.1622	1	1	2	2	4
381	176	1.9545	1	1	1	2	3
382	39	1.3077	1	1	1	1	2
383	1545	3.8913	1	1	3	5	8
384	123	2.3415	1	1	1	2	4
389	8	5.8750	3	3	4	8	10
390	19	3.7368	1	1	3	5	7
392	2508	9.4769	3	4	7	12	19
393	1	8.0000	8	8	8	8	8
394	1724	6.6810	1	2	4	8	15
395	80464	4.5303	1	2	3	6	9
396	17	3.7059	1	1	2	5	6
397	18071	5.2277	1	2	4	7	10
398	18051	5.9638	2	3	5	7	11
399	1614	3.5520	1	2	3	4	7
400	6845	9.0488	1	3	6	12	20
401	5827	11.1903	2	5	8	14	23
402	1483	3.9400	1	1	3	5	8
403	32911	8.0630	2	3	6	10	17
404	4457	4.2257	1	2	3	6	9
406	2546	10.2859	3	4	7	13	21
407	695	4.4086	1	2	4	6	8
408	2247	7.7036	1	2	5	10	18
409	3281	5.9113	2	3	4	6	11
410	40862	3.7202	1	2	3	5	6
411	13	2.3077	1	1	2	4	4
412	29	2.7241	1	1	2	3	6
413	6515	7.2391	2	3	6	9	14
414	746	4.0804	1	2	3	5	8
415	39856	14.1713	4	6	11	18	28
416	195783	7.3483	2	4	6	9	14
417	32	6.1875	1	2	4	7	13
418	22097	6.1239	2	3	5	7	11
419	15859	4.8212	2	2	4	6	9
420	3091	3.5642	1	2	3	4	6
421	12242	3.8638	1	2	3	5	7
422	96	5.2708	1	2	2	5	7
423	8073	8.1416	2	3	6	10	17
424	1354	13.3936	2	5	9	16	28
425	15006	4.0716	1	2	3	5	8
426	4313	4.5613	1	2	3	6	9
427	1660	5.0283	1	2	3	6	10
428	839	7.1025	1	2	4	8	15
429	30016	6.4824	2	3	5	8	12
430	58011	8.2066	2	3	6	10	16
431	295	6.5864	2	3	5	8	13
432	389	4.7506	1	2	3	5	9
433	5781	3.0073	1	1	2	4	6
434	21835	5.0844	1	2	4	6	9
435	14486	4.2925	1	2	4	5	8
436	3499	12.8337	4	7	11	17	25
437	9750	8.9544	3	5	8	11	15
439	1287	8.1756	1	3	5	10	17
440	5017	8.8433	2	3	6	10	19
441	579	3.2383	1	1	2	4	7
442	15896	8.2292	1	3	6	10	17
443	3547	3.3941	1	1	2	4	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
444	5150	4.2252	1	2	3	5	8
445	2223	3.0031	1	1	2	4	5
447	4854	2.5117	1	1	2	3	5
448	1	4.0000	4	4	4	4	4
449	26543	3.6722	1	1	3	4	7
450	6363	2.0525	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	21656	4.9536	1	2	3	6	10
453	4464	2.8156	1	1	2	3	5
454	4930	4.5554	1	2	3	6	9
455	1070	2.6262	1	1	2	3	5
461	3357	4.5594	1	1	2	5	11
462	12630	11.5264	4	6	9	15	21
463	18895	4.2653	1	2	3	5	8
464	5455	3.0761	1	1	2	4	6
465	227	3.3612	1	1	2	3	7
466	1719	3.8674	1	1	2	4	8
467	1301	4.0638	1	1	2	4	7
468	58391	12.9318	3	6	10	17	26
471	11423	5.7339	3	4	5	6	9
473	7615	12.8411	2	3	7	19	32
475	109112	11.1767	2	5	9	15	22
476	4448	11.6369	2	5	10	15	21
477	25690	8.1425	1	3	6	10	17
478	111191	7.3157	1	3	5	9	15
479	22375	3.6220	1	2	3	5	7
480	460	19.1848	7	9	14	23	38
481	229	27.1485	16	19	23	32	43
482	6119	12.7756	4	7	10	15	24
483	47190	38.8624	14	21	32	49	70
484	323	13.3065	2	5	10	18	28
485	2932	9.3905	4	5	7	11	17
486	2012	12.1511	1	5	9	16	24
487	3491	7.5408	1	3	6	10	15
488	767	16.9465	4	7	12	21	34
489	14253	8.5597	2	3	6	10	18
490	5283	5.1333	1	2	4	6	10
491	11332	3.4896	2	2	3	4	6
492	2667	16.1234	4	5	9	26	34
493	54030	5.7170	1	3	5	7	11
494	27254	2.4838	1	1	2	3	5
495	145	20.2552	6	8	12	18	33
496	1270	9.9843	4	5	7	12	18
497	22593	6.2173	2	3	5	7	11
498	19133	3.4179	1	2	3	4	6
499	30738	4.7687	1	2	4	6	9
500	42090	2.6897	1	1	2	3	5
501	1943	10.5713	4	5	8	13	20
502	612	5.9379	2	3	5	7	10
503	5563	3.9730	1	2	3	5	7
504	122	30.0984	10	15	25	40	60
505	153	4.7190	1	1	2	6	12
506	962	17.6258	4	8	14	24	37
507	280	9.1857	2	4	7	13	18
508	637	7.1350	2	3	5	9	15
509	165	6.1333	1	2	4	8	12
510	1653	7.8506	2	3	5	9	17
511	594	4.4646	1	1	3	6	10
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2000

State	Urban	Rural
ALABAMA	0.401	0.355
ALASKA	0.469	0.722
ARIZONA	0.373	0.516
ARKANSAS	0.478	0.454
CALIFORNIA	0.344	0.443
COLORADO	0.427	0.560
CONNECTICUT	0.495	0.503
DELAWARE	0.507	0.449
DISTRICT OF COLUMBIA	0.521	.....
FLORIDA	0.363	0.380
GEORGIA	0.474	0.486
HAWAII	0.409	0.554
IDAHO	0.549	0.570
ILLINOIS	0.427	0.515
INDIANA	0.532	0.543
IOWA	0.493	0.623
KANSAS	0.443	0.656
KENTUCKY	0.477	0.493
LOUISIANA	0.406	0.495
MAINE	0.597	0.554
MARYLAND	0.759	0.821
MASSACHUSETTS	0.525	0.537
MICHIGAN	0.558	0.597
MINNESOTA	0.510	0.590
MISSISSIPPI	0.455	0.455
MISSOURI	0.413	0.506
MONTANA	0.525	0.570
NEBRASKA	0.468	0.623
NEVADA	0.293	0.483
NEW HAMPSHIRE	0.543	0.583
NEW JERSEY	0.411	.....
NEW MEXICO	0.477	0.498
NEW YORK	0.529	0.610
NORTH CAROLINA	0.539	0.489
NORTH DAKOTA	0.622	0.660
OHIO	0.513	0.578
OKLAHOMA	0.422	0.509
OREGON	0.560	0.581
PENNSYLVANIA	0.396	0.517
PUERTO RICO	0.479	0.578
RHODE ISLAND	0.523	.....
SOUTH CAROLINA	0.456	0.452
SOUTH DAKOTA	0.537	0.600
TENNESSEE	0.441	0.482
TEXAS	0.406	0.511
UTAH	0.505	0.627
VERMONT	0.623	0.590
VIRGINA	0.467	0.500
WASHINGTON	0.577	0.652
WEST VIRGINIA	0.577	0.530
WISCONSIN	0.559	0.622
WYOMING	0.475	0.681

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2000

State	Ratio
ALABAMA	0.040
ALASKA	0.070
ARIZONA	0.041
ARKANSAS	0.050
CALIFORNIA	0.037
COLORADO	0.046
CONNECTICUT	0.036
DELAWARE	0.051
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.045
GEORGIA	0.056
HAWAII	0.042
IDAHO	0.049
ILLINOIS	0.042
INDIANA	0.057
IOWA	0.056
KANSAS	0.054
KENTUCKY	0.046
LOUISIANA	0.050
MAINE	0.039
MARYLAND	0.013
MASSACHUSETTS	0.054
MICHIGAN	0.053
MINNESOTA	0.049
MISSISSIPPI	0.045
MISSOURI	0.046
MONTANA	0.050
NEBRASKA	0.054
NEVADA	0.030
NEW HAMPSHIRE	0.063
NEW JERSEY	0.037
NEW MEXICO	0.044
NEW YORK	0.051
NORTH CAROLINA	0.050
NORTH DAKOTA	0.074
OHIO	0.050
OKLAHOMA	0.048
OREGON	0.048
PENNSYLVANIA	0.040
PUERTO RICO	0.043
RHODE ISLAND	0.030
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.066
TENNESSEE	0.051
TEXAS	0.048
UTAH	0.049
VERMONT	0.051
VIRGINIA	0.058
WASHINGTON	0.064
WEST VIRGINIA	0.047
WISCONSIN	0.054
WYOMING	0.057

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.

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 system, 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 Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This proposed rule does 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 2001, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do

not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. 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 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of February 2000, we have included 4,836 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 2000, there were 1,081 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 549 psychiatric, 194 rehabilitation, 238 long-term care, 73 childrens', 17 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,470 psychiatric units and 910 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 36 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 2001 would be between 0 and 3.1 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Graduate Medical Education Impact of National Average Per Resident Amount (PRA)

As discussed in section IV.G. of the preamble, this proposed rule would implement statutory provisions enacted by section 311 of Public Law 106–113 that establish a methodology for the use of a national average PRA in computing direct graduate medical education (GME) payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. The methodology would establish a ''floor'' and ''ceiling'' based on a locality-adjusted, updated national average PRA. Under section 1886(h)(2)(D)(iii) of the Act, as added by section 311(a) of Public Law 106–113, the PRA for a hospital for the cost reporting period beginning during FY 2001 cannot be below 70 percent of the locality-adjusted, updated national average PRA. Thus, if a hospital's PRA for the cost reporting period beginning during FY 2001 would otherwise be below the floor, the hospital's PRA for that cost reporting period would be equal to 70 percent of the locality-adjusted, national average PRA. Under section 1886(h)(2)(D)(iv) of the Act, as added by section 311(a) of Public Law 106–113, if a hospital's PRA exceeds 140 percent of the locality-adjusted, updated national average PRA, the hospital's PRA would be frozen (for FYs 2001 and 2002) or subject to a 2-percent reduction to the otherwise applicable update (for FYs 2003 through 2005). See section IV.G. of the preamble for a fuller explanation of this policy.

For purposes of the proposed rule, we have calculated an estimated impact of this proposed policy on teaching hospitals' PRAs for FY 2001 making assumptions about update factors and geographic adjustment factors (GAF) for each hospital. Generally, utilizing FY 1997 data, we calculated a floor and a ceiling and estimated the impact on hospitals. This impact was then inflated to FY 2001 to estimate the total impact on the Medicare program for FY 2001. The estimated numbers for this impact should not be used by hospitals in calculating their own individual PRAs; hospitals must use the methodology stated in section IV.G. of this proposed rule to revise (if appropriate) their individual PRAs.

In calculating this impact, we utilized Medicare cost report data for all cost reports ending in FY 1997. We excluded hospitals that file manual cost reports because we did not have access to their Medicare utilization data. We also excluded all teaching hospitals in Maryland because these hospitals are paid under a Medicare waiver. For those hospitals that had two cost reporting periods ending in FY 1997, we used the later of the two periods. A total of 1,231 teaching hospitals were included in this analysis.

Utilizing the proposed FY 1997 weighted average PRA of $68,487, we calculated a FY 1997 70-percent floor of $47,941 and a FY 1997 140-percent ceiling of $95,882. We then estimated that, for cost reporting periods ending in FY 1997, 339 hospitals had PRAs that were below $47,941 (27.5 percent of 1,231 hospitals), and 180 hospitals had PRAs above $95,882 (14.6 percent of 1,231 hospitals). Thus, for example, to illustrate the extremes in impact for a hospital with PRAs below the floor, Hospital A had a FY 1997 primary care PRA of $22,000 and a non-primary care PRA of $20,000. When these PRAs are replaced by a single PRA of $47,941, the hospital gains over 110 percent in payments per resident. For a hospital with PRAs above the ceiling, Hospital B had a FY 1997 primary care PRA of $150,000 and a non-primary care PRA of $148,000. When these PRAs are frozen and not updated for inflation in FY 2001, the percentage loss in payments per resident that year would be equal to the CPI–U percentage that would otherwise have been used to update the PRA.

For the 339 hospitals that had PRAs below the FY 1997 $47,941 floor, we estimated that the total cost to the Medicare program for FY 2001 of applying the floor would be $33.3 million. For the 180 hospitals that had PRAs above the FY 1997 $95,882 ceiling, we estimated that the total savings to the Medicare program for FY 2001 would be $18.7 million. Subtracting the estimated savings of $18.7 million from the estimated costs of $33.3 million yields an estimated total net cost to the Medicare program for FY 2001 of $14.6 million.

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 estimate the total impact of these changes for FY 2001 payments compared to FY 2000 payments to be approximately a $1.3 billion increase. 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 1999 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these 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 1999 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of 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 the wage index update (FY 1997 data).
- The effects of our proposal to remove from the wage index the costs and hours associated with teaching physicians paid under Medicare Part A, residents, and certified registered nurse anesthetists (CRNAs) during the second year of a 5-year phase-out, by calculating a wage index based on 40 percent of hospitals' average hourly wages after removing these costs and hours, and 60 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2001.
- The total change in payments based on FY 2001 policies relative to payments based on FY 2000 policies.

To illustrate the impacts of the FY 2001 proposed changes, our analysis begins with a FY 2000 baseline simulation model using: The FY 2000 DRG GROUPER (version 17.0); the FY 2000 wage index; and no MGCRB reclassifications. Outlier payments are set a 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 2001 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2000 to FY 2001. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 2001 using the most recently forecasted hospital market basket increase for FY 2001 of 3.1 percent minus 1.1 percentage points (for an update of 2.0 percent).

Under section 1886(b)(3) of the Act, as amended by section 406 of Public Law 106–113, the updates to the average standardized amounts and the hospital-specific amounts for sole community hospitals (SCHs) will be equal to the full market basket increase for FY 2001. Consequently, the update factor used for SCHs in this impact analysis is 3.1 percent. Under section 1886(b)(3)(D) of the Act, the update factor for the hospital-specific amounts for MDHs is equal to the market basket increase of 3.1 percent minus 1.1 percentage points (for an update of 2.0 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2000 to FY 2001 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 2000 that are no longer reclassified in FY 2001 may have a negative payment impact going from FY 2000 to FY 2001; conversely, hospitals not reclassified in FY 2000 that are reclassified in FY 2001 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 2000 will be 6.1 percent of actual total DRG payments. When the FY 2000 final rule was published, we projected FY 2000 outlier payments would be 5.1 percent of total DRG plus outlier payments; the standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2000 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2000 payments per case to estimated FY 2001 payments per case.

Fourth, section 111 of Public Law 106–113 revised section 1886(d)(5)(B)(ii) of the Act so that the IME adjustment changes from FY 2000 to FY 2001 from approximately a 6.25-percent increase for every 100-percent increase in a hospital's resident-to-bed ratio during FY 2000 to approximately a 6.2-percent increase in FY 2001. Similarly, section 112 of Public Law 106–113 revised section 1886(d)(5)(F)(ix) of the Act so that the DSH adjustment for FY 2001 is reduced by 3-percent from what would otherwise have been paid (this is the same percentage reduction that was applied in FY 2000).

Finally, section 405 of Public Law 106–113 provided that certain SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. To be eligible, a SCH must have received for its cost reporting period beginning during 1999, payment on the basis of its hospital-specific rate. For FY 2001, eligible SCHs that elect rebasing receive a hospital-specific rate comprised of 75-percent of the higher of their FY 1982 or FY 1987 hospital-specific rate, and 25-percent of their FY 1996 hospital-specific rate.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,836 hospitals included in the analysis. This number is 86 fewer hospitals than were included in the impact analysis in the FY 2000 final rule (64 FR 41624).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,710 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,545 hospitals located in large urban areas (populations over 1 million), and 1,165 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,126 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2001 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,786, 1,617, 1,169, and 2,050, 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 3,730 nonteaching hospitals in our analysis, 870 teaching hospitals with fewer than 100 residents, and 236 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the 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 (150), SCHs (660), MDHs (352), and SCH and RRCs (58) 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 2001 and, therefore, are not included in these rows.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1998 Medicare cost report files, if available (otherwise FY 1997 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 34 and 35 hospitals, respectively. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 2000 and FY 2001, or for only one of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2001 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

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TABLE I - IMPACT ANALYSIS OF CHANGES FOR FY 2001
OPERATING PROSPECTIVE PAYMENT SYSTEM
(PERCENT CHANGES IN PAYMENTS PER CASE)

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
(BY GEOGRAPHIC LOCATION)							
ALL HOSPITALS	4,836	0.0	0.3	0.0	0.0	0.0	1.2
URBAN HOSPITALS	2,710	0.0	0.1	0.0	-0.1	-0.4	0.9
LARGE URBAN	1,545	0.0	-0.3	0.1	-0.5	-0.5	0.6
OTHER URBAN	1,165	0.0	0.6	0.0	0.4	-0.3	1.4
RURAL HOSPITALS	2,126	0.1	1.4	0.1	1.3	2.4	2.8
BED SIZE (URBAN)							
0- 99 BEDS	687	0.1	0.2	0.1	0.3	-0.4	1.4
100-199 BEDS	928	0.1	0.1	0.1	0.0	-0.5	1.0
200-299 BEDS	543	0.0	0.0	0.1	-0.2	-0.4	0.8
300-499 BEDS	410	-0.1	0.1	0.1	-0.2	-0.4	0.8
500 OR MORE BEDS	142	-0.1	0.1	0.0	-0.3	-0.4	1.0
BED SIZE (RURAL)							
0- 49 BEDS	1,208	0.2	1.4	0.1	1.3	0.3	3.6
50- 99 BEDS	549	0.2	1.4	0.1	1.2	0.8	3.0
100-149 BEDS	217	0.2	1.4	0.1	1.2	3.4	2.5

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
150-199 BEDS	85	0.1	1.5	0.1	1.3	4.9	2.7
200 OR MORE BEDS	67	0.1	1.4	0.1	1.2	4.1	2.2
URBAN BY CENSUS DIVISION							
NEW ENGLAND	146	0.0	-0.2	0.1	0.3	-0.2	1.2
MIDDLE ATLANTIC	412	0.0	-0.3	-0.1	-0.7	-0.5	0.0
SOUTH ATLANTIC	400	0.0	0.2	0.1	0.1	-0.5	1.1
EAST NORTH CENTRAL	457	0.0	0.1	0.0	-0.2	-0.2	1.0
EAST SOUTH CENTRAL	156	0.0	-0.6	0.0	-0.9	-0.4	0.2
WEST NORTH CENTRAL	185	-0.1	0.6	0.0	0.2	-0.4	1.5
WEST SOUTH CENTRAL	343	0.0	0.8	0.1	0.5	-0.5	1.6
MOUNTAIN	132	-0.1	0.2	0.1	-0.2	-0.4	1.3
PACIFIC	434	0.0	0.2	0.1	0.0	-0.4	1.0
PUERTO RICO	45	0.1	-0.7	0.0	-0.8	-0.5	0.9
RURAL BY CENSUS DIVISION							
NEW ENGLAND	52	0.1	0.4	0.0	0.1	2.6	2.6
MIDDLE ATLANTIC	79	0.1	0.4	0.0	0.2	2.8	2.6
SOUTH ATLANTIC	276	0.2	1.9	0.1	1.8	2.8	3.0
EAST NORTH CENTRAL	280	0.1	1.5	0.1	1.3	2.0	3.0

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
EAST SOUTH CENTRAL	265	0.2	1.4	0.1	1.3	2.2	2.4
WEST NORTH CENTRAL	491	0.1	1.3	0.0	1.0	2.5	3.1
WEST SOUTH CENTRAL	337	0.2	1.7	0.1	1.6	2.8	2.7
MOUNTAIN	201	0.1	1.0	0.0	0.8	1.7	3.1
PACIFIC	140	0.2	1.4	0.1	1.3	1.7	2.8
PUERTO RICO	5	0.2	0.1	0.1	0.2	-0.6	0.1
(BY PAYMENT CATEGORIES)							
URBAN HOSPITALS	2,786	0.0	0.1	0.0	-0.1	-0.3	0.9
LARGE URBAN	1,617	0.0	-0.3	0.1	-0.5	-0.4	0.6
OTHER URBAN	1,169	0.0	0.6	0.0	0.5	-0.3	1.4
RURAL HOSPITALS	2,050	0.2	1.4	0.1	1.3	2.1	2.8
TEACHING STATUS							
NON-TEACHING	3,730	0.1	0.5	0.1	0.4	0.3	1.4
LESS THAN 100 RESIDENTS	870	0.0	0.2	0.0	0.0	-0.2	1.1
100+ RESIDENTS	236	-0.1	-0.2	0.0	-0.5	-0.4	0.8
DISPROPORTIONATE SHARE HOSPITALS (DSH)							
NON-DSH	3,025	0.0	0.2	0.0	0.1	0.3	1.1

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
URBAN DSH							
100 BEDS OR MORE	1,377	0.0	0.2	0.0	-0.1	-0.4	1.1
FEWER THAN 100 BEDS	76	0.1	0.5	0.1	0.4	-0.5	1.6
RURAL DSH							
SOLE COMMUNITY (SCH)	153	0.2	1.6	0.1	1.5	0.6	4.7
REFERRAL CENTERS (RRC)	54	0.2	1.8	0.1	1.7	3.9	1.5
OTHER RURAL DSH HOSPITALS							
100 BEDS OR MORE	48	0.2	2.0	0.1	1.9	1.8	2.6
FEWER THAN 100 BEDS	103	0.2	2.0	0.1	2.0	0.4	3.7
URBAN TEACHING AND DSH							
BOTH TEACHING AND DSH	716	-0.1	0.1	0.0	-0.2	-0.4	1.1
TEACHING AND NO DSH	325	-0.1	-0.1	0.0	-0.4	-0.3	0.6
NO TEACHING AND DSH	737	0.1	0.3	0.1	0.2	-0.2	1.1
NO TEACHING AND NO DSH	1,008	0.1	-0.1	0.1	-0.1	-0.3	0.6
RURAL HOSPITAL TYPES							
NONSPECIAL STATUS HOSPITALS	830	0.2	1.9	0.1	1.8	1.2	3.1
RRC	150	0.1	1.7	0.1	1.6	5.3	2.1
SCH	660	0.2	0.8	0.0	0.7	0.4	3.5
MDH	352	0.2	1.4	0.1	1.3	0.3	3.1

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
SCH AND RRC	58	0.1	0.6	0.0	0.4	1.8	2.1
TYPE OF OWNERSHIP							
VOLUNTARY	2,820	0.0	0.2	0.0	0.0	-0.1	1.1
PROPRIETARY	768	0.1	0.2	0.1	0.0	0.0	0.9
GOVERNMENT	1,214	0.0	0.7	0.1	0.4	0.3	1.9
UNKNOWN	34	-0.2	-0.2	0.0	-0.7	-0.5	0.5
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS							
0 - 25	379	0.0	0.2	0.1	-0.1	-0.1	1.4
25 - 50	1,830	0.0	0.1	0.1	-0.2	-0.3	1.0
50 - 65	1,893	0.0	0.5	0.0	0.3	0.2	1.3
OVER 65	699	0.1	0.3	0.0	0.3	0.3	1.2
UNKNOWN	35	-0.2	-0.2	0.0	-0.7	-0.5	0.5
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD							
RECLASSIFICATION STATUS DURING FY 2000 AND FY 2001							
RECLASSIFIED DURING BOTH FY 2000 AND FY 2001	381	0.1	1.2	0.1	1.1	5.4	1.2
URBAN	52	0.0	0.8	0.1	1.0	4.8	-0.2

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
RURAL	329	0.1	1.4	0.1	1.2	5.7	1.8
RECLASSIFIED DURING FY 2001 ONLY	160	0.1	1.1	0.1	0.9	3.9	6.1
URBAN	41	0.0	0.6	0.0	0.3	3.3	4.2
RURAL	119	0.2	1.7	0.1	1.5	4.6	8.5
RECLASSIFIED DURING FY 2000 ONLY	118	0.0	0.5	0.1	0.2	-0.8	-2.8
URBAN	31	0.0	-0.2	0.1	-0.5	-1.1	-2.7
RURAL	87	0.2	1.5	0.1	1.4	-0.4	-2.9
FY 2001 RECLASSIFICATIONS							
ALL RECLASSIFIED HOSPITALS	541	0.1	1.2	0.1	1.0	5.0	2.4
STANDARDIZED AMOUNT ONLY	66	0.1	0.8	0.1	0.7	3.7	0.6
WAGE INDEX ONLY	386	0.1	1.2	0.1	1.1	4.3	0.7
BOTH	46	0.1	0.0	0.1	-0.2	4.4	-1.1
NONRECLASSIFIED	4,312	0.0	0.2	0.0	-0.1	-0.5	1.2
ALL URBAN RECLASSIFIED	93	0.0	0.7	0.1	0.7	4.2	1.5
STANDARDIZED AMOUNT ONLY	16	0.2	-0.6	0.0	-0.7	0.7	0.3
WAGE INDEX ONLY	59	0.0	0.7	0.1	0.8	4.8	2.2
BOTH	18	0.0	1.4	0.1	1.1	3.2	-0.9

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	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
NONRECLASSIFIED	2,592	0.0	0.0	0.0	-0.2	-0.6	0.9
ALL RURAL RECLASSIFIED	448	0.1	1.4	0.1	1.2	5.5	2.9
STANDARDIZED AMOUNT ONLY	53	0.1	1.5	0.1	1.3	4.3	2.7
WAGE INDEX ONLY	372	0.1	1.4	0.1	1.3	5.4	2.9
BOTH	23	0.0	0.9	0.1	0.6	8.4	3.7
NONRECLASSIFIED	1,677	0.2	1.4	0.1	1.3	-0.4	2.7
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.2	-0.2	0.0	-0.3	1.4	0.9

[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 1999, and hospital cost report data are from reporting periods beginning in FY 1997 and FY 1998.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1999 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1997 cost reports.

[4] This column displays the impact of removing 60 percent of the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[5] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 1, 2 and 3, and the FY 2001 budget neutrality factor of .996506.

[6] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2001 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2001. Reclassification for prior years has no bearing on the payment impacts shown here.

[7] This column shows changes in payments from FY 2000 to FY 2001. It incorporates all of the changes displayed in columns 4 and 5 (the changes displayed in columns 1, 2, and 3 are included in column 4). It also displays the impact of the FY 2001 update (including the higher update for SCHs), changes in hospitals' reclassification status in FY 2001 compared to FY 2000, the difference in outlier payments from FY 2000 to FY 2001, and the reductions to payments through the IME adjustment taking effect during FY 2001. It also reflects section 405 of Public law 106-113, which permitted certain SCHs to rebase for a 1996 hospital-specific rate. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the 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 2000 DRG relative weights (GROUPER version 17) to aggregate payments using the proposed FY 2001 DRG relative weights (GROUPER version 18). Overall payments are unaffected by the DRG reclassification and recalibration. Consistent with the minor changes we are proposing for the FY 2001 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.0 percent impact for large and other urban hospitals; a 0.1 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.1 percent increase for hospitals with fewer than 200 beds), and small decreases for larger hospitals (a 0.1 percent decrease for hospitals with more than 300 beds). Among rural hospitals, small hospital categories experience the largest increases, a 0.2 percent increase for hospitals with fewer than 50 beds.

The breakdown by urban census division shows that the small decrease among urban hospitals is confined to the West North Central and Mountain regions. Payments to urban hospitals in most other regions are unchanged, while payments to urban hospitals in Puerto Rico rise by 0.1 percent. All rural hospital census divisions experience payment increases ranging from 0.1 percent for hospitals in New England, Middle Atlantic, East North Central, West North Central, and Mountain regions to 0.2 percent for hospitals in the South Atlantic, East South Central, West South Central, Pacific, and Puerto Rico census divisions.

C. Impact of Updating the Wage Data (Column 2)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2001 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 2 shows the percentage changes in payments when going from a model using the FY 2000 wage index (based on FY 1996 wage data before geographic reclassifications to a model using the FY 2001 prereclassification wage index based on FY 1997 wage data). Sections 152 and 154 of Public Law 106–113 reclassified certain hospitals for purposes of the wage index standardized amounts. For purposes of this column, these hospitals are located in their prereclassification geographic location. The impacts of these statutory reclassifications are shown in column 5, when examining the impacts of geographic reclassification.

The wage data collected on the FY 1997 cost reports are similar to the data used in the calculation of the FY 2000 wage index. For a thorough discussion of the data used to calculate the wage index, see section III.B. of this proposed rule.

The results indicate that the new wage data have an overall impact of a 0.3 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 5). Rural hospitals especially appear to benefit from the update. Their payments increase by 1.4 percent. These increases are attributable to relatively large increases in the wage index values for the rural areas of particular States; Hawaii, Louisiana, and Montana all had increases greater than 6 percent in their prereclassification wage index values.

Urban hospitals as a group are not significantly affected by the updated wage data. The gains of hospitals in other urban areas (0.6 percent increase) are offset by decreases among hospitals in large urban areas (0.3 percent decrease). Urban hospitals in Puerto Rico experience a 7.0 percent decrease, largely due to declines of 6 percent or more in the prereclassified FY 2001 wage indexes of 2 MSAs. Urban hospitals in the East South Central census region experience a 6 percent decline due to several MSAs in Tennessee with prereclassified FY 2001 wage indexes that fall by 6 percent or more. We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 2000 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 largest increases are seen in the rural census divisions. Rural South Atlantic experiences the greatest positive impact, 1.9 percent. Hospitals in five other census divisions receive positive impacts over 1.0 percent: West South Central at 1.7, East North Central at 1.5, East South Central at 1.4, Pacific at 1.4, and West North Central at 1.3. The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 2001. This chart demonstrates the impact of the proposed changes for the FY 2001 wage index relative to the FY 2000 wage index. The majority of labor market areas (322) experience less than a 5-percent change. A total of 39 labor market areas experience an increase of more than 5 percent with 12 having an increase greater than 10 percent. A total of 15 areas experience decreases of more than 5-percent. Of those, 10 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2000	FY 2001
Increase more than 10 percent	8	12
Increase more than 5 percent and less than 10 percent	22	27
Increase or decrease less than 5 percent	318	322
Decrease more than 5 percent and less than 10 percent	17	5
Decrease more than 10 percent	5	10

Among urban hospitals, 125 would experience an increase of between 5 and 10 percent and 19 more than 10 percent. A total of 401 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 55 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Twelve 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	19	0
Increase more than 5 percent and less than 10 percent	125	401
Increase or decrease less than 5 percent	2,499	1,725

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Decrease more than 5 percent and less than 10 percent	55	0
Decrease more than 10 percent	12	0

D. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNAs' Costs (Column 3)

As described in section III.C. of this preamble, the proposed FY 2001 wage index is calculated by blending 60 percent of hospitals' average hourly wages calculated without removing teaching physician (paid under Medicare Part A), residents, or CRNA costs (and hours); and 40 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the second year of a 5-year phase-out of these costs and hours, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

In order to determine the impact of moving from the 80/20 blend percentage to the 60/40 blend percentage, we first estimated the payments for FY 2001 using the FY 2001 prereclassified wage index calculated using the 80/20 blend percentage (Column 2). We then estimated what the payments for FY 2001 would have been if the 60/40 blend percentage was applied to the FY 2001 prereclassified wage index. Column 3 compares the differences in these payment estimates and shows that the 60/40 blend percentage does not significantly impact overall payments (0.0 percent change). Only 53 labor market areas experience a decrease in their wage index and none decreases by more than −0.1 percent.

E. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 4)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 2000 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2001 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.996506. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 4. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1, 2, and 3, minus approximately 0.3 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

F. Impact of MGCRB Reclassifications (Column 5)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2001. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, until FY 2002, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both, or for FYs 1999 through 2001, for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The proposed FY 2001 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2001. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of February 29, 2000. 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 2001.

Section 152 of Public Law 106–113 reclassified certain hospitals for purposes of the wage index and the standardized amounts. The impacts of these statutory reclassifications are included in this column.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.994270 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.4 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.3 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among most of the rural hospital groups. The largest decrease among the rural census divisions is 0.6 percent for Puerto Rico. The largest increases are in rural Middle Atlantic and West South Central. These regions all receive an increase of 2.8 percent.

Among rural hospitals designated as RRCs, 127 hospitals are reclassified for purposes of the wage index only, leading to the 5.3 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 150–199 beds, which has a 4.9 percent increase in payments.

Rural hospitals reclassified for FY 2000 and FY 2001 experience a 5.7 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 2001 only experience a 4.6 percent increase in payments, while rural hospitals reclassified for FY 2000 only experience a 0.4 percent decrease in payments. Urban hospitals reclassified for FY 2001 but not FY 2000 experience a 3.3 percent increase in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 2001 experience a 1.1 percent decline in payments.

The FY 2001 Reclassification rows of Table I show the changes in payments per case for all FY 2001 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive an 8.4 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 5.4 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5 percent for FY 2001.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.4 percent. Rural nonreclassified hospitals decrease by 0.4 percent, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by February 29, 2000. 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.

G. All Changes (Column 6)

Column 6 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2001 (including statutory changes), to our estimate of payments per case in FY 2000. It includes the effects of the 2.0 percent update to the standardized amounts and the hospital-specific rates for MDHs and the 3.1 percent update for SCHs. It also reflects the 1.0 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2000 (6.1 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

Another change affecting the difference between FY 2000 and FY 2001 payments arises from section 1886(d)(5)(8) of the Act, as amended by Public Law 106–113. As noted in the introduction to this impact analysis, for FY 2001, the IME adjustment is decreased from last year (6.5 percent in FY 2000 and 6.25 percent in FY 2001).

We also note that column 6 includes the impacts of FY 2001 MGCRB reclassifications compared to the payment impacts of FY 2000 reclassifications. Therefore, when comparing FY 2001 payments to FY 2000, the percent changes due to FY 2001 reclassifications shown in column 5 need to be offset by the effects of reclassification on hospitals' FY 2000 payments (column 7 of Table 1, July 30, 1999 final rule (64 FR 41625)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 2001 payments was approximately a 2.4 percent increase, offsetting most of the 2.6 percent increase in column 7 for FY 2000. Therefore, the net change in FY 2001 payments due to reclassification for rural hospitals is actually a decrease of 0.2 percent relative to FY 2000. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

Finally, section 405 of Public Law 106–113 provided that certain SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. To be eligible, a SCH must have received payment for cost reporting periods beginning during 1999 on the basis of its hospital-specific rate. For FY 2001, eligible SCHs that elect rebasing receive a hospital-specific rate comprised of 75 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate, and 25 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 6 as well.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 6 may not equal the sum of the changes in columns 4 and 5, plus the other impacts that we are able to identify.

The overall payment change from FY 2000 to FY 2001 for all hospitals is a 1.2 percent increase. This reflects the 2.0 percent update for FY 2001 (3.1 percent for SCHs), the 1.0 percent lower outlier payments in FY 2001 compared to FY 2000 (5.1 percent compared to 6.1 percent); the change in the IME adjustment (6.5 in FY 2000 to 6.2 in FY 2001); and the rebasing of certain SCHs to their 1996 hospital-specific rate.

Hospitals in urban areas experience a 0.9 percent increase in payments per case compared to FY 2000. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 2000. Hospitals in rural areas, meanwhile, experience a 2.8 percent payment increase. As discussed previously, this is primarily due to the positive effect of the wage index and DRG changes (1.2 percent increase).

Among urban census divisions, other than the Middle Atlantic and East South Central regions (which experience no change and a 0.2 percent increase in payments, respectively), payments increased between 0.9 and 1.6 percent between FY 2000 and FY 2001. The rural census division experiencing the smallest increase in payments was Puerto Rico (0.1 percent). The largest increases by rural hospitals are in the Mountain and West North Central regions, both with 3.1 percent. Among other rural census divisions, the largest increases are in the South Atlantic and the East North Central, both with 3.0.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 3.5 percent, 3.1 percent, and 2.1 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 2000 to FY 2001 (from 6.1 of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 2000 to FY 2001 are among hospitals that were reclassified for FY 2000 and are not reclassified for FY 2001. Overall, these hospitals lose 2.8 percent. The urban hospitals in this category lose 2.7 percent, while the rural hospitals lose 2.9 percent. On the other hand, hospitals reclassified for FY 2001 that were not reclassified for FY 2000 would experience the greatest payment increases: 6.1 percent overall; 8.5 percent for 119 rural hospitals in this category and 4.2 percent for 41 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

(BY GEOGRAPHIC LOCATION)	Number of hospitals (1)	Average FY 2000 payment per case (2) [1]	Average FY 2001 payment per case (3) [1]	All changes (4)
ALL HOSPITALS	4,836	$6,816	$6,895	1.2
URBAN HOSPITALS	2,710	7,391	7,457	0.9
LARGE URBAN AREAS	1,545	7,927	7,973	0.6
OTHER URBAN AREAS	1,165	6,694	6,786	1.4
RURAL HOSPITALS	2,126	4,565	4,695	2.8
BED SIZE (URBAN):				
0–99 BEDS	687	4,970	5,041	1.4
100–199 BEDS	928	6,235	6,300	1.0
200–299 BEDS	543	7,022	7,076	0.8
300–499 BEDS	410	7,884	7,943	0.8
500 OR MORE BEDS	142	9,762	9,859	1.0
BED SIZE (RURAL):				
0–49 BEDS	1,208	3,787	3,925	3.6
50–99 BEDS	549	4,273	4,402	3.0
100–149 BEDS	217	4,671	4,789	2.5
150–199 BEDS	85	5,112	5,251	2.7
200 OR MORE BEDS	67	5,719	5,847	2.2
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	146	7,843	7,939	1.2
MIDDLE ATLANTIC	412	8,311	8,314	0.0

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

(BY GEOGRAPHIC LOCATION)	Number of hospitals (1)	Average FY 2000 payment per case (2)[1]	Average FY 2001 payment per case (3)[1]	All changes (4)
SOUTH ATLANTIC	400	7,045	7,120	1.1
EAST NORTH CENTRAL	457	7,113	7,187	1.0
EAST SOUTH CENTRAL	156	6,648	6,660	0.2
WEST NORTH CENTRAL	185	7,128	7,235	1.5
WEST SOUTH CENTRAL	343	6,788	6,898	1.6
MOUNTAIN	132	7,047	7,138	1.3
PACIFIC	434	8,591	8,678	1.0
PUERTO RICO	45	3,169	3,198	0.9
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,462	5,604	2.6
MIDDLE ATLANTIC	79	4,927	5,056	2.6
SOUTH ATLANTIC	276	4,698	4,840	3.0
EAST NORTH CENTRAL	280	4,615	4,751	3.0
EAST SOUTH CENTRAL	265	4,231	4,331	2.4
WEST NORTH CENTRAL	491	4,380	4,517	3.1
WEST SOUTH CENTRAL	337	4,062	4,170	2.7
MOUNTAIN	201	4,895	5,046	3.1
PACIFIC	140	5,612	5,769	2.8
PUERTO RICO	5	2,455	2,457	0.1
(BY PAYMENT CATEGORIES)				
URBAN HOSPITALS:	2,786	7,352	7,419	0.9
LARGE URBAN	1,617	7,852	7,898	0.6
OTHER URBAN	1,169	6,681	6,776	1.4
RURAL HOSPITALS	2,050	4,538	4,665	2.8
TEACHING STATUS:				
NON-TEACHING	3,730	5,502	5,578	1.4
FEWER THAN 100 RESIDENTS	870	7,175	7,256	1.1
100 OR MORE RESIDENTS	236	10,914	11,001	0.8
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON–DSH	3,025	5,850	5,915	1.1
URBAN DSH:				
100 BEDS OR MORE	1,377	7,959	8,047	1.1
FEWER THAN 100 BEDS	76	4,966	5,045	1.6
RURAL DSH:				
SOLE COMMUNITY (SCH)	153	4,198	4,397	4.7
REFERRAL CENTERS (RRC)	54	5,384	5,465	1.5
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	48	4,141	4,249	2.6
FEWER THAN 100 BEDS	103	3,706	3,844	3.7
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	716	8,864	8,962	1.1
TEACHING AND NO DSH	325	7,372	7,413	0.6
NO TEACHING AND DSH	737	6,362	6,432	1.1
NO TEACHING AND NO DSH	1,008	5,711	5,744	0.6
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	830	3,968	4,092	3.1
RRC	150	5,269	5,380	2.1
SCH	660	4,534	4,692	3.5
MDH	352	3,786	3,903	3.1
SCH AND RRC	58	5,533	5,651	2.1
TYPE OF OWNERSHIP:				
VOLUNTARY	2,820	6,987	7,062	1.1
PROPRIETARY	768	6,276	6,335	0.9
GOVERNMENT	1,214	6,307	6,427	1.9
UNKNOWN	34	11,179	11,236	0.5
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	379	9,010	9,136	1.4
25–50	1,830	7,891	7,972	1.0
50–65	1,893	5,958	6,036	1.3
OVER 65	699	5,297	5,358	1.2
UNKNOWN	35	11,178	11,236	0.5
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY 2000 AND FY 2001:				
RECLASSIFIED DURING BOTH FY 2000 AND FY 2001	381	5,848	5,921	1.2
URBAN	52	8,046	8,033	−0.2
RURAL	329	5,272	5,367	1.8

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals	Average FY 2000 payment per case	Average FY 2001 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
RECLASSIFIED DURING FY 2001 ONLY	160	5,900	6,259	6.1
URBAN	41	7,600	7,917	4.2
RURAL	119	4,604	4,994	8.5
RECLASSIFIED DURING FY 2000 ONLY	118	5,940	5,774	−2.8
URBAN	31	7,428	7,226	−2.7
RURAL	87	4,584	4,449	−2.9
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	541	5,861	6,005	2.4
STANDARDIZED AMOUNT ONLY	66	4,864	4,892	0.6
WAGE INDEX ONLY	386	5,889	5,930	0.7
BOTH	46	6,494	6,424	−1.1
NONRECLASSIFIED	4,312	6,944	7,030	1.2
ALL URBAN RECLASSIFIED	93	7,865	7,986	1.5
STANDARDIZED AMOUNT ONLY	16	5,230	5,246	0.3
WAGE INDEX ONLY	59	8,321	8,508	2.2
BOTH	18	8,036	7,962	−0.9
NONRECLASSIFIED	2,592	7,384	7,447	0.9
ALL RURAL RECLASSIFIED	448	5,145	5,296	2.9
STANDARDIZED AMOUNT ONLY	53	4,728	4,856	2.7
WAGE INDEX ONLY	372	5,177	5,327	2.9
BOTH	23	5,267	5,460	3.7
NONRECLASSIFIED	1,677	4,121	4,234	2.7
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,765	4,808	0.9

[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 2001 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2000 with the average estimated per case payments for FY 2001, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 6 of Table I.

VIII. Impact of Organ, Tissue and Eye Procurement Condition of Participation on CAHs

In this proposed rule, we propose to add a CoP for organ, tissue and eye procurement for CAHs. We do not anticipate that this condition would have a substantial economic impact on CAHs. However, we believe it is desirable to inform the public of our projections of its likely effects. There are several provisions in this proposed condition that would impact CAHs to a greater or lesser degree. Specifically, CAHs would be required to have written protocols; have agreements with an OPO, a tissue bank, and an eye bank; refer all deaths that occur in the CAH to the OPO or a third party designated by the OPO; ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as a designated requestor; and work cooperatively with the OPO, tissue bank, and eye bank in educating CAH staff, reviewing death records, and maintaining potential donors. It is important to note that because of the inherent flexibility of this condition, the extent of its economic impact is dependent upon decisions that will be made either by the CAH or by the CAH in conjunction with the OPO or the tissue and eye banks. Thus, the impact on individual CAHs will vary and is subject in large part to their decision making. The impact will also vary based on whether a CAH currently has an organ donation protocol and its level of compliance with existing law and regulations. For example, if a CAH was a Medicare hospital in compliance with the hospital CoP for organ, tissue, and eye procurement prior to converting to a CAH, there will be no additional impact.

The first requirement in the proposed CoP is that CAHs have and implement written protocols that reflect the various other requirements of the proposed CoP. Currently, under section 1138 of the Act, CAHs must have written protocols for organ donation. Most CAHs will need to rewrite their existing protocols to conform with this regulation; however, this is clearly not a requirement that imposes a significant economic burden.

In addition, a CAH must have an agreement with its designated OPO and with at least one tissue bank and at least one eye bank. CAHs are required under section 1138 of the Act to refer all potential donors to an OPO. Also, the OPO regulation at 42 CFR 486.306 requires, as a qualification for designation as an OPO, that the OPO have a working relationship with at least 75 percent of the hospitals in its service area that participate in the Medicare and Medicaid programs and that have an operating room and the equipment and personnel for retrieving organs. Therefore, some CAHs may already have an agreement with their designated OPO. Although CAHs may need to modify those existing agreements, the need to make modifications would not impose a significant economic burden. Although there is no statutory or regulatory requirement for a CAH to have agreements with tissue and eye banks, we must assume some CAHs have agreements with tissue and eye banks, since hospitals are the source for virtually all tissues and eyes.

The CoP would require CAHs to notify the OPO about every death that occurs in the CAH. The average Medicare hospital has approximately 165 beds and 200 deaths per year. However, by statute and regulation, CAHs may use no more than 15 beds for acute care services. Assuming that the number of deaths in a hospital is related to the number of acute care beds, there should be approximately 18 deaths per year in the average CAH. Thus, the economic impact for a CAH of referring all deaths would be small.

Under the proposed CoP, a CAH may agree to have the OPO determine medical suitability for tissue and eye donation or may have alternative arrangements with a tissue bank and an eye bank. These alternative arrangements could include the CAH's direct notification of the tissue and eye bank of potential tissue and eye donors or direct notification of all deaths. Again, the impact is small, and the regulation permits the CAH to decide how this process will take place. We recognize that many communities already have a one-phone-call system in place. In addition, some OPOs are also tissue banks or eye banks or both. A CAH that chose to use the OPO's tissue and eye bank services in these localities would need to make only one telephone call on every death.

This proposed CoP requires that the individual who initiates a request for

donation to the family of a potential donor must be an OPO representative or a designated requestor. A designated requestor is an individual who has taken a course offered or approved by the OPO in the methodology for approaching families of potential donors and requesting donation. The CAH would need to arrange for designated requestor training. Most OPOs have trained designated requestors as part of the hospital CoP for organ, tissue, and eye procurement. Even if the CAH wants to have a sufficient number of designated requestors to ensure that all shifts are covered, this provision of the regulation would not have a significant economic impact on CAHs. In addition, the CAH may be able to choose to have donation requests initiated by the OPO, the tissue bank, or the eye bank staff rather than CAH staff, in which case there is no economic impact.

The regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in educating CAH staff. We do not believe education of CAH staff will demand a significant amount of staff time. In addition, most OPOs already give educational presentations for the staff in their hospitals.

The regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in reviewing death records. Most OPOs currently conduct extensive CAH death record reviews. The CAH's assistance is required only to provide lists of CAH deaths and facilitate access to records.

Finally, the regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in maintaining potential donors while necessary testing and placement of potential donated organs and tissues take place. It is possible that because of the proposed CoP, some CAHs may have their first organ donors. Therefore, we considered the impact on a CAH of maintaining a brain dead potential donor on a ventilator until the organs can be placed. CAHs with full ventilator capability should have no trouble maintaining a potential donor until the organs are placed. However, some CAHs have ventilator capability only so that a patient can be maintained until he or she is transferred to a larger facility for treatment. These CAHs would have the equipment and staffing to maintain a potential donor until transfer to another facility occurs. Some CAHs do not have ventilator capability and would be unable to maintain a potential donor. However, CAHs without ventilator capability would still be obligated to notify the OPO, or a third party designated by the OPO, of all individuals whose death is imminent or who have died in the CAH because there is a potential to obtain a tissue or an eye donation. We do not believe there will be a significant impact on CAHs no matter what their situation—full ventilator capability, ventilator capability only for patients who are to be transferred to a larger facility, or no ventilator capability.

We are sensitive to the possible burden this proposed CoP may place on CAHs. Therefore, we are particularly interested in comments and information concerning the previously mentioned requirements.

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

A. General Considerations

We now have cost report data for the 7th year of the capital prospective payment system (cost reports beginning in FY 1998) available through the December 1999 update of the HCRIS. We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example, in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding fiscal intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 2001 capital cost projections. In Appendix B of this proposed rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2001 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2001. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 2001 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 2001 capital costs for individual hospitals, but with the most recent data on hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the Proposed FY 2001 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 2000 to FY 2001 using a capital cost model. The FY 2001 model, as described in Appendix B of this 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 1998 as reported on the December 1999 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, 2000 in the provider-specific file. We used these data to determine the proposed FY 2001 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1998, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1998. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the proposed FY 2001 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1999	3.16
2000	2.34
2001	1.99

- We estimate that the Medicare case-mix index will increase by 0.5 percent in FY 2000 and in FY 2001.

• The Federal capital rate and the hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2001 update is 0.9 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 2000 to FY 2001. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2001

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	67	62	56	61
High Cost Hospital	33	38	44	39

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital into use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 2000 to FY 2001 using the above described actuarial model. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 5.89 percent in FY 2001. This increase is noticeably higher than last year's (3.34 percent) due to the combination of the increase in the number of hospital admissions, the increase in case-mix, and the increase in the Federal blend percentage from 90 percent to 100 percent and a decrease in the hospital-specific rate percentage from 10 percent to 0 percent for fully prospective payment hospitals.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2001 ON PAYMENTS PER DISCHARGE

	Number of Hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent Change over FY 2000
FY 2000 Payments per Discharge									
Low Cost Hospitals	3,187	6,757,956	$581.11	90.42	$30.20	$2.40	$8.90	$622.61	.....
Fully Prospective	3,015	6,289,996	577.57	90.00	32.44	.....	8.52	618.53	.....
100% Federal Rate	155	430,322	638.22	100.00	.....	.....	3.76	641.98	.....
Hold Harmless	17	37,639	520.20	60.95	.....	431.53	130.53	1,082.26	.....
High Cost Hospitals	1,588	4,091,922	658.45	97.93	.....	19.44	13.10	690.98	.....
100% Federal Rate	1,394	3,742,341	676.37	100.00	.....	.....	9.01	685.38	.....
Hold Harmless	194	349,581	466.63	74.15	.....	227.51	56.83	750.97	.....
Total Hospitals	4,775	10,849,879	610.28	93.33	18.81	8.83	10.48	648.40	.....
FY 2001 Payments per Discharge									
Low Cost Hospitals	3,187	6,869,437	$649.67	99.81	.....	$1.74	$10.12	$661.54	6.25
Fully Prospective	3,015	6,393,759	650.22	100.00	.....	.....	9.55	659.77	6.67
100% Federal Rate	157	442,002	648.25	100.00	.....	.....	4.59	652.84	1.69
Hold Harmless	15	33,676	564.26	68.97	.....	355.91	191.29	1,111.46	2.70
High Cost Hospitals	1,588	4,159,343	666.60	98.79	.....	12.23	19.53	698.36	1.07
100% Federal Rate	1,412	3,853,508	680.13	100.00	.....	.....	13.37	693.50	1.19
Hold Harmless	176	305,834	496.05	81.77	.....	166.38	97.07	759.50	1.14
Total Hospitals	4,775	11,028,780	656.05	99.42	.....	5.70	13.67	675.42	4.17

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 6.67 percent, and high capital cost hospitals will experience an average increase of 1.07 percent. These results are due to the change in the blended percentages to the payment system to 100 percent adjusted Federal rate and 0 percent hospital-specific rate.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 90 percent to 100 percent and the hospital-specific rate payment percentage will decrease from 10 to 0 percent in FY 2001. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 74.15 percent to 81.77 percent. We estimate the percentage of hold-harmless hospitals paid based on 100

percent of the Federal rate will increase from 87.78 percent to 88.92 percent. We estimate that the few remaining high cost hold-harmless hospitals (176) will experience an increase in payments of 1.14 percent from FY 2000 to FY 2001. This increase reflects our estimate that exception payments per discharge will increase 70.81 percent from FY 2000 to FY 2001 for high cost hold-harmless hospitals. While we estimate that this group's regular hold-harmless payments for old capital will decline by 26.87 percent due to the retirement of old capital, we estimate that its high overall capital costs will cause an increase in these hospitals' exceptions payments from $56.83 per discharge in FY 2000 to $97.07 per discharge in FY 2001. This is primarily due to the estimated decrease in outlier payments, which will cause an estimated increase in exceptions payments to cover unmet capital costs.

We expect that the average hospital-specific rate payment per discharge will decrease from $32.44 in FY 2000 to $0.00 in FY 2001. This decrease is due to the decrease in the hospital-specific rate payment percentage from 10 percent in FY 2000 to 0 percent in FY 2001 for fully prospective payment hospitals.

We are proposing no changes in our exceptions policies for FY 2001. As a result, the minimum payment levels would be—

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.62 percent of total capital payments in FY 2000 to 2.02 percent of payments in FY 2001. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2001 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	186	46
High Capital Cost	191	54
Total	377	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

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TABLE IV.— DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS-ESTIMATE FOR FY 2001 PAYMENTS

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,775	4.0	32.9	63.1
Large urban areas (populations over 1 million)	1,514	4.0	41.1	55.0
Other urban areas (populations of 1 million of fewer)	1,144	4.8	40.6	54.5
Rural areas	2,117	3.6	22.8	73.6
Urban hospitals	2,658	4.3	40.9	54.8
0-99 beds	646	5.9	33.7	60.4
100-199 beds	918	5.7	47.2	47.2
200-299 beds	542	3.7	41.9	54.4
300-499 beds	410	0.5	37.3	62.2
500 or more beds	142	2.1	39.4	58.5
Rural hospitals	2,117	3.6	22.8	73.6
0-49 beds	1,201	3.0	16.4	80.6
50-99 beds	547	4.8	28.2	67.1
100-149 beds	217	5.1	35.0	59.9
150-199 beds	85	2.4	28.2	69.4
200 or more beds	67	1.5	46.3	52.2
By Region:				
Urban by Region	2,658	4.3	40.9	54.8
New England	145	0.7	25.5	73.8
Middle Atlantic	407	2.7	34.6	62.7
South Atlantic	395	5.1	52.2	42.8
East North Central	453	3.8	30.2	66.0
East South Central	153	7.2	47.7	45.1
West North Central	180	5.6	37.2	57.2
West South Central	326	9.5	57.4	33.1
Mountain	123	2.4	52.0	45.5
Pacific	431	2.6	37.6	59.9
Puerto Rico	45	0.0	28.9	71.1
Rural by Region	2,117	3.6	22.8	73.6
New England	52	0.0	21.2	78.8
Middle Atlantic	78	3.8	20.5	75.6
South Atlantic	276	1.4	34.1	64.5
East North Central	280	2.5	17.9	79.6
East South Central	265	3.0	33.2	63.8
West North Central	489	3.1	14.5	82.4
West South Central	333	4.5	26.1	69.4
Mountain	200	8.5	16.0	75.5
Pacific	139	5.0	23.7	71.2
By Payment Classification:				
Large urban areas (populations over 1 million)	1,586	3.8	41.1	55.0
Other urban areas (populations of 1 million of fewer)	1,148	4.9	40.2	55.0
Rural areas	2,041	3.6	22.3	74.0
Teaching Status:				
Non-teaching	3,670	4.4	32.2	63.3
Fewer than 100 Residents	869	2.9	35.6	61.6
100 or more Residents	236	1.3	32.6	66.1
Disproportionate share hospitals (DSH):				
Non-DSH	2,974	4.1	28.6	67.2
Urban DSH:				
100 or more beds	1,371	3.8	43.3	53.0
Less than 100 beds	74	5.4	25.7	68.9
Rural DSH:				
Sole Community (SCH/EACH)	153	5.2	22.2	72.5
Referral Center (RRC/EACH)	54	1.9	53.7	44.4

TABLE IV.— DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS-ESTIMATE FOR FY 2001 PAYMENTS

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Other Rural:				
100 or more beds	48	2.1	41.7	56.3
Less than 100 beds	101	2.0	21.8	76.2
Urban teaching and DSH:				
Both teaching and DSH	715	2.0	36.8	61.3
Teaching and no DSH	325	3.7	32.9	63.4
No teaching and DSH	730	5.8	47.8	46.4
No teaching and no DSH	964	5.1	40.9	54.0
Rural Hospital Types:				
Non special status hospitals	822	1.3	24.3	74.3
RRC/EACH	150	1.3	38.0	60.7
SCH/EACH	660	7.7	19.4	72.9
Medicare-dependent hospitals (MDH)	351	1.4	16.0	82.6
SCH, RRC and EACH	58	8.6	25.9	65.5
Type of Ownership:				
Voluntary	2,804	3.6	32.1	64.3
Proprietary	736	6.8	57.9	35.3
Government	1,211	3.4	19.9	76.7
Medicare Utilization as a Percent of Inpatient Days:				
0-25	366	4.4	28.1	67.5
25-50	1,818	3.9	35.3	60.8
50-65	1,882	4.1	31.8	64.1
Over 65	685	3.9	32.7	63.4

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As we explain in Appendix B of this proposed rule, we were not able to use 61 of the 4,836 hospitals in our database due to insufficient (missing or unusable) data. Consequently, the payment methodology distribution is based on 4,775 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) Geographic location; (2) region; and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 32.9 percent in FY 2001.

Table IV indicates that 63.1 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 67 percent for low cost capital hospitals in the chart on ''Capital Transition Payment Methodology for FY 2001,'' in section VII.B.2. of this impact analysis takes into account the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (74.0 percent and 76.7 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 35.3 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2001 actuarial model to estimate the potential impact of our proposed changes for FY 2001 on total capital payments per case, using a universe of 4,775 hospitals. The individual hospital payment parameters are taken from the best available data, including: the January 1, 2000 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the proposed FY 2001 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 2000 and FY 2001. Column 5 shows the total percentage change in payments from FY 2000 to FY 2001. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.60 percent increase in the Federal rate, a 0.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including the change from 90 percent to 100 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 4.2 percent in FY 2001. The results show that the effect of the Federal rate change alone is to increase payments by 0.9 percent. In addition to the increase attributable to the Federal rate change, a 3.3 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (3.9 percent and 5.9 percent, respectively). This difference is due to the lower rate of increase for urban hospitals relative to rural hospitals (0.6 percent and 2.7 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.3 percent versus 3.2 percent, respectively) from the effects of all other changes.

All regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 90 to 100 percent). Changes by region vary from a minimum of 2.6 percent increase (Middle Atlantic urban region) to a maximum of 7.5 percent increase (East North Central rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (5.6 percent, a 1.4 percent increase due to the Federal rate changes, and a 4.2 percent increase from the effects of all other changes). Payments to voluntary hospitals will increase 4.0 percent (a 0.9 percent increase due to Federal rate changes, and a 3.1 percent increase from the effects of all other changes) and payments to proprietary hospitals will increase 3.6 percent (a 0.4 percent increase due to Federal rate changes, and a 3.2 percent increase from the effects of all other changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both and for purposes of DSH for FYs 1999 through 2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2001 compared to the effects of reclassification for FY 2000, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2001 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2001 as a whole are projected to experience a 5.9 percent increase in payments (a 2.4 percent increase attributable to Federal rate changes and a 3.5 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (4.2 percent) than reclassified hospitals (5.9 percent) overall. Payments to nonreclassified hospitals will increase less than reclassified hospitals from the Federal rate changes (0.9 percent compared to 2.4 percent), but they will gain about the same from the effects of all other changes (3.3 percent compared to 3.5 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2000 PAYMENTS COMPARED TO FY 2001 PAYMENTS)

	Number of Hospitals	Average FY 2000 pay-ments/case	Average FY 2001 pay-ments/case	All Changes	Portion Attributable to Federal Rate Change
By Geographic Location:					
All hospitals	4,775	648	675	4.2	0.9
Large urban areas (populations over 1 million)	1,514	752	779	3.5	0.2
Other urban areas (populations of 1 million of fewer)	1,144	639	667	4.4	1.1
Rural areas	2,117	434	460	5.9	2.7
Urban hospitals	2,658	703	730	3.9	0.6
0-99 beds	646	503	525	4.3	1.3
100-199 beds	918	613	635	3.7	0.9
200-299 beds	542	671	697	4.0	0.7
300-499 beds	410	731	761	4.1	0.4
500 or more beds	142	912	944	3.6	0.2
Rural hospitals	2,117	434	460	5.9	2.7
0-49 beds	1,201	360	386	7.4	3.6
50-99 beds	547	408	432	5.9	2.8
100-149 beds	217	453	476	5.2	2.4
150-199 beds	85	473	501	6.0	2.7
200 or more beds	67	535	564	5.4	2.2
By Region:					
Urban by Region	2,658	703	730	3.9	0.6
New England	145	727	764	5.0	1.0
Middle Atlantic	407	772	793	2.6	-0.2
South Atlantic	395	682	705	3.4	0.7
East North Central	453	678	710	4.7	0.9
East South Central	153	645	664	2.9	-0.8
West North Central	180	694	727	4.7	1.2
West South Central	326	668	695	4.2	1.1
Mountain	123	672	703	4.6	1.0
Pacific	431	794	830	4.6	0.6
Puerto Rico	45	290	304	4.7	2.1
Rural by Region	2,117	434	460	5.9	2.7
New England	52	516	539	4.5	1.5
Middle Atlantic	78	460	487	6.1	2.5
South Atlantic	276	447	473	5.8	2.9
East North Central	280	444	478	7.5	3.0
East South Central	265	398	422	5.9	2.4
West North Central	489	425	448	5.5	3.0
West South Central	333	392	410	4.7	2.4
Mountain	200	458	482	5.3	3.0
Pacific	139	508	543	7.0	3.1
By Payment Classification:					
All hospitals	4,775	648	675	4.2	0.9
Large urban areas (populations over 1 million)	1,586	745	772	3.5	0.3
Other urban areas (populations of 1 million of fewer)	1,148	638	666	4.5	1.1
Rural areas	2,041	430	456	5.9	2.7
Teaching Status:					
Non-teaching	3,670	537	558	4.0	1.3
Fewer than 100 Residents	869	678	710	4.7	0.9
100 or more Residents	236	993	1,029	3.6	-0.1
Urban DSH:					
100 or more beds	1,371	743	773	4.0	0.6
Less than 100 beds	74	519	520	0.0	1.2
Rural DSH:					
Sole Community (SCH/EACH)	153	376	411	9.2	3.9
Referral Center (RRC/EACH)	54	494	512	3.5	1.3
Other Rural:					
100 or more beds	48	390	410	5.0	3.2
Less than 100 beds	101	346	372	7.5	3.9

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE
(FY 2000 PAYMENTS COMPARED TO FY 2001 PAYMENTS)

	Number of Hospitals	Average FY 2000 payments/case	Average FY 2001 payments/case	All Changes	Portion Attributable to Federal Rate Change
Urban teaching and DSH:					
Both teaching and DSH	715	816	849	4.1	0.5
Teaching and no DSH	325	708	740	4.5	0.5
No teaching and DSH	730	615	637	3.7	0.9
No teaching and no DSH	964	573	591	3.1	0.7
Rural Hospital Types:					
Non special status hospitals	822	382	406	6.3	3.3
RRC/EACH	150	499	525	5.3	2.1
SCH/EACH	660	421	451	7.0	2.8
Medicare-dependent hospitals (MDH)	351	358	387	8.0	3.5
SCH, RRC and EACH	58	523	539	3.1	1.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY00 and FY01:					
Reclassified During Both FY00 and FY01	381	550	575	4.6	1.3
Reclassified During FY01 Only	160	555	610	9.9	5.8
Reclassified During FY00 Only	144	568	567	-0.1	-2.8
FY01 Reclassifications:					
All Reclassified Hospitals	541	552	584	5.9	2.4
All Nonreclassified Hospitals	4,251	661	689	4.2	0.9
All Urban Reclassified Hospitals	93	719	760	5.7	1.4
Urban Nonreclassified Hospitals	2,540	703	730	3.8	0.5
All Reclassified Rural Hospitals	448	491	521	6.0	2.9
Rural Nonreclassified Hospitals	1,668	389	412	5.9	2.6
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	478	492	2.9	0.8

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE
(FY 2000 PAYMENTS COMPARED TO FY 2001 PAYMENTS)

	Number of Hospitals	Average FY 2000 payments/case	Average FY 2001 payments/case	All Changes	Portion Attributable to Federal Rate Change
Type of Ownership:					
Voluntary	2,804	663	690	4.0	0.9
Proprietary	736	631	654	3.6	0.4
Government	1,211	580	612	5.6	1.4
Medicare Utilization as a Percent of Inpatient Days:					
0-25	366	805	853	6.0	0.6
25-50	1,818	743	771	3.8	0.5
50-65	1,882	578	603	4.4	1.2

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Appendix B: Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 7 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this proposed rule: The December 31, 1999 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), PPS–XIV (cost reporting periods beginning in FY 1997), and PPS–XV (cost reporting periods beginning in FY 1998). In addition, to model payments, we use the January 1, 2000 update of the provider-specific file, and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 2000 hospital-specific rates using the provider-specific file and the intermediary audit file.

(We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Provider-Specific File Only	129
Provider-Specific and Audit File	4,707
Total	4,836

Eighty-two of the 4,836 hospitals had unusable or missing data, or had no cost reports available. For 20 of the 82 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 20 hospitals in the analysis. We were able to estimate hospital-specific amounts for one additional hospital from the PPS–IX cost reports. Hence we were able to use 21 of the 82 hospitals. We used 4,775 hospitals for the analysis. Sixty-one hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 0.7 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should decrease as assets become fully depreciated and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution, allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution, allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed size for large hospitals. We found the probability somewhat dependent on the prior year change in bed size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed size for large hospitals, we first projected changes in bed size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1999 (the MedPAR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals had considerably more discharges in FY 1999 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge, since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1999 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1999 MedPAR file using the FY 2001 DRG relative weights included in section VI. of the Addendum to this proposed rule. The case-mix index is increased each year after FY 1999 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 0.5 percent in FY 2000. We project that case-mix will increase 0.5 percent in FY 2001. (Since we are using FY 1999 cases for our analysis, the FY 1999 increase in case-mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 2000, the budget neutrality adjustment factors were 1.00142 for the national rate and 1.00134 for the Puerto Rico rate.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

To determine the factors for FY 2001, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2001 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 2000 relative weights and the FY 2001 geographic adjustment factor. In making the comparison, we held the FY 2001 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99846 for FY 2001 to the previous cumulative FY 2000 adjustment of 1.00142, yielding a cumulative adjustment of 0.99988 through FY 2001. For the Puerto Rico geographic adjustment factor, we applied an incremental budget neutrality adjustment of 1.00312 for FY 2001 to the previous cumulative FY 2000 adjustment of 1.00134, yielding a cumulative adjustment of 1.00446 through FY 2001. We then compared estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2001 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2001 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00019 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2001 would be 1.00007 nationally and 1.00465 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992				1.00000				
1993			0.99800	0.99800				
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001	0.99846	1.00019	0.99865	1.00007	1.00312	1.00019	1.00331	1.00465

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FYs 1992 through 2000, the proposed factors for FY 2001, and the estimated factors that would be applicable through FY 2005. We caution that these are estimates for FYs 2001 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 1.00007 (1.00465 for Puerto Rico) for FY 2001 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2001.

The projections are as follows:

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Fiscal Year	Update Factor	Exceptions Reduction Factor	Budget Neutrality Factor	DRG/GAF Adjustment Factor[1]	Outlier Adjustment Factor	Federal Rate Adjustment	Federal Rate (after outlier) reduction)
1992 .	N/A	0.9813	0.9602		.9497		415.59
1993 .	6.07	.9756	.9162	.9980	.9496		417.29
1994 .	3.04	.9485	.8947	1.0053	.9454	.9260[2]	378.34
1995 .	3.44	.9734	.8432	.9998	.9414		376.83
1996 .	1.20	.9849	N/A	.9994	.9536	.9972[3]	461.96
1997 .	0.70	.9358	N/A	.9987	.9481		438.92
1998 .	0.90	.9659	N/A	.9989	.9382	.8222[4]	371.51
1999 .	0.10	.9783	N/A	1.0028	.9392		378.10
2000 .	0.30	.9730	N/A	.9985	.9402		377.03
2001 .	0.90	.9796	N/A	.9987	.9416		383.06
2002 .	0.80	1.0000[6]	N/A	1.0000[5]	.9416[5]		394.17
2003 .	0.70	1.0000[6]	N/A	1.0000	.9416	1.0255[4]	407.07
2004 .	0.70	1.0000[6]	N/A	1.0000	.9416		409.92
2005 .	0.80	1.0000[6]	N/A	1.0000	.9416		413.19

[1]Note: The incremental change over the previous year.

[2]Note: OBRA 1993 adjustment.

[3]Note: Adjustment for change in the transfer policy.

[4]Note: Balanced Budget Act of 1997 adjustment.

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

[6]Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

APPENDIX C—REPORT TO CONGRESS

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

APR 17 2000

The Honorable Albert Gore, Jr.
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) 2001 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 2001 budget includes, an update for PPS hospitals, except sole community hospitals (SCHs), equal to the market basket minus 1.1 percentage points. The update for SCHs in current law and the President's 2001 budget is equal to the market basket rate of increase. The President's FY 2001 budget estimated the PPS market basket rate of increase for FY 2001 to be 3.2 percent. Based on this estimate, we recommend an update for SCHs of 3.2 percent and for other hospitals in both large urban and other areas of 2.1 percent.

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 3.2 percent to the SCH hospital-specific rate and 2.1 percent to the MDH 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 2001 budget incorporates an increase to the TEFRA limit using

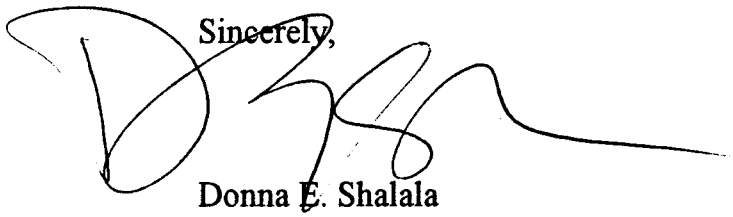
3.2 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase minus a percentage between 0 and 2.5 percentage points, or 0, resulting in an increase in the TEFRA limits of between .7 and 3.2 percent, or 0.

My recommendation for the updates is based on cost projections used in the President's FY 2001 budget. A final recommendation on the appropriate percentage increases for FY 2001 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 of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

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 adjustment to the DRG weighting factors for FY 2001.

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.

Sincerely,



Donna E. Shalala

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

APR 17 2000

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) 2001 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.

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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

Page 2 - The Honorable J. Dennis Hastert

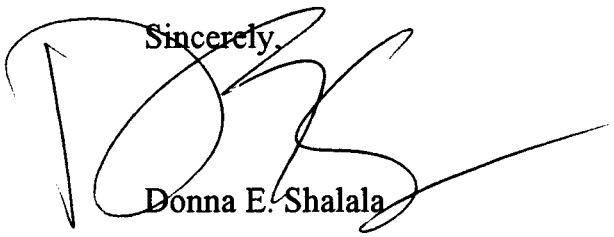
President's FY 2001 budget incorporates an increase to the TEFRA limit using 3.2 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase minus a percentage between 0 and 2.5 percentage points, or 0, resulting in an increase in the TEFRA limits of between .7 and 3.2 percent, or 0.

My recommendation for the updates is based on cost projections used in the President's FY 2001 budget. A final recommendation on the appropriate percentage increases for FY 2001 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 of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

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 adjustment to the DRG weighting factors for FY 2001.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate.

Sincerely,



Donna E. Shalala

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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 2001 by hospitals subject to the prospective payment system and by hospitals or units excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XVI) of the Act sets the FY 2001 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.1 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2001 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act. For Medicare-dependent, small rural hospitals, the percentage increase is the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.1 percentage points. Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i) of the Act to provide that, for sole community hospitals, the rate of increase in the hospital-specific rates for FY 2001 only is equal to the market basket percentage increase. Prior to FY 2001, sole community hospitals were subject to the same percentage increase to their hospital-specific rates as all other hospitals subject to the prospective payment system set forth in section 1886(b)(3)(B)(i) of the Act.

Under section 1886(b)(3)(B)(ii) of the Act, the FY 2001 percentage increase in the rate-of-increase limits for hospitals and units excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available, or 0 percentage point if costs do not exceed two-thirds of the limit.

In accordance with section 1886(d)(3)(A) of the Act, we are 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 2000 forecast of the FY 2001 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 2.0 percent (that is, the market basket rate of increase minus 1.1 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to Medicare-dependent, small rural hospitals is also 2.0 percent. The proposed update to the hospital-specific rate applicable to sole community hospitals is 3.1 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 3.1 percent) minus a percentage between 0 and 2.5 percentage points, or 0 percentage point, resulting in an increase in the rate-of-increase limit between 0.6 and 3.1 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.

In its March 1, 2000 report, MedPAC did not make a specific update recommendation for FY 2001 payments for Medicare acute inpatient hospitals. However, at its April 13, 2000 public meeting, MedPAC announced that it was recommending a combined update between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001. This recommendation is higher than the current law amount as prescribed by Public Law 105–33 and proposed in this rule. Because of the timing of the announcement and our need for ample time to perform a proper analysis of the recommendation, we will address the comparison of HCFA's update recommendation and MedPAC's update recommendation in the FY 2001 final rule in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation.

We describe the basis for our FY 2001 update recommendation (Table 1) in section II. of this Appendix.

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 2.0 percentage points for hospitals located in large urban and other areas. We are also recommending an update of 2.0 percentage points to the hospital-specific rate for Medicare-dependent, small rural hospitals. In addition, we are recommending an update of 3.1 percentage points to the hospital-specific rate for sole community hospitals. We believe these recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

We recommend that hospitals excluded from the prospective payment system receive an update of between 0.6 and 3.1 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 3.1 percent.

Our update recommendation of 2.0 percent (market basket increase minus 1.1 percent) for prospective payment system operating costs standardized amounts is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case-mix:

A. Productivity

Service level productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use a labor productivity measure since this update framework applies to operating payment. To recognize that we are apportioning the short-run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure for operating costs by the share of direct labor services in the market basket to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989, or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

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 labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low and larger in years that output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the

range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply the sum of the expected change in intensity (0.0 percent), projected admissions change (1.6 percent for FY 2001), and projected real case-mix growth (0.5 percent), or 2.1 percent. The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.4 percent.

Multiplying the expected change in total hospital service output (2.1 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.4, provides our productivity standard of −0.5 to −0.4 percent.

B. Intensity

We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2001, we recommend an adjustment of 0.0 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level of quality-enhancing technology changes. A study published in the Winter 1992 issue of the *Health Care Financing Review,* ''Contributions of case mix and intensity change to hospital cost increases'' (pp. 151–163), suggests that one-third of the intensity change is attributable to high-cost technology. The balance was unexplained but the authors speculated that it is attributable to fixed costs in service delivery.

Typically, a specific new technology increases cost in some uses and decreases cost in other uses. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies and new technologies.

Other things being equal, per-discharge fixed costs tend to fluctuate in inverse proportion to changes in volume. Fixed costs exist whether patients are treated or not. If volume is declining, per-discharge fixed costs will rise, but the reverse is true if volume is increasing.

Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1995 through 1999 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the CPI for hospital and related services and changes in real case-mix. Thus, in order to measure changes in intensity, one must measure changes in real case-mix.

For FYs 1995 through 1999, observed case-mix index change ranged from a low of −0.3 percent to a high of 1.7 percent, with a 5-year average change of 0.6 percent. Based on evidence from past studies of case-mix change, we estimate that real case-mix change fluctuates between 1.0 and 1.4 percent and the observed values generally fall in this range, although some years the figures fall outside this range. The average percentage change in charge per discharge was 3.6 percent and the average annual change in the CPI for hospital and related services was 4.1 percent. Dividing the change in charge per discharge by the quantity of the real case-mix index change and the CPI for hospital and related services yields an average annual change in intensity of −1.9 percent. Assuming the technology/fixed cost ratio still holds (.33), technology would account for a −0.6 percent annual decline while fixed costs would account for a −1.3 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, has increased during the period. In the past, we have not recommended a negative intensity adjustment. Although we are not recommending a negative adjustment for FY 2001, we are reflecting the possible range that such a negative adjustment could span, based on our analysis. Accordingly, for FY 2001, we are recommending an intensity adjustment between 0 percent and −0.6 percent.

C. Change in Case-Mix

Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2001 update recommendation, we are projecting a 0.5 percent increase in the case-mix index. We define real case-mix as actual changes in the mix (and resources requirements) of Medicare patients as opposed to changes in coding behavior that results in assignment of cases to higher weighted DRGS, but do not reflect greater resource requirements. Unlike in past years, where we differentiated between ''real'' case-mix increase and increases attributable to changes in coding behavior, we do not feel changes in coding behavior will impact the overall case-mix in FY 2001. As such for FY 2001, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 adjustment for case-mix.

D. Effect of FY 1999 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 1999 resulted in a 0.0 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. Our update framework for FY 2001 does not reflect a forecast error correction because, for FY 1999, there was less than a 0.25 percentage point difference between the actual market basket and the forecasted market basket.

As we explained in section I. of this Appendix, a comparison of our update recommendation to MedPAC's recommendation is unavailable for this proposed rule. MedPAC did not announce its recommendation for a combined update of between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001 until its April 13, 2000 public meeting. This recommendation is higher than the current law amount as prescribed by Public Law 105–33 and proposed in this rule. Because of the timing of the announcement and our need for ample time to perform a proper analysis of the recommendation, we will address the comparison of HCFA's update recommendation and MedPAC's update recommendation in the FY 2001 final rule in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation. The following is a summary of the update range supported by our analyses:

TABLE 1.—HHS' FY 2001 UPDATE RECOMMENDATION

Market basket	MB
Policy Adjustments Factors:	
Productivity	−0.5 to −0.4
Intensity	0.0 to −0.6
Subtotal	−0.5 to −1.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	−0.5
Real Across DRG Change	0.5
Subtotal	0.0
Effect of 1999 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Recommended Update	MB −0.5 to MB −1.0

Consistent with current law, we are recommending an update of market basket increase minus 1.1 percentage points (or 2.0 percent). We note that this approximates the lower bound of the range suggested by our framework when accounting for a negative intensity change.

For FY 2001, we believe that a 2.0 update factor appropriately reflects 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. We also recommend that the hospital-specific rates applicable to Medicare-dependent, small rural hospitals be increased by the same update, 2.0 percentage points. Furthermore, we recommend that the hospital-specific rates applicable to sole community hospitals be increased by an update of 3.1 percentage points.

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