

APPENDIX D. MEDICARE REIMBURSEMENT TO HOSPITALS

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GENERAL SUMMARY

Medicare part A provides reimbursement for inpatient hospital care through a payment system based on prospectively set rates, the prospective payment system (PPS), for hospital cost reporting periods beginning on or after October 1, 1983. PPS was enacted by the Social Security Amendments of 1983 (Public Law 98-21). This appendix describes the major reimbursement provisions of PPS.

Medicare payment for hospital inpatient services is made according to a prospective payment system, rather than a retrospective cost-based system. Medicare payments are made at predetermined, specific rates which represent the average cost, nationwide, of treating a Medicare patient according to his or her medical condition. The classification system used to group hospital inpatients according to their diagnoses is known as diagnosis-related groups (DRGs). Separate DRG rates apply depending on whether a hospital is located in a large urban area (greater than 1 million population, or 970,000 in New England) or other area of the country, as determined by the Office of Management and Budget (OMB) metropolitan statistical area (MSA) system.

During a 4-year transition period, a declining portion of the total prospective payment was based on a hospital's historical reasonable costs and an increasing portion was based on a combination of regional and national Federal DRG rates. Since the fifth year of the program (fiscal year 1988), Medicare payments have been generally determined under a national DRG payment methodology. Special transition provisions apply to hospitals located in certain geographic regions. If a hospital can treat a patient for less than the payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. A hospital is prohibited from charging Medicare beneficiaries any amounts (except for deductibles, copayment amounts, and services not covered by Medicare) which represent any difference between the hospital's cost of providing covered care and the Medicare DRG payment amount.

Certain hospital costs are excluded from the prospective payment system and are paid on a reasonable cost basis, subject to rate of increase limits. Authority is provided for States to establish their own all-payer hospital payment systems if they meet certain Federal requirements.

BASIC PAYMENT SYSTEM

Unless excluded from PPS, each Medicare participating hospital is paid a predetermined payment rate per discharge for each type of patient treated. Types of patients are defined by the diagnosis related groups patient classification system which assigns each hospital inpatient to one of 495 patient categories (DRGs) based on the diagnosis and the type of treatment received (medical or surgical).

The payment rate for each DRG is the product of two components: a base payment amount which applies for all DRGs, and a relative weighting factor for the particular DRG. The base payment amount is intended to represent the cost of a typical (average) Medicare inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG

compared to the cost of the overall average Medicare case (i.e., relative to the base payment amount). When the DRG relative weights are each multiplied by the base payment amount, the result is a complete set of prices for all DRGs. Separate DRG rates apply to hospitals located in large urban or other areas (separate base payment amounts apply in these areas, but the DRG relative weighting factors are the same). In addition, the base payment amount (and, therefore, each DRG rate) is adjusted for area differences in hospital wage levels compared to the national average hospital wage level.

TRANSITION PERIOD

Although the transition to prospective payment rates was completed in fiscal year 1988, special transition provisions applied to hospitals located in certain geographic regions. In a few regions with historically higher costs, Public Law 103-66 (OBRA 1993) provided for the continued use of Federal amounts based in part on regional rates until October 1, 1996. Under this transition provision, known as the “regional floor,” the DRG payment rate was determined as the higher of 100 percent of the national amount, or 85 percent of the national amount plus 15 percent of the regional amount.

UPDATE FACTORS

PPS payment rates are updated each year using an “update factor.” The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index (MBI). The MBI measures the cost of goods and services purchased by hospitals, yielding one price inflator for all hospitals in a given year. Table D-1 shows the categories of expense used in developing the index. The update factor also includes adjustments for increases in hospital productivity, technological change, and other factors that affect the level of operating cost per discharge. The annual update factor is also adjusted to include increases in average payments per case attributable to increases in case mix due to changes in coding and reporting accuracy.

Before fiscal year 1988, the same factor was used for all hospitals; however, in subsequent years separate factors were applied to hospitals according to their locations. Separate update factors were set for hospitals located in large urban, other urban, and rural areas. However, beginning in October 1, 1995, a single update factor applied for all hospitals in all areas. Table D-2 compares the hospital market basket increases to actual updates for the past 13 years and shows the increases in PPS payments per case that resulted from the updates and other policy changes.

For fiscal year 1997, the market basket increase was 2.5 percent, the average update was 2.0 percent, and the increase in operating payments per case was 3.9 percent (see table D-2).

TABLE D-1.—HOSPITAL PROSPECTIVE PAYMENT SYSTEM INPUT PRICE INDEX ("THE MARKET BASKET") EXPENSE CATEGORIES AND RATES OF PRICE CHANGE, FISCAL YEARS 1992-98

Expense category	Base- year 1992 weights ¹ (percent)	Federal fiscal year percentage rates of price change						
		1992 ²	1993 ²	1994 ²	1995 ²	1996 ²	1997 ³	1998 ³
1. Wages and salaries ⁴	50.24	3.7	3.1	2.9	2.7	2.9	2.9	3.3
2. Employee benefits ⁴	11.15	6.1	5.7	4.2	2.7	2.1	2.5	3.1
3. Professional fees: Nonmedical ⁴	2.13	4.7	4.2	3.4	2.6	3.0	2.8	3.3
4. Energy and utilities	2.47	-0.7	2.9	0.9	0.0	2.1	4.2	-1.3
A. Fuel oil, coal, etc	0.35	-12.5	-1.5	-7.6	3.5	8.7	10.4	-11.7
B. Electricity	1.35	2.0	2.2	1.5	2.4	0.2	0.4	0.3
C. Natural gas	0.67	0.0	6.1	3.2	-6.7	2.6	8.9	-0.5
D. Water and sewerage	0.11	7.1	5.9	5.2	3.5	3.9	3.0	6.1
5. Professional liability insurance	1.19	2.9	3.4	-0.7	-3.3	-0.9	-1.4	-0.4
6. All other	32.83	1.3	2.2	1.8	4.7	2.1	1.7	2.1
A. All other products	24.03	0.8	1.8	1.3	5.3	1.8	0.8	1.5
1. Pharmaceuticals	4.16	7.2	5.0	3.5	2.5	3.8	2.4	2.9
2. Food: Direct purchase	2.36	0.0	1.0	1.9	0.1	5.0	2.2	1.5
3. Food: Contract service	1.10	2.4	1.7	1.7	2.1	2.3	3.3	3.8
4. Chemicals	3.80	-4.4	1.4	0.5	14.7	-1.0	0.7	0.1
5. Medical instruments	3.13	1.9	2.3	0.9	1.1	1.4	0.8	1.4
6. Photographic supplies	0.40	-0.7	-0.9	0.4	0.5	2.9	0.1	-0.7
7. Rubber and plastics	4.87	-0.3	0.9	0.7	5.6	0.7	-0.1	0.4
8. Paper products	2.06	-0.5	-0.3	0.2	13.4	2.5	-3.3	2.7
9. Apparel	0.88	2.2	1.3	0.2	0.5	0.7	0.8	1.6
10. Machinery and equipment	0.21	0.5	0.5	0.8	1.0	0.5	0.0	1.8
11. Miscellaneous products	1.07	0.8	1.6	0.4	1.7	2.4	2.0	1.0
B. All other services	8.79	2.9	3.1	3.3	3.0	3.0	4.0	3.6

1. Business services ⁴	3.82	3.3	3.4	3.5	2.9	3.2	4.0	3.7
2. Computer services ⁴	1.93	1.3	3.5	4.5	3.6	4.0	5.8	3.6
3. Transportation and shipping	0.19	1.0	3.1	2.8	4.0	2.3	3.3	3.6
4. Telephone	0.53	1.2	0.2	1.8	0.8	1.2	2.3	2.0
5. Postage	0.27	4.9	0.0	0.0	7.7	2.4	0.0	8.1
6. All other labor intensive services ⁴	1.71	4.2	3.2	2.7	2.5	1.9	3.1	3.3
7. All other nonlabor intensive services	0.34	3.0	3.0	2.6	2.8	2.8	2.8	2.7
Total	100.00	3.1	3.1	2.6	3.2	2.5	2.4	2.7

¹ Weights may not sum to 100.00 due to rounding.

² Historical data subject to change only upon revision of underlying series.

³ Projected data subject to change in future forecasts.

⁴ Considered labor related.

Note.—The historical market basket has been revised due to the update from a 1987 to a 1992 base year.

Source: Health Care Financing Administration, Office of the Actuary.

TABLE D-2.—COMPARISON OF INCREASE IN PPS HOSPITAL MARKET BASKET INDEX, AVERAGE PPS UPDATE, AND INCREASE IN PPS PAYMENTS PER CASE, FISCAL YEARS 1984–97

[In percent]

Fiscal year	Forecasted increase in market basket index ¹	Average update ²	Increase in operating payments per case ³
1984	4.9	4.7	18.5
1985	4.0	4.5	10.5
1986	4.3	0.5	3.2
1987	3.7	1.2	5.4
1988	4.7	1.5	6.0
1989	5.4	3.3	6.6
1990	5.5	4.7	6.5
1991	5.2	3.4	6.0
1992	4.4	3.0	5.2
1993	4.1	2.7	3.8
1994	4.3	2.0	3.6
1995	3.6	2.0	4.0
1996	3.5	1.5	3.4
1997	2.5	2.0	3.9

¹Based on data available when final PPS rates were set.²From 1988 to 1995, there were separate updates for hospitals in large urban, other urban, and rural areas. Update for 1990 adjusted to reflect 1.22 percent across-the-board reduction in DRG weights.³Data on PPS operating payments for 1984 through 1995 are for hospital accounting years beginning during each Federal fiscal year. Changes are based on cohorts of hospitals with Medicare Cost Reports in two consecutive years. Increases for 1996 and 1997 estimated from current update and case-mix index trends.

Source: Prospective Payment Assessment Commission.

For fiscal year 1998, the market basket increase is forecast at 2.8 percent. The Balanced Budget Act of 1997 sets the update for fiscal year 1998 at 0 percent; fiscal year 1999 at the MBI minus 1.9 percent; fiscal year 2000 at the MBI minus 1.8 percent; fiscal years 2001 and 2002 at the MBI minus 1.1 percent; and for fiscal year 2003 and each subsequent fiscal year, at the MBI percentage increase for all hospitals in all areas.

DRG WEIGHTING FACTORS

Public Law 98–21 required the Secretary to adjust the DRG definitions and weighting factors in fiscal year 1986 and at least every 4 years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. Public Law 99–509, however, required the Secretary to adjust the DRG definitions and weighting factors each year, beginning in fiscal year 1988.

OBRA 1989 required the Secretary to reduce the weighting factor for each DRG by 1.22 percent for discharges in fiscal year 1990. In addition, the Secretary was prohibited from adjusting DRG weighting factors on other than a budget neutral basis beginning in fiscal year 1991.

Table D-3 shows the 20 DRGs accounting for the largest numbers of Medicare inpatient discharges during fiscal year 1995. DRG relative weights appear in table D-21 at the end of this appendix.

TABLE D-3.—TWENTY DIAGNOSIS-RELATED GROUPS (DRGs) WITH THE MOST HOSPITAL DISCHARGES, FISCAL YEAR 1995

DRG number	Description	Discharges	Percent total	Average length of stay (days)
127	Heart failure and shock	706,045	6.0	6.2
89	Simple pneumonia and pleurisy ¹	448,587	3.8	7.1
14	Specific cerebrovascular disorders except transient ischemic attack	371,815	3.2	7.3
88	Chronic obstructive pulmonary disease	368,439	3.2	6.1
209	Major joint and limb reattachment procedures	344,458	2.9	6.7
430	Psychoses	274,966	2.4	13.5
182	Esophagitis, gastroenteritis, and miscellaneous metabolic disorders	246,431	2.1	4.9
174	G.I. hemorrhage ²	246,339	2.1	5.5
296	Nutritional and miscellaneous metabolic disorders ¹	231,548	2.0	6.4
79	Respiratory infections and inflammations	221,867	1.9	9.3
138	Cardiac arrhythmia and conduction disorders ²	211,494	1.8	4.5
416	Septicemia	202,024	1.7	8.2
112	Vascular procedures except major reconstruction without pump	201,066	1.7	4.7
462	Rehabilitation	197,730	1.7	16.0
140	Angina pectoris	184,772	1.6	3.5
320	Kidney and urinary tract infections ¹	181,641	1.6	6.4
121	Circulatory disorders with acute myocardial infarction and cerebrovascular complications, discharged alive	167,202	1.4	7.4
148	Major small and large bowel procedures ²	150,746	1.3	13.4
15	Transient ischemic attack and precerebral occlusions	145,915	1.2	4.5
124	Circulatory disorders except acute myocardial infarction, with cardiac catheterization and complex diagnosis	145,560	1.2	4.9
Total, all DRGs		11,680,874	100.0	7.1

¹Age greater than 17, with complications.

²With complications.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

SOURCE AND CALCULATION OF THE HOSPITAL WAGE INDEX

The hospital wage index is used to adjust a hospital's base payment amount for the wage level of the hospital's area. This is accomplished by multiplying the labor-related component of the national standardized payment amount by a wage index. The wage

index is intended to measure the average wage level for hospital workers in each urban area (metropolitan statistical area or MSA) or rural area (non-MSA parts of States) relative to the national average wage level.

The Secretary is required to update the wage index annually beginning October 1, 1993. The Secretary is required to base the update on a survey of wages and wage-related costs of short-term acute care hospitals. Tables D-18, D-19, and D-20, at the end of this appendix, give the current wage index values for urban areas, for all rural areas in a State, and a special index for hospitals that are reclassified.

Calculation of the index begins with the area average hospital hourly wage. For each MSA or non-MSA area (i.e., all non-MSA counties in a State), total county compensation and total paid hours data are summed separately over all counties included in the area. Then aggregate hospital compensation for the area is divided by aggregate paid hours of hospital employment in the area to produce the area average hourly wage. The hospital wage index is calculated by dividing the average hourly wage for each area by the national average hourly wage (determined by dividing national aggregate compensation by national aggregate paid hours of employment).

This procedure results in an index number, such as 0.9072 (Asheville, North Carolina) or 1.2202 (Sacramento, California), for each MSA or non-MSA area in the United States. Since the national average wage level is represented by an index value of 1.000, the wage index value for any area has a direct and simple interpretation. The value of 1.2202 for Sacramento means that the hourly wage rate for hospital workers is 22.02 percent higher in the Sacramento MSA than nationwide.

Thus, in computing the hospital payment rates applicable for hospitals in the Sacramento MSA, the labor-related component of the national large urban adjusted standardized payment amount (\$2,752.36) is multiplied by 1.2202 in order to adjust for the higher level of hourly wage rates in this area. Similarly, the calculation of the labor portion of the rates for hospitals in Asheville would involve a reduction in the published labor-related component of the national adjusted standardized payment amount, to reflect the fact that hourly wage levels in this MSA are 9.28 percent lower than the national average (as indicated by the wage index value of 0.9072).

SAMPLE PAYMENT CALCULATION

The Federal large urban and other area base payment amounts per discharge for fiscal year 1998 were published in the *Federal Register* on August 29, 1997 (see table D-4). The payment rates for most hospitals are computed using the national adjusted operating standardized amounts. Puerto Rico has its own adjusted operating standardized amounts for DRG payment purposes. The Balanced Budget Act of 1997 changes the way the standardized amount for Puerto Rico is determined from a 25 percent Federal, 75 percent local blend rate, to a 50 percent Federal, 50 percent local rate.

Each payment amount is divided into a labor-related component and a nonlabor-related component. The sum of these components

represents the base payment amount that would apply for a hospital located in an area with a wage index of 1.0 (i.e., average wage rates for hospital workers in the area match the national average of hospital wage rates across all areas).

TABLE D-4.—NATIONAL AND REGIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/ NONLABOR, FISCAL YEAR 1998

	Large urban areas		Other areas	
	Labor related	Nonlabor related	Labor related	Nonlabor related
National average	\$2,776.21	\$1,128.44	\$2,732.26	\$1,110.58
Puerto Rico:				
National	2,752.36	1,118.74	2,752.36	1,118.74
Puerto Rico	1,323.01	532.55	1,302.07	524.11

Source: Federal Register, 1997.

The basic payment to a hospital for a case in a particular DRG is the applicable national payment amount, adjusted by the local wage index value and multiplied by the weighting factor for the DRG.

For an example of a payment calculation, assume a hospital is located in Washington, DC. Such a hospital would be in a large urban area. Payment is based on the large urban national standardized amount. First, the labor-related portion of this amount (\$2,776.21 in fiscal year 1998) is multiplied by the appropriate wage index (1.0780 for Washington, DC):

$$\$2,776.21 \times 1.0780 = \$2,992.75$$

To this total is added the nonlabor-related portion of the standardized amount:

$$\$2,992.75 + \$1,128.44 = \$4,121.19$$

For each discharge, this new total is then multiplied by the relative weight factor for the DRG to which the case has been assigned. These weights range from a low of 0.2086 for DRG 382 (false labor) to a high of 16.0413 for DRG 483 (certain tracheostomies). The payment rates for the sample hospital in fiscal year 1998 would therefore vary from a low of \$859.68 ($\$4,121.19 \times 0.2086$) to a high of \$66,109.25 ($\$4,121.19 \times 16.0413$).

In addition to the basic payment amount for each case, additional payments may be made to teaching hospitals and hospitals that serve a disproportionate share of low-income patients. Any hospital may receive additional payments for outliers (cases with extraordinarily high costs or a very long stay, relative to other cases in the DRG) and for treatment of beneficiaries with end-stage renal disease. Finally, certain hospital costs are excluded from PPS and reimbursed separately. The next sections of this appendix discuss additional PPS payments and the separate reimbursement of excluded costs.

ADDITIONAL PAYMENT AMOUNTS

In addition to the DRG prospective payment rates, Medicare payments are made to hospitals for four additional items or services.

GRADUATE MEDICAL EDUCATION

Financing of graduate medical education, the period of training following medical school, is provided predominantly through inpatient revenues (both hospital payments and faculty physician fees) and a complex mix of Federal and State government funds. The Federal Government is the largest single explicit financing source for graduate medical education through the Medicare Program and through its support of residencies in Veterans Administration hospitals. Medicare recognizes the costs of graduate medical education under two mechanisms: direct medical education payments and an indirect medical education adjustment. In fiscal year 1997, Medicare paid approximately \$2.5 billion in direct medical education payments and \$4.6 billion in indirect adjustments.

Direct medical education costs

The direct costs of approved medical education programs (such as the salaries of residents and teachers and other education costs for residents, for nurses, and for allied health professionals trained in provider-operated programs) are excluded from the prospective payment system. The direct medical education costs for the training of nurses and allied health professionals in provider-operated programs are paid for on a reasonable cost basis. Residency training programs for physicians are funded through formula payments based on each hospital's per resident costs.

Medicare's payment to each hospital equals the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's cost reporting period that began in fiscal year 1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the Consumer Price Index (CPI). The number of FTE residents is calculated at 100 percent after July 1, 1986, only for residents in their initial residency period (i.e., within the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not to exceed 5 years; residents in geriatrics or preventive medicine are allowed 2 additional years). For residents not in their initial residency period, the weighing factor is 50 percent after that date. Residents who are foreign or international medical graduates are not counted as FTE residents unless they have passed certain examinations.

OBRA 1993 provided that the amounts paid per resident for the direct costs of graduate medical education would not be updated by the CPI for cost reporting periods beginning during fiscal years 1994 and 1995, except for primary care residents and residents in obstetrics and gynecology. Primary care residents are defined to include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, and osteopathic gen-

eral practice. For fiscal year 1997, the per resident amount was updated by the CPI.

The Balanced Budget Act of 1997 made several changes to the way in which Medicare makes payments for direct GME costs. The Balanced Budget Act of 1997 includes: (1) a cap on the total number of residents reimbursed under Medicare at the level that existed for the cost reporting period ending on or before December 31, 1996; (2) payments to qualified nonhospital providers for their direct GME costs (federally qualified health centers, rural health clinics, MedicarePlus organizations, and other appropriate providers); (3) incentive payments to teaching hospitals that voluntarily agree to reduce the number of medical residents in training; (4) a demonstration project under which direct GME payments are to be made to qualifying consortia that consist of a teaching hospital and one or more specified entities who operate an approved medical residency training program; (5) a study on the variations in the costs of hospital overhead and supervisory physician medical education costs among hospitals; and (6) the requirement that the Medicare Payment Advisory Commission (MedPAC) make recommendations on long-term payment policies regarding teaching hospitals and GME.

Indirect medical education costs

Additional payments are made to hospitals under PPS for the indirect costs attributable to approved medical education programs. These indirect costs may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

The additional payment to a hospital is based on a formula that has provided an increase of approximately 7.7 percent in the Federal portion of the DRG payment for each 0.1 increase in the hospital's intern and resident-to-bed ratio on a curvilinear basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). The Balanced Budget Act of 1997 includes reductions in the IME adjustment from 7.7 to 7.0 percent in fiscal year 1998; to 6.5 percent in fiscal year 1999; to 6.0 percent in fiscal year 2000; and to 5.5 percent in fiscal year 2001 and subsequent years.

DISPROPORTIONATE SHARE HOSPITALS

Public Law 99-272 (COBRA) provided that additional payments would be made to hospitals that serve a disproportionate share of low-income patients. The adjustment was extended several times until OBRA 1990 (Public Law 101-508) made it a permanent payment adjustment. A hospital's disproportionate patient percentage is defined as the hospital's total number of inpatient days attributable to Federal Supplemental Security Income (SSI) Medicare beneficiaries divided by the total number of Medicare patient days,

plus the number of Medicaid patient days divided by the total patient days.

Table D-5 shows the minimum disproportionate patient percentages required to qualify for the adjustment and the formulas for computing the adjustment effective October 1, 1993. For discharges occurring after September 1994, hospitals with a disproportionate share greater than 20.2 percent would receive a disproportionate share adjustment equal to 5.88 percent plus 0.825 percent of the difference between 20.2 percent and the hospital's disproportionate share patient percentage.

TABLE D-5.—CRITERIA TO QUALIFY FOR DISPROPORTIONATE SHARE ADJUSTMENT AND FORMULAS FOR COMPUTING ADDITIONAL PAYMENT, EFFECTIVE OCTOBER 1, 1993

Type of hospital	Qualifying disproportionate patient percentage (P)	Formula or fixed percentage adjustment
Urban, 100 or more beds ..	15 percent	$(P-15)(0.6) 0.65 + 2.5$.
Urban, 100 or more beds ..	20.2 percent	$(P-20.2) 0.8 + 5.88$.
Urban, 100 or more beds ..	30 percent of inpatient revenue from State or local indigent care funds.	35 percent.
Urban, under 100 beds	40 percent	5 percent.
Rural, over 500 beds	Not specified in law; regulations set threshold at 15 percent.	Same as urban, 100 or more beds.
Rural, over 100 beds	30 percent	4 percent.
Rural, under 100 beds	45 percent	4 percent.
Rural, sole community hospital.	30 percent	10 percent.
Rural, rural referral center and—		
(a) not a sole community hospital, 100 or more beds.	30 percent	$(P-30)(0.6) + 4.0$.
(b) not a sole community hospital, under 100 beds.	45 percent	$(P-30)(0.6) + 4.0$.
(c) also a sole community hospital.	30 percent	Greater of 10 percent or $(P-30)(0.6) + 4.0$.

Note.—The disproportionate patient percentage (P) is equal to the sum of (a) the number of Medicare inpatient days provided to Supplemental Security Income recipients divided by total Medicare inpatient days, and (b) the number of inpatient days provided to Medicaid beneficiaries divided by total inpatient days.

Source: Prospective Payment Assessment Commission.

The Balanced Budget Act of 1997 includes reductions in the current DSH payment formula amounts of 1 percent for fiscal year 1998; 2 percent in fiscal year 1999; 3 percent in fiscal year 2000; 4 percent in fiscal year 2001; 5 percent in fiscal year 2002; and 0 percent in fiscal year 2003 and each subsequent fiscal year. The Balanced Budget Act of 1997 also requires the Secretary to submit to the House Ways and Means and Senate Finance Committees, no

later than 1 year after enactment, a report that contains a new formula for determining additional DSH payments to hospitals.

ESRD BENEFICIARY DISCHARGES

Effective with cost reporting periods beginning on or after October 1, 1984, additional payments are made to hospitals for inpatient dialysis provided to end-stage renal disease (ESRD) beneficiaries if total discharges of such beneficiaries from non-ESRD related DRGs account for 10 percent or more of the hospital's total Medicare discharges. A hospital meeting the criteria is paid an additional payment for each ESRD beneficiary discharge based on the estimated weekly cost of dialysis and the average length of stay of its ESRD beneficiaries.

OUTLIERS

Additional amounts are paid to hospitals for atypical cases (known as "outliers") which have either extremely long length of stay (day outliers) or extraordinarily high costs (cost outliers) compared to most discharges classified in the same DRG. The law requires that total outlier payments to all hospitals covered by the system represent no less than 5 percent and no more than 6 percent of the total estimated PPS payments for the fiscal year. Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases meeting the criteria for cost outliers. Outlier payments are financed by an offsetting overall reduction in the base payment amount per discharge. Effective October 1, 1986, Public Law 99-509 established separate urban and rural set-aside factors for financing outlier payments. The separate set-aside factors for rural and urban hospitals for financing outlier payments ended when the other urban/rural payment differential was eliminated in fiscal year 1995, as enacted in OBRA 1990.

Public Law 100-203 increased payments for outlier cases classified in DRGs relating to patients with burns from April 1, 1988, through September 30, 1989. This legislation also prohibited the Secretary from issuing any final regulations before September 1, 1988, which changed the method of payment for outlier cases (other than burn cases).

The Secretary published new outlier rules on September 30, 1988, effective for discharges on or after October 1, 1988. The new rules modified the thresholds used in determining whether a case is an outlier and increased the allowable payment amounts for cost outliers. The effect of the changes increased the proportion of all outlier payments going to cost outliers. Previously, about 85 percent of outlier payments were made for length-of-stay (LOS) outliers and 15 percent for cost outliers. Under the new rules, 60 percent of payments were made for cost outliers and 40 percent for LOS outliers. (Cases that meet both length-of-stay and cost outlier criteria are paid under the policy that produces the higher payment.)

To determine the amount of additional payments for outlier cases, the LOS for each case in a DRG is first compared against the applicable LOS threshold for the category. If the LOS for a case

exceeds the threshold, then the case qualifies as a day outlier. In this instance, the hospital is paid its regular payment rate per discharge (for this DRG), plus a per diem amount (44 percent of the hospital's per diem rate for the DRG) for each Medicare covered day above the LOS threshold.

If the case does not qualify as a day outlier, then it may qualify as a cost outlier. The case will qualify for extra payments on this basis if the hospital's Medicare covered charges for the case, adjusted to operating costs (and reduced by its indirect teaching and disproportionate share adjustments, if applicable), exceed its cost outlier threshold for the DRG. In this instance, the hospital is paid its regular payment rate per discharge for the DRG, plus the Federal portion of 75 percent of the difference between its adjusted (and reduced) charges for the case and the cost outlier threshold.

In October 1991, Medicare began a transition from cost-based to prospective payment for hospital capital expenses (see below). In the August 30, 1991, final rule implementing this change, the Secretary established a unified outlier payment system for capital and operating costs. For day outliers, payments for covered days were set equal to a percentage of the combined per diem operating and capital payment rates for the DRG. For cost outliers, payments are made only if the combined operating and capital cost for the case exceed the cost outlier threshold for the DRG. As in the case of operating cost payments, standardized capital payment amounts are reduced to establish a pool for outlier payments.

OBRA 1993 legislated two changes in outlier policy that became effective in fiscal year 1995. First, day outliers are phased out over a period of 4 years. By fiscal year 1999, all outlier payments will be based solely on cost. Second, cost-outlier thresholds are based on a fixed amount beyond the payment rate for each case so that hospitals incur the same loss on every case before outlier payments are applied.

The Balanced Budget Act of 1997 eliminates the use of the indirect medical education adjustment and disproportionate share hospital payments as part of costs that trigger outlier payments, effective beginning in fiscal year 1998.

PAYMENT FOR CAPITAL

Until fiscal year 1992, Medicare paid a share of hospitals' reasonable capital-related costs, based on services used by beneficiaries as a proportion of total services furnished by the hospital. (Payments in recent years have been subject to fixed percentage reductions described below.) Four basic types of costs are allowable for Medicare reimbursement:

1. Interest on mortgages, bonds, or other borrowing used to finance capital investments or current operations. Interest costs are generally offset by any interest income earned by the hospital on investments;
2. Depreciation, figured on a straight line basis, for plant and equipment, but not for land;
3. Rental payments for plant and equipment;
4. Property taxes and insurance premiums related to capital assets.

One other type of capital cost was formerly recognized under Medicare, but has not been reimbursable for hospital services since fiscal year 1989: return on equity for investor-owned hospitals. Return on equity payments provided a return to investors equivalent to what they would have earned if they had used their money for some other purpose.

When the new PPS system was enacted in 1983, Congress excluded capital costs. However, the Secretary was instructed to report to Congress on methods for including capital in PPS and was authorized (but not required) to implement prospective payment for capital on or after October 1, 1986.

The Secretary's authority to include capital in PPS was postponed twice. The Supplemental Appropriations Act of 1986 (Public Law 99-349) delayed prospective capital payment until October 1, 1987. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) delayed prospective payment until October 1, 1991. However, the Secretary was required, not merely authorized, to implement a prospective system by that date. The system was required to provide that capital payments be made on a per-discharge basis, with adjustments based on each discharge's classification under the DRGs or some similar system. At the Secretary's discretion, the system could include adjustments to reflect variations in costs of construction or borrowing, exceptions (including exceptions for hospitals with existing obligations), and adjustments to reflect hospital occupancy rates.

While prospective payment for capital was delayed (see below), Congress included in budget reconciliation legislation fixed percentage reductions in amounts otherwise payable by Medicare for capital costs. These cuts began in fiscal year 1987, with a 3.5-percent reduction. Medicare would compute its share of total costs for each hospital and then reduce that computed share by 3.5 percent. The percentage reduction increased to 7 percent for the first quarter of fiscal year 1988, 12 percent for the rest of that fiscal year, and 15 percent for fiscal year 1989 through fiscal year 1991. Delays in completing budget legislation meant that there were brief intervals in 1987 and 1989 when no reduction was taken. The reductions originally applied only to capital costs related to inpatient care. Beginning in fiscal year 1990, capital payments for outpatient hospital services were also reduced. The reductions did not apply to certain types of rural hospitals defined in Medicare law, including sole community hospitals, essential access community hospitals, and rural primary care hospitals.

The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) continued capital payment reductions through fiscal year 1995, with the reduction percentage lowered to 10 percent for fiscal years 1992 through 1995. Because prospective payment began in fiscal year 1992, the reductions were not applied directly to each hospital's computed capital costs. Instead, the Secretary was required to set payments under the new system (or under the new system and PPS combined) in such a way as to achieve an aggregate inpatient hospital capital spending reduction of 10 percent, as compared to what would have been spent under the reasonable cost system.

The administration's rules for prospective payment for capital costs were published in the *Federal Register* on August 30, 1991. The rule provides for a 10-year transition to fully prospective payment beginning October 1, 1991.

Under the rule, the Secretary establishes a standard per case capital payment rate, based on average capital costs per case in fiscal year 1989 and updated for inflation and other factors. Through fiscal year 1995, the base rate was adjusted in order to meet the requirement that capital payment rates be set in such a way as to achieve an aggregate saving of 10 percent relative to what would have been paid under a full cost system. Beginning with fiscal year 1996, that requirement expired. As a result, the standardized payment rates increased by more than 20 percent. For fiscal year 1998 the standardized payment rate for capital is \$371.51 (\$177.57 in Puerto Rico). Rates are adjusted using the DRG weights and a geographic factor based on area wage indices.

Hospitals in large urban areas receive a 3-percent increase and hospitals in Alaska and Hawaii receive a cost-of-living adjustment. A disproportionate share adjustment is provided for urban hospitals with more than 100 beds. A hospital receives approximately a 2.1 percent point increase in capital payments for each 10 percent increment in its disproportionate share percentage.

An adjustment is also made for the indirect costs of medical education. This adjustment is based on the ratio of residents to average daily inpatient census. Capital payments increase approximately 2.8 percentage points for each 10 percent increment in the residents to average daily census ratio. Additional capital payments are issued for outlier cases.

During a transition period that ends September 30, 2000, each individual hospital's capital payment rate is a blended rate based partly on its own historic capital costs and partly on the Federal rate. In fiscal year 1996, rates are 50 percent hospital-specific and 50 percent Federal. The hospital-specific portion will drop by 10 percent a year, until fully Federal rates take effect in fiscal year 2001.

The Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) reduced the Federal rate for inpatient capital expenses by 7.4 percent to correct for inflation forecast errors.

The transition rules include two provisions to assist hospitals most disadvantaged by the shift to prospective payment: a "hold harmless" payment system and exception payments for certain facilities. Hospitals with base year capital costs above average continue to be paid on a cost basis for the portion of their costs related to "old" capital investments (generally assets put in use or obligated by the end of 1990). The rest of the hospital's capital payments are based on the prospective rates. For example, if 75 percent of a hospital's costs are for depreciation and interest on a pre-1990 building, the hospital is paid Medicare's share of those costs (subject to the current 10-percent reduction). For "new" capital, it receives a portion of the prospective rate based on the hospital's own ratio of new to total capital. In this case, because old capital accounts for 75 percent of costs, the hospital's new capital payment is 25 percent of the prospective rate for each case treated. This hold harmless payment system will continue until the end of the

10-year transition, or until a hospital's old capital costs drop to the point at which it is more advantageous for the hospital to shift to fully prospective payment.

Exception payments are made to hospitals whose capital payments under the new system fall significantly short of their actual capital costs. Most hospitals are assured of receiving a minimum of 70 percent of costs. Specified urban hospitals with a disproportionate share of low-income patients receive at least 80 percent of costs, and rural sole community hospitals at least 90 percent. Computation of exception payments is cumulative. If a hospital received more than the minimum in 1 year but a shortfall the next, the surplus from the first year would be applied before any additional payment would be made in the second year.

The Balanced Budget Act of 1997 requires the Secretary to rebase the capital payment rates for discharges occurring on or after October 1, 1997 by the actual rates in effect in fiscal year 1995, so that aggregate capital payments will equal 90 percent of what payments would have been under reasonable cost payments, with an additional reduction in the capital payment rate of 2.1 percent from October 1, 1997 through September 30, 2002. The Balanced Budget Act of 1997 eliminates the allowance for return on equity capital. In addition, when a facility undergoes a change of ownership, the Balanced Budget Act of 1997 provides for a depreciation adjustment of the historical cost of the asset recognized by Medicare, less depreciation allowed, to the owner of record as of the date of enactment, or to the first owner of record of the asset in the case of an asset not in existence as of the date of enactment.

Table D-6 shows the average capital payments per case received by PPS hospitals in each year since the implementation of PPS for inpatient operating costs in 1984. The decrease in average capital payments per case in 1988 reflects the provision in the Omnibus Budget Reconciliation Acts of 1986 and 1987 that reduced Medicare payments below costs. The decrease in 1994 reflects the provision in the Omnibus Budget Reconciliation Act of 1993 that corrected for previous errors in setting the base capital payment rates. Capital payments generally have stayed between 8 and 9 percent of total inpatient payments. The proportion of capital costs covered by those payments fell from 100 percent under cost-based reimbursement to a low of 87.4 percent in 1990. The implementation of capital PPS initially resulted in increased payment-to-cost ratios, but those fell as the payment rates were adjusted to reflect more accurate data. The jump in the payment-to-cost ratio in 1995—when Medicare inpatient capital payments exceeded cost for the first time ever—reflects the elimination of the budget neutrality requirement in fiscal year 1996.

The per case capital payment amount varies widely by hospital group, as shown in table D-7. Urban hospitals had an average payment rate of \$682 in 1995, for example, while rural hospitals received only \$422 per case. Major teaching hospitals were paid \$922 for each case, while nonteaching hospitals got \$545. However, the share of total PPS inpatient payments, which include both operating and capital payments, was very similar for different types of hospitals. Moreover, the share of capital costs covered by these payments frequently was higher for groups with lower payment

amounts. Despite urban hospitals' much higher average payment, that amount equalled 101.5 percent of their capital costs, while rural hospitals were paid 102.3 percent of their capital costs.

TABLE D-6.—PPS CAPITAL PAYMENTS PER CASE, SHARE OF TOTAL PPS INPATIENT PAYMENTS, AND RATIO OF PAYMENTS TO COSTS, 1984-95

Year	Capital pay- ments per case	In percent	
		Share of total PPS inpatient payments	Payment-to-cost ratio
1984	\$310	8.1	100.0
1985	371	8.6	100.0
1986	409	9.1	99.3
1987	426	9.0	97.5
1988	423	8.5	90.2
1989	463	8.6	87.9
1990	476	8.3	87.4
1991	510	8.4	87.6
1992	586	9.1	97.2
1993	589	8.9	95.2
1994	585	8.5	92.7
1995	628	8.8	101.6

Note.—Data on PPS capital costs and payments are for hospital accounting years beginning during each Federal fiscal year. Hospitals in Massachusetts and New York excluded from data in 1984 and 1985; hospitals in New Jersey excluded from data in 1984 through 1988; hospitals in Maryland excluded from data in all years.

Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

TABLE D-7.—PROSPECTIVE PAYMENT SYSTEM CAPITAL PAYMENTS PER CASE, SHARE OF TOTAL PPS INPATIENT PAYMENTS, AND RATIO OF PAYMENTS TO COSTS BY HOSPITAL GROUP, 1995

Hospital group	Capital payments per case	In percent	
		Share of total PPS inpatient payments	Payment-to-cost ratio
Urban	\$682	8.8	101.5
Rural	422	8.9	102.3
Large urban	722	8.7	102.3
Other urban	631	9.0	100.3
Rural referral	517	9.2	96.5
Sole community	415	8.7	106.3
Other rural	392	8.9	103.5
Major teaching	922	7.9	105.8
Other teaching	668	8.7	100.6
Nonteaching	545	9.3	100.9
Disproportionate share large urban	768	8.3	104.1
Disproportionate share other urban	646	8.7	100.6
Disproportionate share rural	431	9.0	98.6
Nondisproportionate share	572	9.2	100.8
Teaching and disproportionate share ..	767	8.2	103.3
Teaching only	683	8.7	100.4
Disproportionate share only	575	9.1	100.7
Nonteaching nondisproportionate share ..	523	9.5	101.1
Voluntary	640	8.8	101.3
Proprietary	665	9.8	102.2
Urban government	664	8.0	103.4
Rural government	369	8.4	104.3
All hospitals	\$628	8.8	101.6

Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

PAYMENTS ON A REASONABLE COST BASIS

Costs for certain items are excluded from the prospective payment system and thus are not included in the prospective payment rates. As explained in the sections below, Medicare pays for its share of several costs according to the former reasonable cost-based system.

PHYSICIANS IN TEACHING HOSPITALS

Physician services in hospitals are paid under the physician fee schedule. If a teaching hospital so elects, the direct medical and surgical services of physicians in such hospitals would be paid for on the basis of reasonable costs.

ORGAN ACQUISITION COSTS

The estimated net expenses associated with Medicare organ acquisition in certified transplantation centers are excluded from the prospective payment system and paid on a reasonable cost basis.

PASSTHROUGH PAYMENTS FOR HEMOPHILIA INPATIENTS

OBRA 1989 excluded the cost of administering blood clotting factors for hemophilia inpatients from PPS, for items furnished from June 19, 1990, through December 19, 1991. OBRA 1993 further extended this provision through fiscal year 1994. The price per unit for the blood clotting factors was set at a predetermined rate, in consultation with ProPAC, and the cost of administering the blood clotting factors was determined by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual. The Balanced Budget Act of 1997 makes the payment for the costs of administering blood clotting factor permanent effective October 1, 1997.

BAD DEBTS OF MEDICARE BENEFICIARIES

An additional payment is made to hospitals for bad debts attributable to unpaid deductible and copayment amounts related to covered services received by Medicare beneficiaries.

The Secretary is prohibited from making any change in the policy in effect on August 1, 1987, including changes in hospital documentation requirements. OBRA 1989 prohibited the Secretary from requiring hospitals to change their bad debt collection policy if a fiscal intermediary accepted the policy in accordance with the rules in effect as of August 1, 1987, for indigency determination procedures, for recordkeeping, and for determining whether to refer a claim to an external collection agency. For such facilities, the Secretary also may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy. The Balanced Budget Act of 1997 reduces bad debt payments by 25 percent in fiscal year 1998; 40 percent in fiscal year 1999; and 45 percent in fiscal year 2000 and each subsequent fiscal year.

SPECIAL TREATMENT OF CERTAIN FACILITIES UNDER PPS

SOLE COMMUNITY HOSPITALS

Sole community hospitals (SCHs) are hospitals that, because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area, or are located more than 35 road miles from another hospital. In addition, the Secretary is authorized to designate a hospital as an SCH if, by reason of factors such as travel time to the nearest alternative source of appropriate inpatient care, location, weather conditions, travel conditions, or absence of other like hospitals, the Secretary determines that it is the sole source of inpatient hospital services reasonably available to individuals in a geographic area.

OBRA 1989 established new payment provisions that apply to all SCHs for cost reporting periods beginning after April 1, 1990. An SCH may receive the higher of the following rates as the basis of reimbursement: a target amount based on 100 percent hospital-specific prospective rates based on fiscal year 1982 costs updated to the present; a target amount based on hospital-specific prospective rates based on fiscal year 1987 costs updated to the present; or the Federal PPS rate. Current SCHs not meeting the criteria are allowed to continue to qualify for payments as an SCH.

OBRA 1989 made permanent the provision by which an SCH may request additional payments if the hospital experiences a decrease of more than 5 percent in its total inpatient cases due to circumstances beyond its control. An SCH may receive such payments if it meets sole community hospital criteria but is not being paid as a sole community hospital. As of September 1997, 641 hospitals were classified as sole community providers.

MEDICARE DEPENDENT HOSPITALS

OBRA 1989 created a new classification of hospitals termed Medicare dependent hospitals. Medicare dependent hospitals are hospitals that are located in a rural area, have 100 beds or less, are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in the hospital cost reporting period that began during fiscal year 1987 were attributable to Medicare. These hospitals are reimbursed in the same fashion as sole community providers during cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. As of September 1997, there were 366 Medicare dependent hospitals. OBRA 1993 (Public Law 103-66) extended additional payments to Medicare dependent hospitals through September 30, 1994, on a phase-down basis. The Balanced Budget Act of 1997 extends the MDH Program through October 1, 2001.

REFERRAL CENTERS

The Secretary is authorized to provide exceptions and adjustments as appropriate for rural referral centers (RRCs). These centers are defined as:

1. Rural hospitals having 275 or more beds;
2. Hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries are furnished to those who live 25 miles or more from the hospital; or
3. Rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:
 - A case-mix index equal to or greater than the median case mix for all urban hospitals (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs. The case-mix index is a measure of the relative costli-

ness of the hospital's mixture of cases among the DRGs compared to the national average mixture of Medicare cases;

- A minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and
- At least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Referral centers are paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index. The applicable amount is the "other urban" rate (i.e., the rate for urban areas with 1 million or fewer people) for all referral centers except those (if any) located in MSAs greater than 1 million.

OBRA 1993 extended the classification through fiscal year 1994 for those referral centers classified as of September 30, 1992. As of September 1997, 158 hospitals were qualified as referral centers.

Although referral centers lose some of the benefit of their classification status because of the equalization of the other urban and rural payment rates in fiscal year 1995, referral centers continue to be entitled to preferential consideration before the Medicare Geographic Classification Review Board (see below).

The Balanced Budget Act of 1997 provides that hospitals designated as RRCs since fiscal year 1991 are permanently classified as RRCs. The Balanced Budget Act of 1997 also provides that any hospital ever classified as an RRC cannot be denied a request for geographic reclassification on the basis of any comparison of its average hourly wage with the average hourly wage of hospitals in the area where the RRC is located.

HOSPITALS IN RURAL COUNTIES TREATED AS URBAN COUNTIES

Public Law 100-203 provided for the reclassification of rural hospitals as urban if the county in which the hospital was located was adjacent to two or more MSAs and met criteria regarding commuting patterns of its residents to the central counties of the adjacent MSAs.

OBRA 1989 (Public Law 101-239) established the Medicare Geographic Classification Review Board to consider appeals by hospitals for a change in classification from rural to urban, or from one urban area to another urban area. The Board was created to determine whether a hospital should be redesignated to an area with which it has close proximity for purposes of using the other area's standardized amount, wage index, or both. For geographic reclassifications effective for discharges in fiscal year 1994 and subsequent years, a hospital may seek reclassification to only one area. Urban hospitals must be no more than 15 miles from the area to which they seek reassignment, and rural hospitals must be no more than 35 miles from such an area.

A hospital may qualify for the payment rate of another area if it proves that its incurred costs are comparable to those of hospitals in that area. To use an area's wage index, a hospital must demonstrate that: (1) its average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation; and (2) its average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wage of hospitals in the area to which it seeks redesignation. For geographic reclassifications effective for discharges in fiscal year 1994 and subsequent years, the wage index guidelines were revised to specify, in addition, that a hospital cannot be reclassified unless its average hourly wage is at least 108 percent of the average hourly wage of the area in which it is located.

Effective for fiscal year 1996 and subsequent years, a hospital may not be reclassified for purposes of using another area's standardized amount if the area to which the hospital seeks reclassification does not have a higher standardized amount than that currently received by the hospital. In addition, a hospital that seeks reclassification for the purpose of using another area's wage index may apply for reclassification only to an area that has a higher pre-reclassified average hourly wage than that of the hospital's original geographic area.

For fiscal year 1998, 313 rural hospitals (14.1 percent) and 109 (4 percent) urban hospitals have been reclassified by the Board. The Balanced Budget Act of 1997 provides that hospitals can request geographic reclassification for the purposes of receiving additional DSH payments for the period ending 30 months after enactment.

HOSPITALS EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM

PPS-EXEMPT HOSPITALS

The following hospitals are by law excluded from the prospective payment system and are paid on the basis of reasonable costs, subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase limits: psychiatric hospitals, rehabilitation hospitals, psychiatric or rehabilitation units which are distinct parts of a hospital, alcohol and drug abuse hospitals and such distinct units of hospitals (for cost reporting periods beginning before October 1, 1987), children's hospitals (with patients averaging under 18 years of age), long-term hospitals (with an average inpatient length of stay greater than 25 days), and cancer hospitals (hospitals extensively involved in treatment for and research on cancer) classified as such before December 31, 1990. In addition, the act provides an exemption for any hospital classified as a cancer hospital before December 31, 1991, that is located in a State that has a PPS waiver under section 1814(b). In addition, there are special cases in which the prospective payment system is not applied, such as emergency services provided to Medicare beneficiaries in hospitals not participating in Medicare.

OBRA 1990 increased the cost limits imposed on hospitals exempt from PPS. Under prior law, hospitals with costs in excess of the cost limits imposed by the Tax Equity and Fiscal Responsibility

Act (TEFRA) would be reimbursed for their cost up to the TEFRA limit. Under OBRA 1990, hospitals with costs in excess of the cost limits imposed by TEFRA receive 50 percent of the costs that are in excess of the limit, up to a maximum of 110 percent of the limit. In addition, the Secretary is directed to develop a new prospective payment methodology for exempt hospitals, or to substantially modify the current target-rate system.

OBRA 1993 provided for an update factor to the cost limits of market basket minus 1.0 percentage point for fiscal years 1994 through 1997. Hospitals with operating costs in fiscal year 1990 that exceeded the target amount by more than 10 percent are exempt from the update reduction, with partial reductions applied to hospitals near the threshold. Hospitals reimbursed under approved State cost control systems are also excluded from the prospective rates.

For PPS-exempt facilities, the Balanced Budget Act of 1997 sets the fiscal year 1998 update at 0 percent, and for fiscal years 1999–2002, the update factor will vary depending on a hospital's target amount and costs. For hospitals (1) with costs that equal or exceed their target amounts by 10 percent or more, the update will be equal to the market basket; (2) that exceed their target, but by less than 10 percent, the update factor will be equal to zero or, if greater, the market basket minus 0.25 percentage points for each percentage point by which costs are less than 10 percent over the target; (3) that are either at their target, or below (but not below $\frac{2}{3}$ of the target amount for the hospital), the update factor will be equal to zero or, if greater, the market basket percentage minus 2.5 percentage points; or (4) that do not exceed $\frac{2}{3}$ of their target amount, the update factor will be equal to 0 percent.

In addition, the Balanced Budget Act of 1997 includes several provisions affecting Medicare payments to PPS-exempt hospitals and units. The Balanced Budget Act of 1997 reduces the capital payment update amount for PPS-exempt hospitals and units by 15 percent for fiscal years 1998–2002. The Balanced Budget Act of 1997 establishes a cap on PPS-exempt TEFRA limits, also known as target amounts, for PPS-exempt hospitals or units for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002. The Secretary is required to estimate the 75th percentile of the target amounts for hospitals for cost reporting periods ending during fiscal year 1996, and then update the amount up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase. For cost reporting periods beginning during each of fiscal years 1999–2002, the Secretary is required to update the amount by a factor equal to the market basket increase.

The Balanced Budget Act of 1997 provides for changing bonus payments to PPS-exempt facilities to equal the lesser of: (1) 15 percent of the amount by which the target amount exceeds the amount of operating costs, or (2) 2 percent of the target amount. In addition, for cost reporting periods beginning on or after October 1, 1997, the Balanced Budget Act of 1997 provides for continuous improvement bonus payments for certain eligible hospitals. The Balanced Budget Act of 1997 establishes different payment and target amount rules for new PPS-exempt hospitals or distinct-part units

within hospitals that first received Medicare payments on or after October 1, 1997. The Balanced Budget Act of 1997 provides PPS-exempt hospitals and distinct units of hospitals that received Medicare payments for services furnished before January 1, 1990, with the option of rebasing the hospital's target amount for the 12-month cost reporting period beginning during fiscal year 1998.

The Balanced Budget Act of 1997 also requires the Secretary to establish a case-mix adjusted PPS for rehabilitation hospitals and distinct-part units, effective beginning in fiscal year 2001. The Secretary is required to establish: (1) classes of discharges of rehabilitation facilities by patient case-mix groups based on impairment, age, related prior hospitalization, comorbidities, and functional capability of the discharged individual and other appropriate factors; and (2) a method of classifying specific discharges from rehabilitation facilities within these groups. The Secretary is further required to collect data to develop, establish, administer, and evaluate a case-mix adjusted prospective payment system for long-term care hospitals.

STATE SYSTEMS

Section 1886(c) of the Social Security Act (as added by TEFRA) gave the HHS Secretary discretion to reimburse hospitals in a State according to the State's hospital reimbursement control system rather than according to Medicare's reimbursement methods if the State requests this change and if HHS determines that the State system meets certain requirements. Currently, only Maryland has a waiver to operate its own system. New York has a waiver covering four counties participating in the Finger Lakes Area Hospital Corporation rural hospital payment demonstration.

Public Laws 98-21 and 98-369 added several more requirements for State systems. According to final regulations published by HHS on April 24, 1986 (51 F.R. 15481) implementing these legislative changes, HHS has the discretion to allow Medicare hospital reimbursement to be made in accordance with a State reimbursement control system if the chief executive officer of the State requests approval of the State system, and provided that the State system:

1. Applies to substantially all non-Federal acute care hospitals in the State;
2. Applies to at least 75 percent of all inpatient revenues or expenses for the State;
3. Provides assurances that payers, hospital employees and patients in the State will be treated equitably under its system;
4. Provides assurances that its system will not result in greater Medicare expenditures over 36-month periods;
5. Does not preclude health maintenance organizations (HMOs) or competitive medical plans (CMPs) from negotiating directly with hospitals concerning payment for inpatient services;
6. Limits hospital charges to Medicare beneficiaries to deductibles, coinsurance, and services for which the beneficiary would not be entitled to have payment made under Medicare part A; and prohibits payment under part B of Medicare for nonphysician services provided to hospital inpatients unless this prohibition is waived.

Public Law 101-239 (OBRA 1989) required the Secretary's test of effectiveness of a State cost containment system to be based on the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available. This provision also extended the waiver for the New York rural hospital payment demonstration.

Special provisions apply to States that have existing demonstration projects approved by HCFA under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendment of 1972 for the operation of State reimbursement control systems. HHS approval of a State's application to continue the operation of a system upon expiration of the demonstration project is mandatory if, and for so long as, the system meets the minimum requirements described in the six items listed above.

Public Law 101-508 revised the Secretary's test of effectiveness of a State cost containment system to be based on the rate of increase in costs per hospital inpatient admission as compared to the rate of increase in such costs with respect to all hospitals between January 1, 1981, and the present. In addition, OBRA 1990 provided that a State no longer qualifying for a PPS waiver be provided with a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system, and required restoration of the waiver if the State returned to compliance during the transition period.

ADMINISTRATION

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION/MEDICARE PAYMENT ADVISORY COMMISSION

The Prospective Payment Assessment Commission (ProPAC) was a commission composed of 17 independent experts charged with advising the Congress on PPS and Medicare payment policies. The Balanced Budget Act of 1997 replaces ProPAC and the Physician Payment Review Commission with a 15-member Medicare Payment Advisory Commission (MedPAC). MedPAC is required to submit annual reports to Congress on March 1 and June 1 concerning the Medicare Program.

ADMINISTRATIVE AND JUDICIAL REVIEW

Administrative and judicial appeals are allowed under procedures and authorities already established under the Medicare Program. However, the law precludes administrative and judicial review of: (1) the "budget neutrality" adjustment (see above), and (2) the DRG payment amounts, including the establishment of DRGs, the methodology for classifying discharges within DRGs, and the DRG weighting factors.

REVIEW ACTIVITIES

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (known as TEFRA), replaced the existing Professional Standards Review Organization (PSRO) Program with the Utilization and Quality Control Peer Review Program. The Secretary of the Department of Health and Human Services was required to

enter into performance-based contracts with physician-sponsored or physician-access organizations known as peer review organizations (PROs). As a condition of receiving payments under the prospective payment system, hospitals are required to enter into an agreement with a PRO under which the PRO reviews the validity of diagnostic and procedural information provided by the hospitals; the completeness, adequacy and quality of care provided; and the appropriateness of admissions patterns, discharges, lengths of stay, transfers, and services furnished in outlier cases.

Since 1982, the statute governing the PRO Program has been amended numerous times, and as of October 1996 the PROs are operating under the fifth "scope of work."

HISTORICAL TRENDS IN PPS PAYMENTS, COSTS, AND MARGINS

MEDICARE PAYMENTS TO HOSPITALS

In fiscal year 1997, hospitals will be paid an estimated \$124.7 billion for Medicare-covered services, as shown in table D-8. The largest share of this amount, \$78.9 billion, will be for PPS inpatient operating costs. The Medicare Program will provide about 90 percent of these payments and the other 10 percent will come from beneficiaries for deductibles and coinsurance. PPS hospitals will also receive some \$8.0 billion in capital payments. Another \$13.2 billion will be paid for operating and capital costs related to services provided in PPS-excluded facilities, which include psychiatric and rehabilitation hospitals and distinct-part units as well as long-term and children's hospitals. Payments for Medicare-covered hospital outpatient services will be \$20.9 billion, with almost 40 percent coming from beneficiaries. Hospitals will also receive \$2.5 billion for the direct costs of training programs, including those for interns and residents and for nursing and allied health personnel. Hospital-based postacute care facilities will be paid an estimated \$9.2 billion.

POLICY CHANGES AND PPS OPERATING PAYMENTS

Since the implementation of PPS, the distribution of Medicare payments to hospitals has changed. Some redistribution has resulted from changes in hospital behavior, but much of it is attributable to policy decisions. These include the transition to national average payment rates, reductions in teaching hospital payments, the addition of a disproportionate share adjustment and increases in the size of that adjustment for many hospitals, and larger update factors for rural hospitals in recent years.

Table D-9 shows the factors affecting the PPS payment rate for different types of hospitals. The average standardized amount is somewhat higher for hospitals in large urban areas than other hospitals; the first column of data in this table shows the variation in payments if hospitals were paid only based on the standardized amount for the area in which they are located. The wage index reflects the average hourly wage for hospitals located there; if hospitals' payments were adjusted by the wage index for the area in

which they were located, their payments would be adjusted as indicated in the second column of the table.

TABLE D-8.—TOTAL MEDICARE PAYMENTS TO HOSPITALS BY PAYMENT TYPE, FISCAL YEAR 1997

Payment category	Amount (in billions)
PPS	\$78.9
Program	72.0
Operating	64.0
Capital	8.0
Beneficiary copayments	6.9
PPS-excluded	13.2
Program	12.0
Operating	11.2
Capital	0.8
Beneficiary copayments	1.2
Outpatient	20.9
Program	12.6
Beneficiary copayments	8.3
Postacute ¹	9.2
Program ¹	9.0
Beneficiary copayments ¹	0.2
Direct medical education	2.5
Interns and residents	2.2
Nursing and allied health	0.3
Total	124.7

¹ Estimate based on Prospective Payment Assessment Commission analysis of data from the Health Care Financing Administration and the Congressional Budget Office.

Source: Prospective Payment Assessment Commission analysis of Congressional Budget Office March 1997 estimates.

Certain hospitals receive other adjustments to their base payment rates under PPS. Hospitals in Alaska and Hawaii have a cost-of-living adjustment to recognize the higher cost of nonlabor input there. In addition, sole community hospitals have the option of payments based on their own updated base-year costs or the PPS rate. Hospitals also can be reclassified into areas where they are not located for the purpose of qualifying for a higher standardized payment amount or wage index. These factors may substantially increase payments to some hospitals, although by definition they have no impact on total PPS payments.

PPS payments also depend on the mix of cases treated by the hospital; this can vary widely across hospitals and groups of hospitals. Moreover, additional payments are made for cases that are exceptionally costly relative to others in the same category; these cases and these payments are not distributed evenly across hospitals. Finally, the PPS payment is adjusted for teaching hospitals and hospitals that treat a disproportionate share of low-income patients; these two adjustments substantially affect the distribution of payments.

TABLE D-9.—FACTORS AFFECTING FISCAL YEAR 1997 PPS OPERATING PAYMENTS PER CASE, BY HOSPITAL GROUP, FISCAL YEAR 1995

Hospital group	Average standard- ized amount (in dollars)	Average wage index	Other payment rate fac- tors	Base pay- ment rate (in dollars)	Average case-mix index	Outlier factor	IME/DSH factor	PPS pay- ments per case (in dollars)
Urban	\$3,882	1.02	1.00	\$3,935	1.50	1.06	1.17	\$7,281
Rural	3,847	0.79	1.04	3,416	1.21	1.03	1.02	4,392
Large urban	3,908	1.09	1.00	4,137	1.50	1.06	1.19	7,836
Other urban	3,847	0.93	1.00	3,671	1.50	1.06	1.13	6,550
Rural referral	3,847	0.79	1.07	3,510	1.37	1.03	1.04	5,261
Sole community	3,847	0.80	1.09	3,631	1.16	1.01	1.02	4,476
Other rural	3,847	0.78	1.01	3,294	1.18	1.03	1.02	4,081
Major teaching	3,895	1.12	1.00	4,208	1.66	1.07	1.49	11,083
Other teaching	3,879	1.00	1.00	3,880	1.55	1.06	1.14	7,225
Nonteaching	3,868	0.93	1.01	3,746	1.33	1.04	1.05	5,474
DSH:								
Large urban	3,908	1.10	1.00	4,168	1.52	1.06	1.31	8,747
Other urban	3,847	0.92	1.00	3,645	1.52	1.06	1.18	6,919
Rural	3,847	0.76	1.03	3,324	1.21	1.03	1.07	4,504
Non-DSH	3,874	0.96	1.01	3,833	1.39	1.05	1.04	5,810
Teaching and DSH	3,883	1.03	1.00	3,963	1.59	1.06	1.32	8,817
Teaching only	3,885	1.04	1.01	4,004	1.56	1.06	1.10	7,283
DSH only	3,867	0.94	1.00	3,719	1.37	1.05	1.11	5,960
No teaching or DSH	3,869	0.93	1.01	3,741	1.31	1.04	1.00	5,125
Urban <100 beds	3,877	1.00	0.99	3,861	1.21	1.04	1.01	4,915
Urban 100-199 beds	3,881	1.03	1.00	3,938	1.36	1.04	1.11	6,198
Urban 200-299 beds	3,880	1.02	1.00	3,931	1.47	1.05	1.11	6,752
Urban 300-399 beds	3,880	1.01	1.00	3,902	1.55	1.06	1.16	7,451
Urban 400-499 beds	3,884	1.02	1.00	3,945	1.59	1.06	1.23	8,210
Urban 500+ beds	3,887	1.04	1.00	3,994	1.70	1.07	1.30	9,438

TABLE D-9.—FACTORS AFFECTING FISCAL YEAR 1997 PPS OPERATING PAYMENTS PER CASE, BY HOSPITAL GROUP, FISCAL YEAR 1995—Continued

Hospital group	Average standard- ized amount (in dollars)	Average wage index	Other payment rate fac- tors	Base pay- ment rate (in dollars)	Average case-mix index	Outlier factor	IME/DSH factor	PPS pay- ments per case (in dollars)
Rural <50 beds	3,847	0.79	1.01	3,304	1.06	1.01	1.01	3,605
Rural 50–99 beds	3,847	0.79	1.03	3,383	1.16	1.02	1.01	4,079
Rural 100–149 beds	3,847	0.79	1.05	3,437	1.26	1.03	1.02	4,581
Rural 150–199 beds	3,847	0.79	1.05	3,433	1.27	1.04	1.03	4,712
Rural 200+ beds	3,847	0.78	1.08	3,528	1.39	1.04	1.06	5,511
New England	3,887	1.14	1.00	4,299	1.42	1.04	1.17	7,439
Middle Atlantic	3,888	1.10	1.00	4,197	1.42	1.07	1.21	7,704
South Atlantic	3,868	0.91	1.01	3,654	1.46	1.05	1.13	6,342
East North Central	3,876	0.96	1.01	3,813	1.43	1.05	1.13	6,479
East South Central	3,855	0.81	1.01	3,377	1.38	1.06	1.11	5,490
West North Central	3,865	0.86	1.02	3,568	1.44	1.04	1.10	5,901
West South Central	3,867	0.85	1.01	3,494	1.45	1.06	1.13	6,080
Mountain	3,873	0.94	1.02	3,795	1.48	1.04	1.09	6,400
Pacific	3,887	1.20	1.00	4,453	1.49	1.04	1.16	8,063
Voluntary	3,877	1.00	1.01	3,905	1.46	1.05	1.14	6,852
Proprietary	3,875	0.95	1.01	3,770	1.44	1.05	1.09	6,254
Urban government	3,874	0.99	1.00	3,837	1.48	1.06	1.32	7,995
Rural government	3,847	0.77	1.02	3,306	1.15	1.03	1.02	4,030
All hospitals	3,875	0.98	1.01	3,856	1.44	1.05	1.15	6,709

Note.—PPS payments are estimated using rules in effect on October 1, 1996. Excludes hospitals in Maryland. Averages are weighted by the number of Medicare cases in each hospital. The other factors category is the combined effect of cost-of-living adjustments for hospitals in Alaska and Hawaii, geographic reclassification, and payment adjustments for sole community hospitals. IME = indirect medical education. DSH = disproportionate share.

Source: ProfPAC PPS payment model and MedPAR data for fiscal year 1995 from the Health Care Financing Administration.

DISTRIBUTION OF PPS HOSPITALS, CASES, AND OPERATING
PAYMENTS

Table D-10 shows estimated PPS operating payments by hospital group for fiscal year 1997. The distribution of payments varies widely across hospital groups. For example, although 56 percent of all PPS hospitals are located in urban areas, these hospitals account for 80 percent of all PPS discharges and receive 87 percent of all PPS operating payments. By contrast, rural hospitals account for 44 percent of PPS hospitals, but only 20 percent of PPS discharges and 13 percent of PPS operating payments.

The indirect medical education (IME) adjustment is intended to recognize hospitals' indirect costs of operating approved graduate medical education programs. The disproportionate share (DSH) adjustment is intended to compensate hospitals that treat large proportions of low-income patients. These two adjustments account for \$9.1 billion in 1997. Almost all of these payments go to hospitals located in urban areas.

Outlier payments are intended to protect hospitals from the risk of financial losses due to cases with exceptionally long stays or high costs. Large urban hospitals and teaching hospitals and those located in the Middle Atlantic region receive the highest proportion of outlier payments. Small urban hospitals and all rural hospitals receive the lowest percentage of outlier payments.

For all PPS hospitals, the basic DRG payment is estimated to account for 83 percent of fiscal year 1997 PPS operating payments. IME, DSH, and outlier payments are expected to account for 17 percent of the total, or about \$12.2 billion. Rural hospitals receive only 5 percent of their total PPS operating payments through these provisions, while urban hospitals count on these mechanisms for 19 percent of their PPS operating payments. This is because teaching and disproportionate share hospitals are much more likely to be located in cities and urban hospitals are much more likely to treat more complex cases that become outliers.

TRENDS IN PPS OPERATING PAYMENTS AND COSTS

The increase in PPS operating payments per case has differed from the update factor in every year, as shown in table D-11. In the first 2 years of prospective payment, payments per discharge rose sharply, by 18.5 percent and 10.5 percent, respectively. This is attributable to two factors: overestimation of the base year hospital costs upon which the initial PPS rates were set due to the use of unaudited Medicare Cost Reports, and a large increase in the aggregate CMI in the early years because of more emphasis on accurate DRG coding and complete documentation of the medical record.

TABLE D-10.—DISTRIBUTION OF PPS HOSPITALS AND DISCHARGES AND ESTIMATED FISCAL YEAR 1997 PPS OPERATING PAYMENTS BY HOSPITAL GROUP

Hospital group	Number of PPS hospitals	Percent of PPS discharges	Percent of PPS operating payments	PPS operating payments (in billions of dollars)			
				Total	Outlier	Indirect medical education	Disproportionate share hospitals
Urban	2,832	80	87	\$61.7	\$2.8	\$4.5	\$4.3
Rural	2,243	20	13	9.2	0.2	0.1	0.2
Large urban	1,567	46	53	37.7	1.7	3.3	2.8
Other urban	1,265	35	34	24.0	1.1	1.1	1.5
Rural referral	130	4	3	2.1	0.1	0.0	(1)
Sole community	648	4	3	2.0	(1)	(1)	(1)
Other rural	1,465	12	7	5.1	0.1	(1)	0.1
Major teaching	263	12	20	14.1	0.6	3.1	1.5
Other teaching	811	32	34	24.3	1.1	1.5	1.5
Nonteaching	4,001	56	46	32.5	1.3	0.0	1.5
Disproportionate share large urban	786	25	32	22.8	0.9	2.5	2.8
Disproportionate share other urban	679	22	23	16.2	0.8	0.9	1.5
Disproportionate share rural	448	5	4	2.6	0.1	(1)	0.2
Nondisproportionate share	3,162	48	41	29.4	1.3	1.1	0.0
Teaching and disproportionate share	701	29	38	26.8	1.1	3.5	3.0
Teaching only	373	15	16	11.7	0.6	1.1	0.0
Disproportionate share only	1,212	23	21	14.8	0.6	0.0	1.5
Nonteaching nondisproportionate share	2,789	33	25	17.7	0.7	0.0	0.0
Urban <100 beds	700	4	3	2.3	0.1	(1)	(1)
Urban 100–199 beds	925	18	16	11.5	0.4	0.2	0.9
Urban 200–299 beds	567	20	20	14.5	0.6	0.6	0.9
Urban 300–399 beds	316	15	17	12.0	0.6	0.8	0.8
Urban 400–499 beds	157	9	11	7.7	0.4	0.8	0.6
Urban 500+ beds	167	14	19	13.6	0.7	2.0	1.1

Rural <50 beds	1,175	4	2	1.5	(¹)	(¹)	(¹)
Rural 50–99 beds	656	6	4	2.6	0.1	(¹)	(¹)
Rural 100–149 beds	240	4	3	2.1	0.1	(¹)	(¹)
Rural 150–199 beds	97	3	2	1.3	(¹)	(¹)	(¹)
Rural 200+ beds	75	3	2	1.7	0.1	(¹)	(¹)
New England	213	6	6	4.4	0.1	0.5	0.1
Middle Atlantic	519	17	20	13.9	0.7	1.4	1.0
South Atlantic	719	18	17	12.0	0.5	0.5	0.8
East North Central	796	18	17	12.2	0.5	0.9	0.5
East South Central	441	8	7	4.9	0.2	0.1	0.3
West North Central	704	8	7	4.9	0.2	0.3	0.1
West South Central	726	11	10	6.8	0.3	0.2	0.6
Mountain	338	4	4	2.9	0.1	0.1	0.1
Pacific	619	10	13	8.9	0.3	0.4	0.9
Voluntary	2,946	74	76	53.7	2.3	3.7	2.9
Proprietary	692	11	10	7.4	0.3	0.1	0.5
Urban government	420	9	10	7.2	0.3	0.8	1.0
Rural government	966	6	4	2.6	0.1	(¹)	0.1
All hospitals	5,075	100	100	70.9	3.1	4.6	4.5

¹ Less than \$0.05 billion.

Note.—PPS payments are estimated using rules in effect as of October 1, 1996. Excludes hospitals in Maryland.

Source: Prospective Payment Assessment Commission PPS payment model, MedPAR data for fiscal year 1995 from the Health Care Financing Administration and Congressional Budget Office March 1997 estimates.

TABLE D-11.—ANNUAL CHANGE IN PPS OPERATING COSTS AND PAYMENTS, FIRST 12 YEARS OF PPS

[In percent]

Year ¹	PPS costs and payments					Update factor ³
	Operating costs	Operating payments	Operating costs per case	Operating payments per case	Market basket forecast ²	
1984	-4.6	11.1	1.8	18.5	4.9	4.7
1985	4.7	4.2	11.0	10.5	3.9	4.5
1986	5.6	-0.6	9.6	3.2	3.9	0.5
1987	7.4	3.8	9.1	5.4	3.5	1.2
1988	9.8	6.7	9.0	6.0	4.7	1.5
1989	10.4	7.7	9.2	6.6	5.5	3.3
1990	10.7	8.2	8.9	6.5	4.6	4.7
1991	9.1	8.0	7.0	5.9	4.3	3.4
1992	6.9	7.4	4.7	5.2	3.1	3.0
1993	3.5	6.1	1.2	3.8	3.0	2.7
1994	0.4	5.2	-1.1	3.6	2.4	2.0
1995	0.1	5.2	-1.1	4.0	3.0	2.0

¹ Data on PPS operating costs and payments are for hospital accounting years beginning during each Federal fiscal year. Data on the market basket and update factor are for the corresponding Federal fiscal year.

² As of September 1 of the previous year.

³ Update factor for 1990 adjusted for 1.22 percent across-the-board reduction in diagnosis-related group weights.

Note.—Changes based on cohorts of hospitals with Medicare Cost Reports in two consecutive years. Hospitals in Massachusetts and New York excluded from data in 1984 and 1985; hospitals in New Jersey excluded from data in 1984 through 1988; hospitals in Maryland excluded from data in all years.

Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

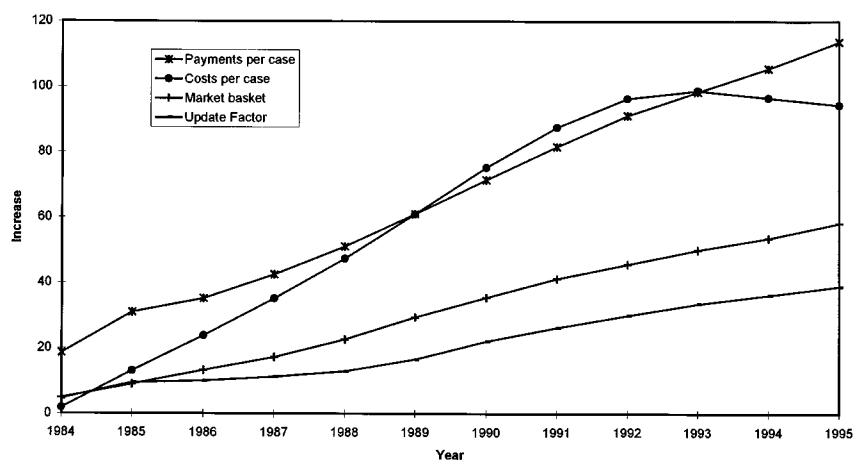
After an increase of 3.2 percent in 1986, payments per case grew at an annual rate of 5.9 percent from 1987 through 1992, as a result of large increases in both the PPS market basket index and the aggregate Medicare case-mix index. From 1993 through 1995, the PPS update was lower, resulting in the smallest 3-year increase in payments per case since the beginning of PPS. Despite this better control over payment rates in recent years, chart D-1 indicates that the increase in operating payments per case during the first 12 years of PPS is almost three times as great as the cumulative value of the annual update factor.

Following an increase of only 1.8 percent in the first year of PPS, PPS operating costs per discharge rose by about 11 percent in the second year, and about 9 percent from 1986 through 1990. However, the 7.0-percent growth in operating costs per case in 1991 was the smallest since the first year of PPS, and the rise of 1.2 percent in 1993 was below general inflation. Costs per case actually decreased in 1994 and 1995.

Cost growth experience has not been uniform across hospitals, as shown in table D-12. Through 1990, urban and rural hospitals had about the same rate of increase. In the first year, both groups reacted to prospective payment by holding their cost growth far below

the rates prevailing before PPS, while annual cost increases in the following 6 years were much higher for both groups. From 1991 through 1995, however, urban hospitals held their cost growth to 1.9 percent annually, while rural hospital costs rose at a 3.4-percent rate.

CHART D-1. CUMULATIVE INCREASES IN PPS MARKET BASKET, UPDATE FACTOR, AND PAYMENTS AND COSTS PER CASE, FIRST 12 YEARS OF PPS (IN PERCENT)



Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

The recent low rate of cost growth among hospitals in large urban areas may reflect the fact that the most rapid changes in the health care system appear to be occurring in the largest cities. From 1991 through 1995, these hospitals' costs per discharge rose at a rate 0.9 percentage points below that for other urban hospitals and 1.9 percentage points below that for rural hospitals.

The pattern of cost increases also varies substantially by ownership. In the first year of PPS, when hospitals perceived potential pressure to control costs, proprietary facilities had by far the smallest increase of any group. Once this pressure lessened, costs increased sharply through 1990 for all groups, including the proprietaries. However, from 1991 on, proprietary hospitals reined in their costs to a far greater extent than the other groups.

TABLE D-12.—ANNUAL RATE OF CHANGE IN PPS OPERATING COSTS PER CASE BY HOSPITAL GROUP AND PERIOD, 1984-95

[In percent]

Hospital group	Period		
	1984	1985-90	1991-95
Urban	1.6	9.4	1.9
Rural	1.5	9.2	3.4
Large urban	0.6	9.2	1.5
Other urban	3.2	9.8	2.4
Rural referral	1.5	9.7	3.4
Sole community	1.3	8.6	3.6
Other rural	1.4	9.2	3.3
Major teaching	1.3	9.1	1.7
Other teaching	1.3	9.4	2.2
Nonteaching	1.9	9.5	2.0
Disproportionate share large urban	0.0	9.0	1.4
Disproportionate share other urban	3.2	9.7	2.6
Disproportionate share rural	0.3	9.7	3.4
Nondisproportionate share	2.4	9.6	2.2
Teaching and disproportionate share	0.7	9.2	2.0
Teaching only	2.6	9.7	2.4
Disproportionate share only	1.8	9.5	1.8
Nonteaching nondisproportionate share	2.0	9.4	2.1
Voluntary	1.8	9.3	2.2
Proprietary	0.7	10.0	0.3
Urban government	2.4	9.6	2.1
Rural government	1.5	9.3	3.9
All hospitals	1.8	9.5	2.1

Note.—Data on PPS operating costs and payments are for hospital accounting years beginning during each Federal fiscal year. Changes based on cohorts of hospitals with Medicare Cost Reports in two consecutive years. Hospitals in Massachusetts and New York excluded from data in 1984 and 1985; hospitals in New Jersey excluded from data in 1984 through 1988; hospitals in Maryland excluded from data in all years.

Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

PPS INPATIENT MARGINS

The PPS inpatient margin compares combined Medicare operating and capital payments with the corresponding costs. In 1995, the aggregate PPS margin rose for the fourth consecutive year to 10.0 percent, as shown in table D-13. This contrasts with a declining trend through the first 8 years of prospective payment, during which the margin fell to a low of -2.4 percent. The turnaround is attributable to the sharp slowdown in hospital cost growth. If current trends continue, the aggregate PPS inpatient margin for 1997 would be 14.2 percent. This would be the highest PPS inpatient margin in the 14 years of prospective payment.

TABLE D-13.—PPS INPATIENT (OPERATING PLUS CAPITAL) MARGINS, BY HOSPITAL GROUP, FIRST 12 YEARS OF PPS

[In percent]

Hospital group	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Urban	14.5	13.9	9.8	6.8	3.3	0.8	-1.2	-2.2	-0.9	1.3	5.7	10.7
Rural	7.7	7.4	2.2	0.2	-1.2	-2.9	-3.7	-3.7	-1.4	-0.7	0.2	5.1
Large urban	15.0	13.9	10.0	6.8	3.1	0.7	-0.7	-1.4	0.4	2.8	7.8	12.7
Other urban	13.8	14.0	9.4	6.8	3.7	0.9	-1.9	-3.4	-2.9	-1.0	2.5	7.8
Rural referral	9.9	12.9	7.9	6.1	3.9	1.2	0.0	-0.6	2.9	2.6	2.8	6.1
Sole community	8.0	6.4	2.1	0.3	-1.2	-2.6	-1.2	-0.8	2.5	3.8	4.4	7.3
Other rural	7.0	6.0	0.3	-1.9	-3.2	-4.5	-6.0	-6.0	-4.8	-3.8	-2.5	3.7
Major teaching	18.6	19.9	15.2	12.9	10.0	7.9	7.2	7.5	9.3	10.9	16.4	20.5
Other teaching	14.9	14.5	10.5	7.2	3.9	1.4	-1.0	-2.2	-1.2	0.8	4.6	9.3
Nonteaching	11.2	10.0	5.2	2.5	-0.7	-3.3	-5.2	-6.4	-5.0	-3.0	0.4	6.0
Disproportionate share large urban	15.3	14.2	10.8	8.3	5.5	3.5	3.0	2.8	5.0	7.8	13.1	17.6
Disproportionate share other urban	13.5	14.2	10.0	7.8	5.0	2.4	0.0	-1.3	-1.0	0.9	4.5	10.0
Disproportionate share rural	8.5	8.2	2.8	0.4	-0.5	-2.1	-2.2	-1.8	0.2	0.5	2.2	7.6
Nondisproportionate share	12.6	11.9	7.0	3.6	-0.3	-2.9	-5.5	-6.7	-5.5	-4.0	-0.7	4.4
Teaching and disproportionate share	15.8	15.9	12.4	10.0	7.6	5.3	4.1	3.6	5.0	7.3	11.8	16.2
Teaching only	16.1	16.3	11.3	7.0	2.2	-0.1	-3.2	-4.0	-2.9	-1.7	2.2	7.0
Disproportionate share only	11.6	10.7	6.1	3.6	0.6	-1.6	-3.0	-3.7	-2.3	-0.1	3.9	10.0
Nonteaching nondisproportionate share	10.8	9.5	4.5	1.5	-1.8	-4.6	-6.9	-8.4	-7.2	-5.4	-2.5	2.7
Voluntary	14.0	13.7	9.6	6.5	3.1	0.7	-1.3	-2.5	-1.1	0.6	4.3	9.0
Proprietary	12.9	11.0	6.3	3.4	0.0	-3.9	-5.7	-4.4	-2.2	1.8	8.6	15.6
Urban government	13.5	14.1	9.1	7.6	4.8	3.6	2.7	1.4	2.2	4.9	9.7	14.5
Rural government	6.6	5.1	-0.6	-2.3	-2.3	-3.7	-4.0	-4.4	-2.6	-2.0	-2.6	2.5
All hospitals	13.4	13.0	8.7	5.9	2.7	0.3	-1.5	-2.4	-1.0	1.0	5.0	10.0

Note.—Data on PPS operating and capital costs and payments are for hospital accounting years beginning during each Federal fiscal year. Hospitals in Massachusetts and New York excluded from data in 1984 and 1985; hospitals in New Jersey excluded from data in 1984 through 1988; hospitals in Maryland excluded from data in all years.

Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

Table D-14 shows that, even with the high aggregate PPS inpatient margin in 1995, more than a third of all PPS hospitals have negative PPS inpatient margins. The PPS margin, however, does not represent the bottom line for the hospital industry. The total margin, which includes expenses and revenues related to Medicare and other inpatient and outpatient care as well as other facility activities, increased steadily from the early 1970s to the early 1980s, peaking in 1984. In subsequent years—as Medicare tightened its control over inpatient payment rate increases—the total margin began to fall. In the late 1980s, however, this decline leveled off at 3.3 percent, and by 1991 the total margin had risen to 4.4 percent. It remained steady through 1993, and then increased to 5.0 percent in 1994 and 5.8 percent in 1995, the highest level since 1986 and above levels experienced before PPS began.

MARGINS BY HOSPITAL TYPE

PPS inpatient margins vary by hospital group. The margin for urban hospitals was 14.5 percent in the first year—exceeding that for rural hospitals by 6.8 percentage points. Beginning in fiscal year 1986, the Congress enacted a series of policy changes designed to increase payment for rural hospitals. By 1988, although the difference between the two groups had decreased to 3.7 percentage points, rural hospitals had negative margins while urban ones were still receiving payments that exceeded their costs. The disparity narrowed to 0.5 percentage points by 1992, but has widened as urban hospitals have constrained their costs more than rural hospitals.

Major teaching hospitals consistently have had the highest aggregate inpatient margin of any hospital group. Moreover, the difference in the margins for major teaching and nonteaching hospitals has grown. For major teaching hospitals, the inpatient margin fell from 19.9 percent in the second year of PPS to a low of 7.2 percent in 1990, while the drop for other teaching and nonteaching hospitals was much sharper. By 1995, all three groups had higher margins than in the early years of the decade, with the largest increase seen in the major teaching group. Their margin was 20.5 percent—11.2 percentage points higher than for other teaching hospitals and 14.5 percentage points higher than for the nonteaching group. These differences had been 3.7 percentage points and 7.4 percentage points, respectively, in the first PPS year.

The trend in inpatient margins by ownership category also reflects changes in payment policy and degree of success in controlling costs. In the first year, voluntary, proprietary, and urban government hospitals all had inpatient margins around 13–14 percent, while rural government hospitals lagged behind. In 1990, the inpatient margin for the proprietary group, which had fallen by more than 18 percentage points since the beginning of PPS to –5.7 percent, was the lowest of the four groups. However, as these hospitals held down their cost growth, their margin increased by more than 20 percentage points, to 15.6 percent in 1995.

TABLE D-14.—DISTRIBUTION OF PPS INPATIENT (OPERATING PLUS CAPITAL) MARGINS AND PERCENT OF HOSPITALS WITH NEGATIVE MARGIN, FIRST 12 YEARS OF PPS

[In Percent]

Percentile ¹	PPS margin											
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
10th	-5.8	-8.2	-15.6	-18.5	-22.6	-24.7	-26.1	-27.3	-26.6	-23.6	-22.4	-16.8
25th	3.1	1.3	-4.2	-6.8	-9.7	-11.9	-13.6	-15.4	-14.3	-12.1	-9.9	-4.6
Median	10.3	9.2	4.5	2.6	0.6	-1.7	-3.3	-4.4	-2.7	-0.7	1.6	6.5
75th	16.2	16.0	11.8	10.4	9.4	7.9	6.6	5.9	7.7	9.5	12.2	17.1
90th	21.5	22.3	18.1	17.4	17.5	16.3	15.8	15.0	16.9	19.3	22.9	27.4
Percent with negative PPS inpatient margin	18.2	21.8	35.6	42.2	48.3	54.7	59.0	61.2	57.1	51.8	45.8	34.1

¹Table entries are the margins of hospitals at the 10th percentile, 25th percentile, median, 75th percentile, and 90th percentile.

Note.—Data on PPS operating and capital costs and payments are for hospital accounting years beginning during each Federal fiscal year. Hospitals in Massachusetts and New York excluded from data in 1984 and 1985; hospitals in New Jersey excluded from data in 1984 through 1988; hospitals in Maryland excluded from data in all years.

Source: Prospective Payment Assessment Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

TABLE D-15.—TOTAL MARGINS BY HOSPITAL GROUP, 1984-95

Hospital group	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Urban	7.7	6.9	4.5	3.7	3.6	3.5	3.5	4.3	4.2	4.4	4.9	5.7
Rural	5.0	4.7	3.0	2.9	3.3	4.2	4.7	5.1	5.3	5.1	5.5	6.6
Large urban	7.5	6.6	4.0	3.2	3.0	2.9	2.4	3.6	3.5	3.8	4.2	4.9
Other urban	8.1	7.2	5.4	4.6	4.5	4.7	5.2	5.6	5.3	5.2	6.1	6.9
Rural referral	7.4	8.4	5.7	5.7	5.1	6.5	6.5	6.5	6.7	6.8	7.1	8.6
Sole community	4.8	4.1	2.7	2.3	2.7	3.3	4.3	5.4	5.6	5.6	5.9	6.3
Other rural	4.4	3.7	2.2	2.1	3.0	3.7	4.2	4.5	4.6	4.3	4.7	5.9
Major teaching	5.2	5.7	2.2	2.1	2.4	1.8	0.9	3.5	3.2	3.3	3.1	4.2
Other teaching	8.4	7.3	5.6	4.4	4.3	4.5	4.4	4.7	4.4	4.7	5.3	6.2
Nonteaching	7.3	6.4	4.5	3.8	3.6	3.9	4.4	4.8	4.9	4.9	5.9	6.4
Disproportionate share:												
Large urban	6.6	5.7	3.2	2.4	2.2	2.0	1.3	3.1	3.0	3.5	3.7	4.3
Other urban	7.9	7.1	5.4	4.7	4.6	4.7	5.3	5.9	5.8	5.4	6.2	7.0
Rural	5.8	5.7	2.5	2.8	3.5	4.4	5.7	7.4	7.7	6.0	6.0	7.8
Nondisproportionate share	7.7	7.0	4.9	4.2	4.2	4.4	4.5	4.6	4.4	4.6	5.4	8.2
Teaching and DSH	6.7	6.1	3.6	3.0	2.9	3.0	2.4	4.0	3.9	4.0	4.1	4.9
Teaching only	9.0	8.5	5.9	4.7	5.0	4.6	4.5	4.7	3.9	4.4	5.1	6.5
DSH only	7.7	6.5	4.6	3.7	3.5	3.4	4.2	5.1	5.2	5.1	6.3	6.8
No teaching or DSH	7.0	6.2	4.4	4.0	3.7	4.3	4.5	4.5	4.7	4.7	5.5	6.1
Voluntary	7.7	7.0	4.9	3.8	3.8	3.9	3.9	4.3	4.0	4.1	4.8	5.7
Proprietary	8.8	7.5	5.6	4.6	3.6	2.9	3.9	5.2	6.6	7.2	9.6	9.3
Urban government	4.4	4.4	0.9	2.3	2.2	2.5	1.7	4.4	4.2	4.4	3.4	4.4
Rural government	4.6	2.9	2.0	1.5	2.4	3.3	4.0	4.8	5.2	4.5	4.7	5.7
All hospitals	7.3	6.6	4.3	3.6	3.5	3.6	3.6	4.4	4.3	4.5	5.0	5.8

Note.—Data are percentages. Data on total revenues and expenses are for hospital accounting years beginning during each Federal fiscal year. Hospitals in Massachusetts and New York excluded from data in 1984 and 1985; hospitals in New Jersey excluded from data in 1984-88; hospitals in Maryland excluded from data in all years.

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

ADDITIONAL HOSPITAL DATA

Table D–16 displays summary characteristics of hospitals participating in the Medicare prospective payment system. These data are derived from PPS payment simulations by CBO. Table D–17 provides historical trends in factors affecting PPS rates and average payments per case, based on data and estimates provided by HCFA’s Office of the Actuary.

TABLE D-16.—FACTORS AFFECTING FISCAL YEAR 1997 PPS OPERATING PAYMENTS PER CASE, BY HOSPITAL GROUP

Hospital group	Number of PPS hospitals	Number of PPS discharges	Average standardized amount	Average wage index	Other payment rate factors	Base payment rate	Average case-mix index	Outlier factor	IME/DSH factor	PPS payments per case
Urban	2,832	8,662,319	\$3,882	1.02	1.00	\$3,935	1.50	1.06	1.17	\$7,281
Rural	2,243	2,139,471	3,847	0.79	1.04	3,416	1.21	1.03	1.02	4,392
Large urban	1,567	4,923,543	3,908	1.09	1.00	4,137	1.50	1.06	1.19	7,836
Other urban	1,265	3,738,776	3,847	0.93	1.00	3,671	1.50	1.06	1.13	6,550
Rural referral	130	407,577	3,847	0.79	1.07	3,510	1.37	1.03	1.04	5,261
Sole community	648	465,468	3,847	0.80	1.09	3,631	1.16	1.01	1.02	4,476
Other rural	1,465	1,266,426	3,847	0.78	1.01	3,294	1.18	1.03	1.02	4,081
Major teaching	263	1,304,199	3,895	1.12	1.00	4,208	1.66	1.07	1.49	11,083
Other teaching	811	3,437,521	3,879	1.00	1.00	3,880	1.55	1.06	1.14	7,225
Nonteaching	4,001	6,060,070	3,868	0.93	1.01	3,746	1.33	1.04	1.05	5,474
Disproportionate share:										
Large urban	786	2,659,569	3,908	1.10	1.00	4,168	1.52	1.06	1.31	8,747
Other urban	679	2,396,608	3,847	0.92	1.00	3,645	1.52	1.06	1.18	6,919
Rural	448	582,226	3,847	0.76	1.03	3,324	1.21	1.03	1.07	4,504
Nondisproportionate share	3,162	5,163,387	3,874	0.96	1.01	3,833	1.39	1.05	1.04	5,810
Teaching and DSH	701	3,102,055	3,883	1.03	1.00	3,963	1.59	1.06	1.32	8,817
Teaching only	373	1,639,665	3,885	1.04	1.01	4,004	1.56	1.06	1.10	7,283
DSH only	1,212	2,536,348	3,867	0.94	1.00	3,719	1.37	1.05	1.11	5,960
No teaching or DSH	2,789	3,523,722	3,869	0.93	1.01	3,741	1.31	1.04	1.00	5,125
Urban, less than 100 beds	700	481,873	3,877	1.00	0.99	3,861	1.21	1.04	1.01	4,915
Urban, 100-199	925	1,898,324	3,881	1.03	1.00	3,938	1.36	1.04	1.11	6,198
Urban, 200-299	567	2,195,938	3,880	1.02	1.00	3,931	1.47	1.05	1.11	6,752
Urban, 300-399	316	1,645,493	3,880	1.01	1.00	3,902	1.55	1.06	1.16	7,451
Urban, 400-499	157	964,132	3,884	1.02	1.00	3,945	1.59	1.06	1.23	8,210

Urban, 500+ beds	167	1,476,559	3,887	1.04	1.00	3,994	1.70	1.07	1.30	9,438
Rural, less than 50 beds	1,175	422,328	3,847	0.79	1.01	3,304	1.06	1.01	1.01	3,605
Rural, 50-99	656	653,095	3,847	0.79	1.03	3,383	1.16	1.02	1.01	4,079
Rural, 100-149	240	466,878	3,847	0.79	1.05	3,437	1.26	1.03	1.02	4,581
Rural, 150-199	97	274,834	3,847	0.79	1.05	3,433	1.27	1.04	1.03	4,712
Rural, 200+ beds	75	322,336	3,847	0.78	1.08	3,528	1.39	1.04	1.06	5,511
New England	213	600,267	3,887	1.14	1.00	4,299	1.42	1.04	1.17	7,439
Middle Atlantic	519	1,849,999	3,888	1.10	1.00	4,197	1.42	1.07	1.21	7,704
South Atlantic	719	1,936,834	3,868	0.91	1.01	3,654	1.46	1.05	1.13	6,342
East North Central	796	1,919,107	3,876	0.96	1.01	3,813	1.43	1.05	1.13	6,479
East South Central	441	914,371	3,855	0.81	1.01	3,377	1.38	1.06	1.11	5,490
West North Central	704	844,212	3,865	0.86	1.02	3,568	1.44	1.04	1.10	5,901
West South Central	726	1,147,927	3,867	0.85	1.01	3,494	1.45	1.06	1.13	6,080
Mountain	338	458,342	3,873	0.94	1.02	3,795	1.48	1.04	1.09	6,400
Pacific	619	1,130,731	3,887	1.20	1.00	4,453	1.49	1.04	1.16	8,063
Voluntary	2,946	8,004,924	3,877	1.00	1.01	3,905	1.46	1.05	1.14	6,852
Proprietary	692	1,206,343	3,875	0.95	1.01	3,770	1.44	1.05	1.09	6,254
Urban government	420	920,619	3,874	0.99	1.00	3,837	1.48	1.06	1.32	7,995
Rural government	966	657,913	3,847	0.77	1.02	3,306	1.15	1.03	1.02	4,030
All hospitals	5,075	10,801,790	3,875	0.98	1.01	3,856	1.44	1.05	1.15	6,709

Source: Congressional Budget Office estimates based on data from the Health Care Financing Administration.

TABLE D-17.—TRENDS IN FACTORS AFFECTING PPS RATES AND AVERAGE PAYMENTS PER CASE, FISCAL YEARS 1983-98

[Percentage change from previous year]

Rate impact factor	Fiscal year															
	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Market basket index ¹	5.5	4.9	4.1	2.9	3.2	4.7	5.4	5.5	5.2	2.4	3.1	4.3	4.3	5.3	2.5	2.8
Annual update factor ⁶ .....	.....	.....	.....	.....	.....	1.7	3.3	5.7	2.8	2.9	2.7	2.1	1.8	1.6	2.0	3.1
Case-mix index ⁷ .....	.....	.....	3.1	2.5	2.1	3.2	2.5	0.8	2.5	1.5	0.8	0.8	1.0	1.5	1.5	1.0
Average payments per discharge ⁸	10.2	10.8	15.0	8.0	3.6	5.0	10.1	8.4	7.2	8.9	4.6	2.5	6.1	6.7	2.9	4.8
Average payments per beneficiary ⁸	11.4	7.8	6.6	1.5	-0.3	3.9	6.5	8.0	5.9	11.5	4.0	5.9	4.3	7.4	3.9	5.9

¹ Estimates as published in the Federal Register for fiscal years 1983-97; fiscal year 1998 President's Budget assumptions shown for fiscal year 1998.

² 4.7 for hospitals excluded from the prospective payment system.

³ 4.2 for hospitals excluded from the prospective payment system.

⁴ 3.7 for hospitals excluded from the prospective payment system.

⁵ 3.4 for hospitals excluded from the prospective payment system.

⁶ Estimates as published in the Federal Register for fiscal years 1989-97; fiscal year 1997 President's Budget assumptions used for fiscal year 1998.

⁷ Estimates based on historical data for fiscal years 1985-97; fiscal year 1998 President's Budget assumptions shown for fiscal years 1996-98.

⁸ Estimates based on historical data and fiscal year 1997 President's Budget assumptions; estimates for fiscal years 1989 and 1990 include the effect of provisions of the Medicare Catastrophic Coverage Act of 1988.

Source: Health Care Financing Administration, Office of the Actuary.

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX (Taylor, TX)	0.8287
Aguadilla, PR (Aguada, PR, Aguadilla, PR, Moca, PR)	0.4224
Akron, OH (Portage, OH, Summit, OH)	0.9728
Albany, GA (Dougherty, GA, Lee, GA)	0.7914
Albany-Schenectady-Troy, NY (Albany, NY, Montgomery, NY, Rensselaer, NY, Saratoga, NY, Schenectady, NY, Schoharie, NY)	0.8480
Albuquerque, NM (Bernalillo, NM, Sandoval, NM, Valencia, NM)	0.9329
Alexandria, LA (Rapides, LA)	0.8269
Allentown-Bethlehem-Easton, PA (Carbon, PA, Lehigh, PA, Northampton, PA)	1.0086
Altoona, PA (Blair, PA)	0.9137
Amarillo, TX (Potter, TX, Randall, TX)	0.9425
Anchorage, AK (Anchorage, AK)	1.2998
Ann Arbor, MI (Lenawee, MI, Livingston, MI, Washtenaw, MI)	1.1785
Anniston, AL (Calhoun, AL)	0.8266
Appleton-Oshkosh-Neenah, WI (Calumet, WI, Outagamie, WI, Winnebago, WI)	0.8996
Arecibo, PR (Arecibo, PR, Camuy, PR, Hatillo, PR)	0.4224
Asheville, NC (Buncombe, NC, Madison, NC)	0.9072
Athens, GA (Clarke, GA, Madison, GA, Oconee, GA)	0.9087
Atlanta, GA (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) ..	0.9823
Atlantic City-Cape May, NJ (Atlantic City, NJ, Cape May, NJ)	1.0724
Augusta-Aiken, GA-SC (Columbia, GA, McDuffie, GA, Richmond, GA, Aiken, SC, Edgefield, SC)	0.9333
Austin-San Marcos, TX (Bastrop, TX, Caldwell, TX, Hays, TX, Travis, TX, Williamson, TX)	0.9133
Bakersfield, CA (Kern, CA)	1.0014
Baltimore, MD (Anne Arundel, MD, Baltimore, MD, Baltimore City, MD, Carroll, MD, Harford, MD, Howard, MD, Queen Annes, MD)	0.9689
Bangor, ME (Penobscot, ME)	0.9478
Barnstable-Yarmouth, MA (Barnstable, MA)	1.4291
Baton Rouge, LA (Ascension, LA, East Baton Rouge, LA, Livingston, LA, West Baton Rouge, LA)	0.8382
Beaumont-Port Arthur, TX (Hardin, TX, Jefferson, TX, Orange, TX)	0.8593
Bellingham, WA (Whatcom, WA)	1.1221
Benton Harbor, MI (Berrien, MI)	0.8923
Bergen-Passaic, NJ (Bergen, NJ, Passaic, NJ)	1.1570
Billings, MT (Yellowstone, MT)	0.9783
Biloxi-Gulfport-Pascagoula, MS (Hancock, MS, Harrison, MS, Jackson, MS)	0.8415
Binghamton, NY (Broome, NY, Tioga, NY)	0.8914
Birmingham, AL (Blount, AL, Jefferson, AL, St. Clair, AL, Shelby, AL)	0.9005
Bismark, ND (Burleigh, ND, Morton, ND)	0.7859
Bloomington, IN (Monroe, IN)	0.9128
Bloomington-Normal, IL (McLean, IL)	0.8733
Boise City, ID (Ada, ID, Canyon, ID)	0.8887

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Boston-Brockton-Nashua, MA—NH (Bristol, MA, Essex, MA, Middlesex, MA, Norfolk, MA, Plymouth, MA, Suffolk, MA, Worcester, MA, Hillsborough, NH, Merrimack, NH, Rockingham, NH, Strafford, NH)	1.1436
Boulder-Longmont, CO (Boulder, CO)	1.0015
Brazoria, TX (Brazoria, TX)	0.9129
Bremerton, WA (Kitsap, WA)	1.0999
Brownsville-Harlingen-San Benito, TX (Cameron, TX)	0.8740
Bryan-College Station, TX (Brazos, TX)	0.8571
Buffalo-Niagara Falls, NY (Erie, NY, Niagara, NY)	0.9272
Burlington, VT (Chittenden, VT, Franklin, VT, Grand Isle, VT)	1.0142
Caguas, PR (Caguas, PR, Cayey, PR, Cidra, PR, Gurabo, PR, San Lorenzo, PR)	0.4508
Canton-Massillon, OH (Carroll, OH, Stark, OH)	0.8961
Casper, WY (Natrona, WY)	0.9013
Cedar Rapids, IA (Linn, IA)	0.8529
Champaign-Urbana, IL (Champaign, IL)	0.8824
Charleston-North Charleston, SC (Berkeley, SC, Charleston, SC, Dorchester, SC)	0.8807
Charleston, WV (Kanawha, WV, Putnam, WV)	0.9142
Charlotte-Gastonia-Rock Hill, NC—SC (Cabarrus, NC, Gaston, NC, Lincoln, NC, Mecklenburg, NC, Rowan, NC, Stanly, NC, Union, NC, York, SC)	0.9710
Charlottesville, VA (Albemarle, VA, Charlottesville City, VA, Fluvanna, VA, Greene, VA)	0.9051
Chattanooga, TN—GA (Catoosa, GA, Dade, GA, Walker, GA, Hamilton, TN, Marion, TN)	0.8658
Cheyenne, WY (Laramie, WY)	0.8247
Chicago, IL (Cook, IL, DeKalb, IL, Du Page, IL, Grundy, IL, Kane, IL, Kendall, IL, Lake, IL, McHenry, IL, Will, IL)	1.0860
Chico-Paradise, CA (Butte, CA)	1.0429
Cincinnati, OH—KY—IN (Dearborn, IN, Ohio, IN, Boone, KY, Campbell, KY, Gallatin, KY, Grant, KY, Kenton, KY, Pendleton, KY, Brown, OH, Clermont, OH, Hamilton, OH, Warren, OH)	0.9521
Clarksville-Hopkinsville, TN—KY (Christian, KY, Montgomery, TN)	0.7852
Cleveland-Lorain-Elyria, OH (Ashtabula, OH, Cuyahoga, OH, Geauga, OH, Lake, OH, Lorain, OH, Medina, OH)	0.9804
Colorado Springs, CO (El Paso, CO)	0.9316
Columbia, MO (Boone, MO)	0.9001
Columbia, SC (Lexington, SC, Richland, SC)	0.9192
Columbus, GA—AL (Russell, AL, Chattahoochee, GA, Harris, GA, Muscogee GA)	0.8288
Columbus, OH (Delaware, OH, Fairfield, OH, Franklin, OH, Licking, OH, Madison, OH, Pickaway, OH)	0.9793
Corpus Christi, TX (Nueces, TX, San Patricio, TX)	0.8945
Cumberland, MD—WV (Allegany, MD, Mineral, WV)	0.8822
Dallas, TX (Collin, TX, Dallas, TX, Denton, TX, Ellis, TX, Henderson, TX, Hunt, TX, Kaufman, TX, Rockwall, TX)	0.9674
Danville, VA (Danville City, VA, Pittsylvania, VA)	0.8146
Davenport-Rock Island-Moline, IA—IL (Scott, IA, Henry, IL, Rock Island, IL)	0.8405

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Dayton-Springfield, OH (Clark, OH, Greene, OH, Miami, OH, Montgomery, OH)	0.9279
Daytona Beach, FL (Flagler, FL, Volusia, FL)	0.8838
Decatur, AL (Lawrence, AL, Morgan, AL)	0.8286
Decatur, IL (Macon, IL)	0.7915
Denver, CO (Adams, CO, Arapahoe, CO, Denver, CO, Douglas, CO, Jefferson, CO)	1.0386
Des Moines, IA (Dallas, IA, Polk, IA, Warren, IA)	0.8837
Detroit, MI (Lapeer, MI, Macomb, MI, Monroe, MI, Oakland, MI, St. Clair, MI, Wayne, MI)	1.0840
Dothan, AL (Dale, AL, Houston, AL)	0.8070
Dover, DE (Kent, DE)	0.9303
Dubuque, IA (Dubuque, IA)	0.8088
Duluth-Superior, MN-WI (St. Louis, MN, Douglas, WI)	0.9779
Dutchess County, NY (Dutchess, NY)	1.0632
Eau Claire, WI (Chippewa, WI, Eau Claire, WI)	0.8764
El Paso, TX (El Paso, TX)	1.0123
Elkhart-Goshen, IN (Elkhart, IN)	0.9081
Elmira, NY (Chemung, NY)	0.8401
Enid, OK (Garfield, OK)	0.7962
Erie, PA (Erie, PA)	0.8862
Eugene-Springfield, OR (Lane, OR)	1.1659
Evansville, IN-KY (Posey, IN, Vanderburgh, IN, Warrick, IN, Henderson, KY)	0.8641
Fargo-Moorhead, ND-MN (Clay, MN, Cass, ND)	0.8837
Fayetteville, NC (Cumberland, NC)	0.8734
Fayetteville-Springdale-Rogers, AR (Benton, AR, Washington, AR)	0.7461
Flagstaff, AZ-UT (Coconino, AZ, Kane, UT)	0.9115
Flint, MI (Genesee, MI)	1.1171
Florence, AL (Colbert, AL, Lauderdale, AL)	0.7716
Florence, SC (Florence, SC)	0.8711
Fort Collins-Loveland, CO (Larimer, CO)	1.0248
Fort Lauderdale, FL (Broward, FL)	1.0487
Fort Myers-Cape Coral, FL (Lee, FL)	0.8838
Fort Pierce-Port St. Lucie, FL (Martin, FL, St. Lucie, FL)	1.0257
Fort Smith, AR-OK (Crawford, AR, Sebastian, AR, Sequoyah, OK)	0.7769
Fort Walton Beach, FL (Okaloosa, FL)	0.8838
Fort Wayne, IN (Adams, IN, Allen, IN, De Kalb, IN, Huntington, IN, Wells, IN, Whitley, IN)	0.8901
Fort Worth-Arlington, TX (Hood, TX, Johnson, TX, Parker, TX, Tarrant, TX)	0.9997
Fresno, CA (Fresno, CA, Madera, CA)	1.0607
Gadsden, AL (Etowah, AL)	0.8815
Gainesville, FL (Alachua, FL)	0.9616
Galveston-Texas City, TX (Galveston, TX)	1.0564
Gary, IN (Lake, IN, Porter, IN)	0.9270
Glens Falls, NY (Warren, NY, Washington, NY)	0.8401
Goldsboro, NC (Wayne, NC)	0.8443
Grand Forks, ND-MN (Polk, MN, Grand Forks, ND)	0.8815
Grand Junction, CO (Mesa, CO)	0.9491

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Grand Rapids-Muskegon-Holland, MI (Allegan, MI, Kent, MI, Muskegon, MI, Ottawa, MI)	1.0147
Great Falls, MT (Cascade, MT)	0.9306
Greeley, CO (Weld, CO)	1.0097
Green Bay, WI (Brown, WI)	0.9585
Greensboro-Winston-Salem-High Point, NC (Alamance, NC, Davidson, NC, Davie, NC, Forsyth, NC, Guilford, NC, Randolph, NC Stokes, NC, Yadkin, NC)	0.9351
Greenville, NC (Pitt, NC)	0.9064
Greenville-Spartanburg-Andersen, SC (Anderson, SC, Cherokee, SC, Greenville, SC, Pickens, SC, Spartanburg, SC)	0.9059
Hagerstown, MD (Washington, MD)	0.9681
Hamilton-Middletown, OH (Butler, OH)	0.8767
Harrisburg-Lebanon-Carlisle, PA (Cumberland, PA, Dauphin, PA, Lebanon, PA, Perry, PA)	1.0187
Hartford, CT (Hartford, CT, Litchfield, CT, Middlesex, CT, Tolland, CT)	1.2617
Hattiesburg, MS (Forrest, MS, Lamar, MS)	0.7192
Hickory-Morganton-Lenoir, NC (Alexander, NC, Burke, NC, Caldwell, NC, Catawba, NC)	0.8285
Honolulu, HI (Honolulu, HI)	1.1817
Houma, LA (Lafourche, LA, Terrebonne, LA)	0.7854
Houston, TX (Chambers, TX, Fort Bend, TX, Harris, TX, Liberty, TX, Montgomery, TX, Waller, TX)	0.9855
Huntington-Ashland, WV-KY-OH (Boyd, KY, Carter, KY, Greenup, KY, Lawrence, OH, Cabell, WV, Wayne, WV)	0.9160
Huntsville, AL (Limestone, AL, Madison, AL)	0.8485
Indianapolis, IN (Boone, IN, Hamilton, IN, Hancock, IN, Hendricks, IN, Johnson, IN, Madison, IN, Marion, IN, Morgan, IN, Shelby, IN)	0.9848
Iowa City, IA (Johnson, IA)	0.9401
Jackson, MI (Jackson, MI)	0.9052
Jackson, MS (Hinds, MS, Madison, MS, Rankin, MS)	0.7790
Jackson, TN (Madison, TN)	0.8522
Jacksonville, FL (Clay, FL, Duval, FL, Nassau, FL, St. Johns, FL)	0.8969
Jacksonville, NC (Onslow, NC)	0.7939
Jamestown, NY (Chautauqua, NY)	0.8401
Janesville-Beloit, WI (Rock, WI)	0.8824
Jersey City, NJ (Hudson, NJ)	1.1412
Johnson City-Kingsport-Bristol, TN-VA (Carter, TN, Hawkins, TN, Sullivan, TN, Unicoi, TN, Washington, TN, Bristol City, VA, Scott, VA, Washington, VA)	0.9114
Johnstown, PA (Cambria, PA, Somerset, PA)	0.8421
Jonesboro, AR (Craighead, AR)	0.7443
Joplin, MO (Jasper, MO, Newton, MO)	0.7541
Kalamazoo-Battlecreek, MI (Calhoun, MI, Kalamazoo, MI, Van Buren, MI)	1.0668
Kankakee, IL (Kankakee, IL)	0.8653
Kansas City, KS-MO (Johnson, KS, Leavenworth, KS, Miami, KS, Wyandotte, KS, Cass, MO, Clay, MO, Clinton, MO, Jackson, MO, Lafayette, MO, Platte, MO, Ray, MO)	0.9564
Kenosha, WI (Kenosha, WI)	0.9196
Killeen-Temple, TX (Bell, TX, Coryell, TX)	1.0252

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Knoxville, TN (Anderson, TN, Blount, TN, Knox, TN, Loudon, TN, Sevier, TN, Union, TN)	0.8831
Kokomo, IN (Howard, IN, Tipton, IN)	0.8416
La Crosse, WI-MN (Houston, MN, La Crosse, WI)	0.8749
LaFayette, LA (Acadia, LA, Lafayette, LA, St. Landry, LA, St. Martin, LA)	0.8227
LaFayette, IN (Clinton, IN, Tippecanoe, IN)	0.9174
Lake Charles, LA (Calcasieu, LA)	0.7776
Lakeland-Winter Haven, FL (Polk, FL)	0.8838
Lancaster, PA (Lancaster, PA)	0.9481
Lansing-East Lansing, MI (Clinton, MI, Eaton, MI, Ingham, MI)	1.0088
Laredo, TX (Webb, TX)	0.7404
Las Cruces, NM (Dona Ana, NM)	0.8658
Las Vegas, NV-AZ (Mohave, AZ, Clark, NV, Nye, NV)	1.0592
Lawrence, KS (Douglas, KS)	0.8608
Lawton, OK (Comanche, OK)	0.9045
Lewiston-Auburn, ME (Androscoggin, ME)	0.9536
Lexington, KY (Bourbon, KY, Clark, KY, Fayette, KY, Jessamine, KY, Madison, KY, Scott, KY, Woodford, KY)	0.8416
Lima, OH (Allen, OH, Auglaize, OH)	0.9185
Lincoln, NE (Lancaster, NE)	0.9231
Little Rock-North Little Rock, AR (Faulkner, AR, Lonoke, AR, Pulaski, AR, Saline, AR)	0.8490
Longview-Marshall, TX (Gregg, TX, Harrison, TX, Upshur, TX)	0.8613
Los Angeles-Long Beach, CA (Los Angeles, CA)	1.2268
Louisville, KY-IN (Clark, IN, Floyd, IN, Harrison, IN, Scott, IN, Bullitt, KY, Jefferson, KY, Oldham, KY)	0.9507
Lubbock, TX (Lubbock, TX)	0.8400
Lynchburg, VA (Amherst, VA, Bedford City, VA, Bedford, VA, Campbell, VA, Lynchburg City, VA)	0.8228
Macon, GA (Bibb, GA, Houston, GA, Jones, GA, Peach, GA, Twiggs, GA) ...	0.9227
Madison, WI (Dane, WI)	1.0055
Mansfield, OH (Crawford, OH, Richfield, OH)	0.8639
Mayaguez, PR (Anasco, PR, Cabo Rojo, PR, Hormigueros, PR, Mayaguez, PR, Sabana Grande, PR, San German, PR)	0.4475
McAllen-Edinburg-Mission, TX (Hidalgo, TX)	0.8371
Medford-Ashland, OR (Jackson, OR)	1.0354
Melbourne-Titusville-Palm Bay, FL (Brevard, FL)	0.8838
Memphis, TN-AR-MS (Crittenden, AR, De Soto, MS, Fayette, TN, Shelby, TN, Tipton, TN)	0.8589
Merced, CA (Merced, CA)	1.0947
Miami, FL (Dade, FL)	0.9859
Middlesex-Somerset-Hunterdon, NJ (Hunterdon, NJ, Middlesex, NJ, Somerset, NJ)	1.0875
Milwaukee, WI (Milwaukee, WI, Ozaukee, WI, Washington, WI, Waukesha, WI)	0.9819
Minneapolis-St. Paul, MN-WI (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)	1.0733
Mobile, AL (Baldwin, AL, Mobile, AL)	0.8455

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Modesto, CA (Stanislaus, CA)	1.0377
Monmouth-Ocean, NJ (Monmouth, NJ, Ocean, NJ)	1.0934
Monroe, LA (Ouachita, LA)	0.8414
Montgomery, AL (Autauga, AL, Elmore, AL, Montgomery, AL)	0.7813
Muncie, IN (Delaware, IN)	0.9173
Myrtle Beach, SC (Horry, SC)	0.8072
Naples, FL (Collier, FL)	1.0109
Nashville, TN (Cheatham, TN, Davidson, TN, Dickson, TN, Robertson, TN, Rutherford, TN, Sumner, TN, Williamson, TN, Wilson, TN)	0.9182
Nassau-Suffolk, NY (Nassau, NY, Suffolk, NY)	1.3807
New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT (Fairfield, CT, New Haven, CT)	1.2619
New London-Norwich, CT (New London, CT)	1.2617
New Orleans, LA (Jefferson, LA, Orleans, LA, Plaquemines, LA, St. Ber- nard, LA, St. Charles, LA, St. James, LA, St. John the Baptist, LA, St. Tammany, LA)	0.9566
New York, NY (Bronx, NY, Kings, NY, New York, NY, Putnam, NY, Queens, NY, Richmond, NY, Rockland, NY, Westchester, NY)	1.3982
Newark, NJ (Essex, NJ, Morris, NJ, Sussex, NJ, Union, NJ, Warren, NJ)	1.1111
Newburgh, NY-PA (Orange, NY, Pike, PA)	1.1283
Norfolk-Virginia Beach-Newport News, VA-NC (Currituck, NC, Chesa- peake 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)	0.8316
Oakland, CA (Alameda, CA, Contra Costa, CA)	1.5158
Ocala, FL (Marion, FL)	0.9032
Odessa-Midland, TX (Ector, TX, Midland, TX)	0.8660
Oklahoma City, OK (Canadian, OK, Cleveland, OK, Logan, OK, McClain, OK, Oklahoma, OK, Pottawatomie, OK)	0.8481
Olympia, WA (Thurston, WA)	1.0901
Omaha, NE-IA (Pottawattamie, IA, Cass, NE, Douglas, NE, Sarpy, NE, Washington, NE)	0.9421
Orange County, CA (Orange, CA)	1.1532
Orlando, FL (Lake, FL, Orange, FL, Osceola, FL, Seminole, FL)	0.9397
Owensboro, KY (Daviess, KY)	0.7772
Panama City, FL (Bay, FL)	0.8838
Parkersburg-Marietta, WV-OH (Washington, OH, Wood, WV)	0.8046
Pensacola, FL (Escambia, FL, Santa Rosa, FL)	0.8838
Peoria-Pekin, IL (Peoria, IL, Tazewell, IL, Woodford, IL)	0.8586
Philadelphia, PA-NJ (Burlington, NJ, Camden, NJ, Gloucester, NJ, Salem, NJ, Bucks, PA, Chester, PA, Delaware, PA, Montgomery, PA, Philadel- phia, PA)	1.1379
Phoenix-Mesa, AZ (Maricopa, AZ, Pinal, AZ)	0.9606
Pine Bluff, AR (Jefferson, AR)	0.7826
Pittsburgh, PA (Allegheny, PA, Beaver, PA, Butler, PA, Fayette, PA, Washington, PA, Westmoreland, PA)	0.9725
Pittsfield, MA (Berkshire, MA)	1.0960
Pocatello, ID (Bannock, ID)	0.9586

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Ponce, PR (Guayanilla, PR, Juana Diaz, PR, Penuelas, PR, Ponce, PR, Villalba, PR, Yauco, PR)	0.4589
Portland, ME (Cumberland, ME, Sagadahoc, ME, York, ME)	0.9627
Portland-Vancouver, OR-WA (Clackamas, OR, Columbia, OR, Multnomah, OR, Washington, OR, Yamhill, OR, Clark, WA)	1.1344
Providence-Warwick, RI (Bristol, RI, Kent, RI, Newport, RI, Providence, RI, Washington, RI)	1.1049
Provo-Orem, UT (Utah, UT)	1.0073
Pueblo, CO (Pueblo, CO)	0.8450
Punta Gorda, FL (Charlotte, FL)	0.8838
Racine, WI (Racine, WI)	0.8934
Raleigh-Durham-Chapel Hill, NC (Chatham, NC, Durham, NC, Franklin, NC, Johnston, NC, Orange, NC, Wake, NC)	0.9818
Rapid City, SD (Pennington, SD)	0.8345
Reading, PA (Berks, PA)	0.9516
Redding, CA (Shasta, CA)	1.1790
Reno, NV (Washoe, NV)	1.0768
Richland-Kennewick-Pasco, WA (Benton, WA, Franklin, WA)	1.0221
Richmond-Petersburg, VA (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)	0.9152
Riverside-San Bernardino, CA (Riverside, CA, San Bernardino, CA)	1.1145
Roanoke, VA (Botetourt, VA, Roanoke, VA, Roanoke City, VA, Salem City, VA)	0.8402
Rochester, MN (Olmstead, MN)	1.0502
Rochester, NY (Genesee, NY, Livingston, NY, Monroe, NY, Ontario, NY, Orleans, NY, Wayne, NY)	0.9524
Rockford, IL (Boone, IL, Ogle, IL, Winnebago, IL)	0.9081
Rocky Mount, NC (Edgecombe, NC, Nash, NC)	0.9029
Sacramento, CA (El Dorado, CA, Placer, CA, Sacramento, CA)	1.2202
Saginaw-Bay City-Midland, MI (Bay, MI, Midland, MI, Saginaw, MI)	0.9564
St. Cloud, MN (Benton, MN, Stearns, MN)	0.9544
St. Joseph, MO (Andrews, MO, Buchanan, MO)	0.8366
St. Louis, MO-IL (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)	0.9130
Salem, OR (Marion, OR, Polk, OR)	0.9976
Salinas, CA (Monterey, CA)	1.4513
Salt Lake City-Ogden, UT (Davis, UT, Salt Lake, UT, Weber, UT)	0.9862
San Angelo, TX (Tom Green, TX)	0.7780
San Antonio, TX (Bexar, TX, Comal, TX, Guadalupe, TX, Wilson, TX)	0.8499
San Diego, CA (San Diego, CA)	1.2225
San Francisco, CA (Marin, CA, San Francisco, CA, San Mateo, CA)	1.4091
San Jose, CA (Santa Clara, CA)	1.4332

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
San Juan-Bayamon, PR (Aguas Buenas, PR, Barceloneta, PR, Bayamon, PR, Canovanas, PR, Carolina, PR, Catano, PR, Ceiba, PR, Comerio, PR, Corozal, PR, Dorado, PR, Fajardo, PR, Florida, PR, Guaynabo, PR, Humacao, PR, Juncos, PR, Los Piedras, PR, Loiza, PR, Luguillo, PR, Manati, PR, Naranjito, PR, Rio Grande, PR, San Juan, PR, Toa Alta, PR, Toa Baja, PR, Trujillo Alto, PR, Vega Alta, PR, Vega Baja, PR, Yabucoa, PR)	0.4618
San Luis Obispo-Atascadero-Pasa Robles, CA (San Luis Obispo, CA)	1.1374
Santa Barbara-Santa Maria-Lompoc, CA (Santa Barbara, CA)	1.0688
Santa Cruz-Watsonville, CA (Santa Cruz, CA)	1.4187
Santa Fe, NM (Los Alamos, NM, Santa Fe, NM)	1.0332
Santa Rosa, CA (Sonoma, CA)	1.2267
Sarasota-Bradenton, FL (Manatee, FL, Sarasota, FL)	0.9757
Savannah, GA (Bryan, GA, Chatham, GA, Effingham, GA)	0.8638
Scranton-Wilkes Barre-Hazleton, PA (Columbia, PA, Lackawanna, PA, Luzerne, PA, Wyoming, PA)	0.8539
Seattle-Bellevue-Everett, WA (Island, WA, King, WA, Snohomish, WA)	1.1375
Sharon, PA (Mercer, PA)	0.8783
Sheboygan, WI (Sheboygan, WI)	0.8471
Sherman-Denison, TX (Grayson, TX)	0.8499
Shreveport-Bossier City, LA (Bossier, LA, Caddo, LA, Webster, LA)	0.9381
Sioux City, IA-NE (Woodbury, IA, Dakota, NE)	0.8031
Sioux Falls, SD (Lincoln, SD, Minnehaha, SD)	0.8712
South Bend, IN (St. Joseph, IN)	0.9880
Spokane, WA (Spokane, WA)	1.0486
Springfield, IL (Menard, IL, Sangamon, IL)	0.8713
Springfield, MO (Christian, MO, Greene, MO, Webster, MO)	0.8036
Springfield, MA (Hampden, MA, Hampshire, MA)	1.0718
State College, PA (Centre, PA)	0.9635
Steubenville-Weirton, OH-WV (Jefferson, OH, Brook, WV, Hancock, WV) ...	0.8645
Stockton-Lodi, CA (San Joaquin, CA)	1.1518
Sumter, SC (Sumter, SC)	0.7921
Syracuse, NY (Cayuga, NY, Madison, NY, Onondaga, NY, Oswego, NY)	0.9480
Tacoma, WA (Pierce, WA)	1.1016
Tallahassee, FL (Gadsden, FL, Leon, FL)	0.8838
Tampa-St. Petersburg-Clearwater, FL (Hernando, FL, Hillsborough, FL, Pasco, FL, Pinellas, FL)	0.9196
Terre-Haute, IN (Clay, IN, Vermillion, IN, Vigo, IN)	0.8614
Texarkana, AK-Texarkana, TX (Miller, AR, Bowie, TX)	0.8699
Toledo, OH (Fulton, OH, Lucas, OH, Wood, OH)	1.0140
Topeka, KS (Shawnee, KS)	0.9438
Trenton, NJ (Mercer, NJ)	1.0380
Tucson, AZ (Pima, AZ)	0.9180
Tulsa, OK (Creek, OK, Osage, OK, Rogers, OK, Tulsa, OK, Wagoner, OK) ..	0.8074
Tuscaloosa, AL (Tuscaloosa, AL)	0.8187
Tyler, TX (Smith, TX)	0.9567
Utica-Rome, NY (Herkimer, NY, Oneida, NY)	0.8401
Vallejo-Fairfield-Napa, CA (Napa, CA, Solano, CA)	1.3528
Ventura, CA (Ventura, CA)	1.0544
Victoria, TX (Victoria, TX)	0.8474

TABLE D-18.—WAGE INDEX FOR URBAN AREAS, FISCAL YEAR 1996—Continued

Urban area (constituent counties or county equivalents)	Wage index
Vineland-Millville-Bridgeton, NJ (Cumberland, NJ)	1.0110
Visalia-Tulare-Porterville, CA (Tulare, CA)	0.9977
Waco, TX (McLennan, TX)	0.7696
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, Culpepper, VA, Fairfax, VA, Fairfax City, VA, Falls Church City, VA, Fauquier, VA, Fredericksburg City, VA, King George, VA, Loudoun, VA, Manassas City, VA, Manassas Park City, VA, Prince William, VA, Spotsylvania, VA, Stafford, VA, Warren, VA, Berkeley, WV, Jefferson, WV)	1.0780
Waterloo-Cedar Falls, IA (Black Hawk, IA)	0.8643
Wausau, WI (Marathon, WI)	1.0545
West Palm Beach-Boca Raton, FL (Palm Beach, FL)	1.0309
Wheeling, OH—WV (Belmont, OH, Marshall, WV, Ohio, WV)	0.7707
Wichita, KS (Butler, KS, Harvey, KS, Sedgwick, KS)	0.9403
Wichita Falls, TX (Archer, TX, Wichita, TX)	0.7646
Williamsport, PA (Lycoming, PA)	0.8548
Wilmington-Newark, DE—MD (New Castle, DE, Cecil, MD)	1.1538
Wilmington, NC (New Hanover, NC, Brunswick, NC)	0.9322
Yakima, WA (Yakima, WA)	1.0221
Yolo, CA (Yolo, CA)	1.1431
York, PA (York, PA)	0.9415
Youngstown-Warren, OH (Columbiana, OH, Mahoning, OH, Trumbull, OH)	0.9937
Yuba City, CA (Sutter, CA, Yuba, CA)	1.0324
Yuma, AZ (Yuma, AZ)	0.9732

Source: Health Care Financing Administration.

TABLE D-19.—WAGE INDEX FOR RURAL AREAS, FISCAL YEAR 1998

State	Wage index	State	Wage index
Alabama	0.7260	Nebraska	0.7401
Alaska	1.2302	Nevada	0.8914
Arizona	0.7989	New Hampshire	0.9724
Arkansas	0.6995	New Jersey	(¹)
California	0.9977	New Mexico	0.8110
Colorado	0.8129	New York	0.8401
Connecticut	1.2617	North Carolina	0.7939
Delaware	0.8925	North Dakota	0.7360
Florida	0.8838	Ohio	0.8434
Georgia	0.7761	Oklahoma	0.7072
Hawaii	1.0229	Oregon	0.9976
Idaho	0.8221	Pennsylvania	0.8421
Illinois	0.7644	Puerto Rico	0.4224
Indiana	0.8161	Rhode Island	(¹)
Iowa	0.7391	South Carolina	0.7921
Kansas	0.7203	South Dakota	0.6983
Kentucky	0.7772	Tennessee	0.7353
Louisiana	0.7383	Texas	0.7404
Maine	0.8468	Utah	0.8926
Maryland	0.8617	Vermont	0.9314
Massachusetts	1.0718	Virginia	0.7782
Michigan	0.8923	Washington	1.0221
Minnesota	0.8180	West Virginia	0.7966
Mississippi	0.6911	Wisconsin	0.8471
Missouri	0.7207	Wyoming	0.8247
Montana	0.8302		

¹ All counties within this State are classified as urban.

Source: Health Care Financing Administration.

TABLE D-20.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED, FISCAL YEAR
1996

Area reclassified to	Wage index
Abilene, TX	0.8287
Albuquerque, NM	0.9329
Alexandria, LA	0.8269
Amarillo, TX	0.9277
Anchorage, AK	1.2998
Asheville, NC	0.9072
Athens, GA	0.9087
Atlanta, GA	0.9823
Austin-San Marcos, TX	0.9133
Bangor, ME	0.9478
Barnstable-Yarmouth, MA	1.3827
Baton Rouge, LA	0.8382
Benton Harbor, MI	0.8923
Bergen-Passaic, NJ	1.1570
Billings, MT	0.9609
Birmingham, AL	0.9005
Bismarck, ND	0.7859
Boise City, ID	0.8887
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1436
Caguas, PR	0.4508
Casper, WY	0.9013
Champaign-Urbana, IL	0.8706
Charlotte-Gastonia-Rock Hill, NC	0.9710
Charlottesville, VA	0.8885
Chattanooga, TN-GA	0.8658
Chicago, IL	1.0759
Cincinnati, OH-KY-IN	0.9521
Cleveland-Lorain-Elyria, OH	0.9804
Columbia, MO	0.8759
Columbus, OH	0.9793
Dallas, TX	0.9674
Davenport-Rock Island-Moline, IA-IL	0.8405
Denver, CO	1.0386
Des Moines, IA	0.8837
Detroit, MI	1.0840
Duluth-Superior, MN-WI	0.9779
Dutchess County, NY	1.0364
Eugene-Springfield, OR	1.1659
Fargo-Moorhead, ND-MN	0.8729
Fayetteville, NC	0.8491
Flint, MI	1.1171
Florence, AL	0.7716
Florence, SC	0.8711
Fort Lauderdale, FL	1.0487
Fort Pierce-Port St. Lucie, FL	1.0008
Fort Walton Beach, FL	0.8653
Fort Worth-Arlington, TX	0.9997
Gadsden, AL	0.8815
Gainesville, FL	0.9616

TABLE D-20.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED, FISCAL YEAR
1996—Continued

Area reclassified to	Wage index
Gary, IN	0.9114
Grand Forks, ND-MN	0.8815
Grand Junction, CO	0.9491
Great Falls, MT	0.9306
Greeley, CO	0.9791
Green Bay, WI	0.9585
Greensboro-Winston-Salem-High Point, NC	0.9351
Harrisburg-Lebanon-Carlisle, PA	1.0076
Honolulu, HI	1.1817
Houma, LA	0.7854
Houston, TX	0.9855
Huntington-Ashland, WV-KY-OH	0.9160
Huntsville, AL	0.8485
Indianapolis, IN	0.9848
Iowa City	0.9198
Jackson, MS	0.7790
Johnson City-Kingsport-Bristol, TN	0.9114
Jonesboro, AR	0.7443
Joplin, MO	0.7541
Kalamazoo-Battle Creek, MI	1.0668
Kansas City, MO-KS	0.9564
Knoxville, TN	0.8831
Lafayette, LA	0.8227
Lafayette, IN	0.9174
Lansing-East Lansing, MI	1.0088
Las Cruces, NM	0.8658
Las Vegas, NV-AZ	1.0592
Lexington, KY	0.8416
Lima, OH	0.9185
Lincoln, NE	0.9035
Little Rock-North Little Rock, AR	0.8490
Longview-Marshall, TX	0.8509
Los Angeles-Long Beach, CA	1.2268
Louisville, KY-IN	0.9507
Macon, GA	0.9227
Madison, WI	1.0055
Mansfield, OH	0.8639
Medford-Ashland, OR	1.0354
Memphis, TN-AR-MS	0.8589
Milwaukee-Waukesha, WI	0.9819
Minneapolis-St. Paul, MN-WI	1.0733
Monroe, LA	0.8414
Montgomery, AL	0.7813
Nashville, TN	0.9182
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2619
New London-Norwich, CT	1.2258
New Orleans, LA	0.9566
New York-Newark, NY-NJ-PA	1.3982
Newark, NJ	1.1111

TABLE D-20.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED, FISCAL YEAR
1996—Continued

Area reclassified to	Wage index
Newburgh, NY-PA	1.1283
Oakland, CA	1.5158
Odessa-Midland, TX	0.8516
Oklahoma City, OK	0.8481
Omaha, NE-IA	0.9421
Orange County, CA	1.1532
Peoria-Pekin, IL	0.8586
Philadelphia, PA-NJ	1.1379
Pittsburgh, PA	0.9583
Pocatello, ID	0.9000
Portland, ME	0.9627
Portland-Vancouver, OR-WA	1.1344
Provo-Orem, UT	1.0073
Raleigh-Durham-Chapel Hill, NC	0.9818
Rapid City, SD	0.8345
Rochester, MN	1.0502
Rockford, IL	0.9081
Sacramento, CA	1.2202
Saginaw-Bay City-Midland, MI	0.9564
St. Cloud, MN	0.9544
St. Louis, MO-IL	0.9130
Salinas, CA	1.4299
Salt Lake City-Ogden, UT	0.9862
San Diego, CA	1.2225
San Francisco, CA	1.4091
Santa Fe, NM	1.0007
Santa Rosa, CA	1.2146
Seattle-Bellevue-Everett, WA	1.1375
Sherman-Denison, TX	0.8324
Sioux City, IA-NE	0.8031
Sioux Falls, SD	0.8607
South Bend, IN	0.9880
Spokane, WA	1.0311
Springfield, IL	0.8610
Springfield, MO	0.8036
Stockton-Lodi, CA	1.1518
Syracuse, NY	0.9480
Tampa-St. Petersburg-Clearwater, FL	0.9196
Texarkana, TX-Texarkana, AR	0.8699
Topeka, KS	0.9310
Tucson, AZ	0.9180
Tulsa, OK	0.8074
Tyler, TX	0.9421
Vallejo-Fairfield-Napa, CA	1.3528
Washington, DC-MD-VA-WV	1.0780
Waterloo-Cedar Falls, IA	0.8643
Wausau, WI	0.9845
Wichita, KS	0.9157
Wichita Falls, TX	0.7646

TABLE D-20.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED, FISCAL YEAR
1996—Continued

Area reclassified to	Wage index
Rural Florida	0.8838
Rural Louisiana	0.7383
Rural Minnesota	0.8180
Rural Missouri	0.7207
Rural New Hampshire	0.9724
Rural New Mexico	0.8110
Rural North Carolina	0.7939
Rural Oregon	0.9976
Rural Washington	1.0221
Rural West Virginia	0.7966
Rural Wyoming	0.8247

Source: Health Care Financing Administration.

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998

DRG	MDC	Type	Title	1997	1998	Percent change
1	1	SURG	Craniotomy age >17 except for trauma	3.0486	3.0907	1.4
2	1	SURG	Craniotomy for trauma age >17	3.0134	3.0511	1.3
3	1	SURG ¹	Craniotomy age 0-17	1.9167	1.9484	1.7
4	1	SURG	Spinal procedures	2.3399	2.3858	2.0
5	1	SURG	Extracranial vascular procedures	1.5143	1.5041	-0.7
6	1	SURG	Carpal tunnel release	0.7419	0.7582	2.2
7	1	SURG	Periph and cranial nerve and other nerv syst proc with CC	2.4886	2.4717	-0.7
8	1	SURG	Periph and cranial nerve and other nerv syst proc without CC	1.0962	1.2142	10.8
9	1	MED	Spinal disorders and injuries	1.2677	1.2646	-0.2
10	1	MED	Nervous system neoplasms with CC	1.2196	1.2184	-0.1
11	1	MED	Nervous system neoplasms without CC	0.8000	0.7879	-1.5
12	1	MED	Degenerative nervous system disorders	0.9457	0.9370	-0.9
13	1	MED	Multiple sclerosis and cerebellar ataxia	0.7770	0.7832	0.8
14	1	MED	Specific cerebrovascular disorders except TIA	1.1999	1.1889	-0.9
15	1	MED	Transient ischemic attack and precerebral occlusions	0.7231	0.7241	0.1
16	1	MED	Nonspecific cerebrovascular disorders with CC	1.0371	1.0452	0.8
17	1	MED	Nonspecific cerebrovascular disorders without CC	0.6331	0.6161	-2.7
18	1	MED	Cranial and peripheral nerve disorders with CC	0.9319	0.9399	0.9
19	1	MED	Cranial and peripheral nerve disorders without CC	0.6230	0.6293	1.0
20	1	MED	Nervous system infection except viral meningitis	2.4854	2.5786	3.7
21	1	MED	Viral meningitis	1.4910	1.4866	-0.3
22	1	MED	Hypertensive encephalopathy	0.8353	0.8594	2.9
23	1	MED	Nontraumatic stupor and coma	0.8089	0.7777	-3.9
24	1	MED	Seizure and headache age >17 with CC	0.9694	0.9578	-1.2
25	1	MED	Seizure and headache age >17 without CC	0.5793	0.5821	0.5
26	1	MED	Seizure and headache age 0-17	0.7387	0.9601	30.0
27	1	MED	Traumatic stupor and coma, coma >1 HR	1.3060	1.2670	-3.0

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
28	1	MED	Traumatic stupor and coma, coma <1 HR age >17 with CC	1.2033	1.1707	-2.7
29	1	MED	Traumatic stupor and coma, coma <1 HR age >17 without CC	0.6371	0.6383	0.2
30	1	MED ¹	Traumatic stupor and coma, coma <1 HR age 0-17	0.3241	0.3295	1.7
31	1	MED	Concussion age >17 with CC	0.8412	0.8369	-0.5
32	1	MED	Concussion age >17 without CC	0.4861	0.5109	5.1
33	1	MED ¹	Concussion age 0-17	0.2037	0.2071	1.7
34	1	MED	Other disorders of nervous system with CC	1.0673	1.0385	-2.7
35	1	MED	Other disorders of nervous system, without CC	0.6149	0.5941	-3.4
36	2	SURG	Retinal procedures	0.6134	0.6265	2.1
37	2	SURG	Orbital procedures	0.9323	0.9725	4.3
38	2	SURG	Primary iris procedures	0.4282	0.4826	12.7
39	2	SURG	Lens procedures with or without vitrectomy	0.5184	0.5406	4.3
40	2	SURG	Extraocular procedures except orbit age >17	0.7072	0.7341	3.8
41	2	SURG ¹	Extraocular procedures except orbit age 0-17	0.3299	0.3354	1.7
42	2	SURG	Introcular procedures except retina, iris and lens	0.5816	0.5676	-2.4
43	2	MED	Hyphema	0.4520	0.4119	-8.9
44	2	MED	Acute major eye infections	0.6237	0.6072	-2.6
45	2	MED	Neurological eye disorders	0.6525	0.6730	3.1
46	2	MED	Other disorders of the eye age >17 with CC	0.7656	0.7234	-5.5
47	2	MED	Other disorders of the eye age >17 without CC	0.4664	0.4623	-0.9
48	2	MED ¹	Other disorders of the eye age 0-17	0.2907	0.2955	1.7
49	3	SURG	Major head and neck procedures	1.7245	1.8074	4.8
50	3	SURG	Sialoadenectomy	0.7686	0.8143	5.9
51	3	SURG	Salivary gland procedures except sialoadenectomy	0.7345	0.8367	13.9
52	3	SURG	Cleft lip and palate repair	1.0271	1.2768	24.3
53	3	SURG	Sinus and mastoid procedures age >17	1.0128	1.0682	5.5
54	3	SURG ¹	Sinus and mastoid procedures age 0-17	0.4712	0.4790	1.7

55	3	SURG	Miscellaneous ear, nose, mouth and throat procedures	0.7880	0.8366	6.2
56	3	SURG	Rhinoplasty	0.8283	0.8830	6.6
57	3	SURG	T&A proc, except tonsillectomy and/or adenoidectomy only age >17	0.9325	1.0182	9.2
58	3	SURG ¹	T&A proc, except tonsillectomy and/or adenoidectomy only age 0-17	0.2676	0.2720	1.6
59	3	SURG	Tonsillectomy and/or adenoidectomy only age >17	0.7439	0.8238	10.7
60	3	SURG ¹	Tonsillectomy and/or adenoidectomy only age 0-17	0.2038	0.2072	1.7
61	3	SURG	Myringotomy with tube insertion age >17	1.1960	1.1181	-6.5
62	3	SURG ¹	Myringotomy with tube insertion age 0-17	0.2885	0.2933	1.7
63	3	SURG	Other ear, nose, mouth and throat O.R. procedures	1.2168	1.2444	2.3
64	3	MED	Ear, nose, mouth and throat malignancy	1.1737	1.1568	-1.4
65	3	MED	Dysequilibrium	0.5195	0.5177	-0.3
66	3	MED	Epistaxis	0.5366	0.5605	4.5
67	3	MED	Epiglottitis	0.8397	0.7866	-6.3
68	3	MED	Otitis media and uri age >17 with CC	0.7098	0.6831	-3.8
69	3	MED	Otitis media and uri age >17 without CC	0.5239	0.5160	-1.5
70	3	MED	Otitis media and uri age 0-17	0.3727	0.3892	4.4
71	3	MED	Laryngotracheitis	0.7702	0.6688	-13.2
72	3	MED	Nasal trauma and deformity	0.6532	0.6364	-2.6
73	3	MED	Other ear, nose, mouth and throat diagnoses age >17	0.7505	0.7660	2.1
74	3	MED ¹	Other ear, nose, mouth and throat diagnoses age 0-17	0.3278	0.3332	1.6
75	4	SURG	Major chest procedures	3.1951	3.1958	0.0
76	4	SURG	Other resp system O.R. procedures with CC	2.6036	2.6427	1.5
77	4	SURG	Other resp system O.R. procedures without CC	1.1593	1.1150	-3.8
78	4	MED	Pulmonary embolism	1.4292	1.4264	-0.2
79	4	MED	Respiratory infections and inflammations age 17 with CC	1.6300	1.6258	-0.3
80	4	MED	Respiratory infections and inflammations age 17 without CC	0.9436	0.9121	-3.3
81	4	MED ¹	Respiratory infections and inflammations age 0-17	1.4845	1.5091	1.7
82	4	MED	Respiratory neoplasms	1.3319	1.3329	0.1
83	4	MED	Major chest trauma with CC	0.9782	0.9716	-0.7
84	4	MED	Major chest trauma without CC	0.5319	0.5260	-1.1
85	4	MED	Pleural effusion with CC	1.2200	1.2212	0.1
86	4	MED	Pleural effusion without CC	0.7117	0.6715	-5.6

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
87	4	MED	Pulmonary edema and respiratory failure	1.3615	1.3639	0.2
88	4	MED	Chronic obstructive pulmonary disease	0.9846	0.9705	-1.4
89	4	MED	Simple pneumonia and pleurisy age >17 with CC	1.1156	1.1006	-1.3
90	4	MED	Simple pneumonia and pleurisy age >17 without CC	0.6978	0.6773	-2.9
91	4	MED	Simple pneumonia and pleurisy age 0-17	0.7524	0.7940	5.5
92	4	MED	Interstitial lung diseases with CC	1.2029	1.1947	-0.7
93	4	MED	Interstitial lung disease without CC	0.7498	0.7423	-1.0
94	4	MED	Pneumothorax with CC	1.1780	1.1857	0.7
95	4	MED	Pneumothorax without CC	0.5996	0.5974	-0.4
96	4	MED	Bronchitis and asthma age >17 with CC	0.8272	0.8005	-3.2
97	4	MED	Bronchitis and asthma age >17 without CC	0.6035	0.5887	-2.5
98	4	MED	Bronchitis and asthma age 0-17	0.7807	0.6298	-19.3
99	4	MED	Respiratory signs and symptoms with CC	0.6869	0.6710	-2.3
100	4	MED	Respiratory signs and symptoms without CC	0.5113	0.5109	-0.1
101	4	MED	Other respiratory system diagnoses with CC	0.8748	0.8518	-2.6
102	4	MED	Other respiratory system diagnoses without CC	0.5335	0.5295	-0.7
103	5	SURG	Heart transplant	15.3358	16.5746	8.1
104	5	SURG	Cardiac valve procedures with cardiac cath	7.3199	7.3563	0.5
105	5	SURG	Cardiac valve procedures without cardiac cath	5.5998	5.7109	2.0
106	5	SURG	Coronary bypass with cardiac cath	5.5564	5.5843	0.5
107	5	SURG	Coronary bypass without cardiac cath	4.0685	4.0812	0.3
108	5	SURG	Other cardiothoracic procedures	5.9135	6.1282	3.6
109	.....	.....	No longer valid .....	.....	.....	.....
110	5	SURG	Major cardiovascular procedures with CC	4.1589	4.1964	0.9
111	5	SURG	Major cardiovascular procedures without CC	2.2875	2.2409	-2.0
112	5	SURG	Percutaneous cardiovascular procedures	2.0946	2.0025	-4.4
113	5	SURG	Amputation for circ system disorders except upper limb and toe	2.6935	2.6579	-1.3

114	5	SURG	Upper limb and toe amputation for circ system disorders	1.5152	1.5363	1.4
115	5	SURG	Perm cardiac pacemaker implant with ami, Heart failure or shock	3.6827	3.5476	-3.7
116	5	SURG	Other perm cardiac pacemaker implant or acid lead or generator proc	2.4150	2.5321	4.8
117	5	SURG	Cardiac pacemaker revision except device replacement	1.1764	1.1950	1.6
118	5	SURG	Cardiac pacemaker device replacement	1.5825	1.5889	0.4
119	5	SURG	Vein ligation and stripping	1.1435	1.1997	4.9
120	5	SURG	Other circulatory system O.R. procedures	1.9318	1.9158	-0.8
121	5	MED	Circulatory disorders with ami and c.v. comp disch alive	1.6482	1.6537	0.3
122	5	MED	Circulatory disorders with ami without c.v. comp disch alive	1.1617	1.1446	-1.5
123	5	MED	Circulatory disorders with ami, expired	1.4555	1.4695	1.0
124	5	MED	Circulatory disorders except ami, with card cath and complex diag	1.3258	1.3565	2.3
125	5	MED	Circulatory disorders except ami, with card cath without complex diag	0.9246	0.9738	5.3
126	5	MED	Acute and subacute endocarditis	2.5379	2.4879	-2.0
127	5	MED	Heart failure and shock	1.0265	1.0199	-0.6
128	5	MED	Deep vein thrombophlebitis	0.7861	0.7807	-0.7
129	5	MED	Cardiac arrest, unexplained	1.1316	1.1414	0.9
130	5	MED	Peripheral vascular disorders with CC	0.9352	0.9410	0.6
131	5	MED	Peripheral vascular disorders without CC	0.6038	0.6040	0.0
132	5	MED	Atherosclerosis with CC	0.6840	0.6749	-1.3
133	5	MED	Atherosclerosis without CC	0.5537	0.5360	-3.2
134	5	MED	Hypertension	0.5787	0.5760	-0.5
135	5	MED	Cardiac congenital and valvular disorders age 17 with CC	0.8838	0.8336	-5.7
136	5	MED	Cardiac congenital and valvular disorders age 17 without CC	0.5629	0.5709	1.4
137	5	MED ¹	Cardiac congenital and valvular disorders age 0-17	0.7999	0.8131	1.7
138	5	MED	Cardiac arrhythmia and conduction disorders with CC	0.8008	0.7962	-0.6
139	5	MED	Cardiac arrhythmia and conduction disorders without CC	0.4971	0.4982	0.2
140	5	MED	Angina pectoris	0.6205	0.5993	-3.4
141	5	MED	Syncope and collapse with CC	0.7128	0.7005	-1.7
142	5	MED	Syncope and collapse without CC	0.5288	0.5231	-1.1
143	5	MED	Chest pain	0.5223	0.5200	-0.4
144	5	MED	Other circulatory system diagnoses with CC	1.0857	1.0904	0.4
145	5	MED	Other circulatory system diagnoses without CC	0.6208	0.6401	3.1

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
146	6	SURG	Rectal resection with CC	2.6363	2.7356	3.8
147	6	SURG	Rectal resection without CC	1.6018	1.5885	-0.8
148	6	SURG	Major small and large bowel procedures with CC	3.3710	3.3883	0.5
149	6	SURG	Major small and large bowel procedures without CC	1.5999	1.5495	-3.2
150	6	SURG	Peritoneal adhesiolysis with CC	2.6828	2.7109	1.0
151	6	SURG	Peritoneal adhesiolysis without CC	1.2910	1.2645	-2.1
152	6	SURG	Minor small and large bowel procedures with CC	1.9311	1.9139	-0.9
153	6	SURG	Minor small and large bowel procedures without CC	1.1568	1.1634	0.6
154	6	SURG	Stomach, esophageal and duodenal procedures age >17 with CC	4.1817	4.1851	0.1
155	6	SURG	Stomach, esophageal and duodenal procedures age >17 without CC	1.4059	1.3350	-5.0
156	6	SURG ¹	Stomach, esophageal and duodenal procedures age 0-17	0.8238	0.8374	1.7
157	6	SURG	Anal and stomal procedures with CC	1.1352	1.1824	4.2
158	6	SURG	Anal and stomal procedures without CC	0.6077	0.6272	3.2
159	6	SURG	Hernia procedures except inguinal and femoral age >17 with CC	1.2268	1.2548	2.3
160	6	SURG	Hernia procedures except inguinal and femoral age >17 without CC	0.7026	0.7177	2.1
161	6	SURG	Inguinal and femoral hernia procedures age >17 with CC	1.0066	1.0573	5.0
162	6	SURG	Inguinal and femoral hernia procedures age >17 without CC	0.5707	0.5856	2.6
163	6	SURG	Hernia procedures age 0-17	0.7706	0.8660	12.4
164	6	SURG	Appendectomy with complicated principal diag with CC	2.3386	2.3412	0.1
165	6	SURG	Appendectomy with complicated principal diag without CC	1.2582	1.2270	-2.5
166	6	SURG	Appendectomy without complicated principal diag with CC	1.4497	1.4582	0.6
167	6	SURG	Appendectomy without complicated principal diag without CC	0.8431	0.8373	-0.7
168	3	SURG	Mouth procedures with CC	1.0929	1.1187	2.4
169	3	SURG	Mouth procedures without CC	0.6717	0.6903	2.8
170	6	SURG	Other digestive system O.R. procedures with CC	2.7453	2.7587	0.5
171	6	SURG	Other digestive system O.R. procedures without CC	1.1202	1.1146	-0.5
172	6	MED	Digestive malignancy with CC	1.2920	1.2867	-0.4

173	6	MED	Digestive malignancy without CC	0.6769	0.6744	-0.4
174	6	MED	G.I. Hemorrhage with CC	0.9952	0.9925	-0.3
175	6	MED	G.I. Hemorrhage without CC	0.5485	0.5366	-2.2
176	6	MED	Complicated peptic ulcer	1.0856	1.1011	1.4
177	6	MED	Uncomplicated peptic ulcer with CC	0.8335	0.8556	2.7
178	6	MED	Uncomplicated peptic ulcer without CC	0.6091	0.6241	2.5
179	6	MED	Inflammatory bowel disease	1.1188	1.1100	-0.8
180	6	MED	G.I. obstruction with CC	0.9194	0.9153	-0.4
181	6	MED	G.I. obstruction without CC	0.5338	0.5204	-2.5
182	6	MED	Esophagitis, gastroent and misc digest disorders age >17 with CC	0.7789	0.7664	-1.6
183	6	MED	Esophagitis, gastroent and misc digest disorders age >17 without CC	0.5553	0.5496	-1.0
184	6	MED	Esophagitis, gastroent and misc digest disorders age 0-17	0.5414	0.5930	9.5
185	3	MED	Dental and oral dis except extractions and restorations age >17	0.8424	0.8424	0.0
186	3	MED ¹	Dental and oral dis except extractions and restorations age 0-17	0.3140	0.3192	1.7
187	3	MED	Dental extractions and restorations	0.7104	0.7049	-0.8
188	6	MED	Other digestive system diagnoses age >17 with CC	1.0591	1.0727	1.3
189	6	MED	Other digestive system diagnoses age >17 without CC	0.5640	0.5488	-2.7
190	6	MED	Other digestive system diagnoses age 0-17	0.8769	0.8786	0.2
191	7	SURG	Pancreas, liver and shunt procedures with CC	4.4543	4.3490	-2.4
192	7	SURG	Pancreas, liver and shunt procedures without CC	1.7889	1.7057	-4.7
193	7	SURG	Biliary tract proc except only cholecyst with or without C.D.E. with CC	3.2878	3.2666	-0.6
194	7	SURG	Biliary tract proc except only cholecyst with or without C.D.E. without CC	1.7549	1.6688	-4.9
195	7	SURG	Cholecystectomy with C.D.E. with CC	2.6894	2.7112	0.8
196	7	SURG	Cholecystectomy with C.D.E. without CC	1.6127	1.6075	-0.3
197	7	SURG	Cholecystectomy except by laparoscope without C.D.E. with CC	2.2679	2.3085	1.8
198	7	SURG	Cholecystectomy except by laparoscope without C.D.E. without CC	1.1738	1.1693	-0.4
199	7	SURG	Hepatobiliary diagnostic procedure for malignancy	2.3728	2.3523	-0.9
200	7	SURG	Hepatobiliary diagnostic procedure for nonmalignancy	3.1772	3.0210	-4.9
201	7	SURG	Other hepatobiliary or pancreas O.R. procedures	3.7669	3.4752	-7.7
202	7	MED	Cirrhosis and alcoholic hepatitis	1.3675	1.3255	-3.1
203	7	MED	Malignancy of hepatobiliary system or pancreas	1.2486	1.2605	1.0
204	7	MED	Disorders of pancreas except malignancy	1.2004	1.2117	0.9

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
205	7	MED	Disorders of liver except malig, cirr, alc hepa with CC	1.2194	1.2144	-0.4
206	7	MED	Disorders of liver except malig, cirr, alc hepa without CC	0.7159	0.6543	-8.6
207	7	MED	Disorders of the biliary tract with CC	1.0508	1.0507	0.0
208	7	MED	Disorders of the biliary tract without CC	0.6045	0.6039	-0.1
209	8	SURG	Major joint and limb reattachment procedures of lower extremity	2.2606	2.2337	-1.2
210	8	SURG	Hip and femur procedures except major joint age >17 with CC	1.8460	1.8265	-1.1
211	8	SURG	Hip and femur procedures except major joint age >17 without CC	1.2740	1.2541	-1.6
212	8	SURG	Hip and femur procedures except major joint age 0-17	1.1487	1.1311	-1.5
213	8	SURG	Amputation for musculoskeletal system and conn tissue disorders	1.7049	1.6513	-3.1
214	.....	.....	No longer valid	1.9255	.....	.....
215	.....	.....	No longer valid	1.1119	.....	.....
216	8	SURG	Biopsies of musculoskeletal system and connective tissue	2.0784	2.1082	1.4
217	8	SURG	WND debrid and skin graft except hand, for musculoskeletal and conn tiss dis	2.8812	2.8033	-2.7
218	8	SURG	Lower extrem and humer proc except hip, foot, femur age >17 with CC	1.4574	1.4576	0.0
219	8	SURG	Lower extrem and humer proc except hip, foot, femur age >17 without CC	0.9553	0.9631	0.8
220	8	SURG ¹	Lower extrem and humer proc except hip, foot, femur age 0-17	0.5706	0.5800	1.6
221	.....	.....	No longer valid .....	.....	.....	.....
222	.....	.....	No longer valid .....	.....	.....	.....
223	8	SURG	Major shoulder/elbow proc, or other upper extremity proc with CC	0.8720	0.9007	3.3
224	8	SURG	Shoulder, elbow or forearm proc, exc major joint proc, without CC	0.7417	0.7466	0.7
225	8	SURG	Foot procedures	1.0020	1.0124	1.0
226	8	SURG	Soft tissue procedures with CC	1.3831	1.4095	1.9
227	8	SURG	Soft tissue procedures without CC	0.7449	0.7729	3.8
228	8	SURG	Major thumb or joint proc, or other hand or wrist proc with CC	0.9349	0.9542	2.1
229	8	SURG	Hand or wrist proc, except major joint proc, without CC	0.6512	0.6706	3.0
230	8	SURG	Local excision and removal of int fix devices of hip and femur	1.0567	1.1296	6.9
231	8	SURG	Local excision and removal of int fix devices except hip and femur	1.2263	1.2727	3.8

232	8	SURG	Arthroscopy	1.0884	1.0629	-2.3
233	8	SURG	Other musculosket sys and conn tiss O.R. proc without CC	2.0170	2.0329	0.8
234	8	SURG	Other musculosket sys and conn tiss O.R. proc without CC	1.0675	1.1126	4.2
235	8	MED	Fractures of femur	0.8395	0.7710	-8.2
236	8	MED	Fractures of hip and pelvis	0.7620	0.7338	-3.7
237	8	MED	Sprains, strains and dislocations of hip, pelvis and thigh	0.5637	0.5952	5.6
238	8	MED	Osteomyelitis	1.3796	1.3250	-4.0
239	8	MED	Pathological fractures and musculoskeletal and conn tiss malignancy	1.0115	0.9865	-2.5
240	8	MED	Connective tissue disorders with CC	1.2112	1.2098	-0.1
241	8	MED	Connective tissue disorders without CC	0.6029	0.5862	-2.8
242	8	MED	Septic arthritis	1.0492	1.0501	0.1
243	8	MED	Medical back problems	0.7241	0.7158	-1.1
244	8	MED	Bone disease and specific arthropathies with CC	0.7279	0.7199	-1.1
245	8	MED	Bone disease and specific arthropathies without CC	0.4954	0.5002	1.0
246	8	MED	Nonspecific arthropathies	0.5887	0.5713	-3.0
247	8	MED	Signs and symptoms of musculoskeletal system and conn tissue	0.5523	0.5587	1.2
248	8	MED	Tendonitis, myositis and bursitis	0.7325	0.7428	1.4
249	8	MED	Aftercare, musculoskeletal system and connective tissue	0.6522	0.6559	0.6
250	8	MED	FX, sprn, strn and disl of forearm, hand, foot age >17 with CC	0.6915	0.6995	1.2
251	8	MED	FX, sprn, strn and disl of forearm, hand, foot age >17 without CC	0.4640	0.4517	-2.7
252	8	MED ¹	FX, sprn, strn and disl of forearm, hand, foot age 0-17	0.2479	0.2520	1.7
253	8	MED	FX, sprn, strn and disl of uparm, lowleg ex foot age >17 with CC	0.7438	0.7265	-2.3
254	8	MED	FX, sprn, strn, and disl of uparm, lowleg ex foot age >17 without CC	0.4451	0.4350	-2.3
255	8	MED ¹	FX, sprn, strn and disl of uparm, lowleg ex foot age 0-17	0.2886	0.2934	1.7
256	8	MED	Other musculoskeletal system and connective tissue diagnoses	0.7651	0.7826	2.3
257	9	SURG	Total mastectomy for malignancy with CC	0.9015	0.9276	2.9
258	9	SURG	Total mastectomy for malignancy without CC	0.7087	0.7162	1.1
259	9	SURG	Subtotal mastectomy for malignancy with CC	0.8640	0.8874	2.7
260	9	SURG	Subtotal mastectomy for malignancy without CC	0.6083	0.6092	0.1
261	9	SURG	Breast proc for nonmalignancy except biopsy and local excision	0.8286	0.8961	8.1
262	9	SURG	Breast biopsy and local excision for nonmalignancy	0.7695	0.7820	1.6
263	9	SURG	Skin graft and/or debrid for skn ulcer or cellulitis with CC	2.1226	2.0221	-4.7

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
264	9	SURG	Skin graft and/or debrid for skin ulcer or cellulitis without CC	1.1270	1.0773	-4.4
265	9	SURG	Skin graft and/or debrid except skin ulcer or cellulitis with CC	1.4993	1.5166	1.2
266	9	SURG	Skin graft and/or debrid except for skin ulcer or cellulitis without CC	0.7629	0.7909	3.7
267	9	SURG	Perianal and pilonidal procedures	0.8330	0.8424	1.1
268	9	SURG	Skin, subcutaneous tissue and breast plastic procedures	0.9916	1.0090	1.8
269	9	SURG	Other skin, subcut tiss and breast proc with CC	1.6416	1.5733	-4.2
270	9	SURG	Other skin, subcut tiss and breast proc without CC	0.7003	0.7061	0.8
271	9	MED	Skin ulcers	1.0816	1.0259	-5.1
272	9	MED	Major skin disorders with CC	1.0158	0.9950	-2.0
273	9	MED	Major skin disorders without CC	0.6346	0.6618	4.3
274	9	MED	Malignant breast disorders with CC	1.0760	1.1229	4.4
275	9	MED	Malignant breast disorders without CC	0.5085	0.5882	15.7
276	9	MED	Nonmalignant breast disorders	0.6374	0.6122	-4.0
277	9	MED	Cellulitis age >17 with CC	0.8526	0.8322	-2.4
278	9	MED	Cellulitis age >17 without CC	0.5774	0.5574	-3.5
279	9	MED ¹	Cellulitis age 0-17	0.7190	0.7309	1.7
280	9	MED	Trauma to the skin subcut tiss & breast age >17 with CC	0.6750	0.6757	0.1
281	9	MED	Trauma to the skin subcut tiss & breast age >17 without CC	0.4560	0.4558	0.0
282	9	MED ¹	Trauma to the skin subcut tiss & breast age 0-17	0.2509	0.2551	1.7
283	9	MED	Minor skin disorders with CC	0.6990	0.6936	-0.8
284	9	MED	Minor skin disorders without CC	0.4340	0.4371	0.7
285	10	SURG	Amputat of lower limb for endocrine, nutrit and metabol disorders	2.2015	2.1556	-2.1
286	10	SURG	Adrenal and pituitary procedures	2.3775	2.2671	-4.6
287	10	SURG	Skin grafts and wound debrid for endoc, nutrit and metab disorders	1.9765	1.8727	-5.3
288	10	SURG	O.R. procedures for obesity	2.0104	2.0255	0.8
289	10	SURG	Parathyroid procedures	1.0198	0.9827	-3.6
290	10	SURG	Thyroid procedures	0.8798	0.8970	2.0

291	10	SURG	Thyroglossal procedures	0.5189	0.7372	42.1
292	10	SURG	Other endocrine, nutrit and metab. O.R. proc with CC	2.6450	2.5483	-3.7
293	10	SURG	Other endocrine, nutrit and metab. O.R. proc without CC	1.2671	1.2297	-3.0
294	10	MED	Diabetes age >35	0.7594	0.7546	-0.6
295	10	MED	Diabetes age 0-35	0.7159	0.7359	2.8
296	10	MED	Nutritional and misc metabolic disorders age >17 with CC	0.8929	0.8657	-3.0
297	10	MED	Nutritional and misc metabolic disorders age >17 without CC	0.5364	0.5188	-3.3
298	10	MED	Nutritional and misc metabolic disorders age 0-17	0.5221	0.4207	-19.4
299	10	MED	Inborn errors of metabolism	0.8330	0.8716	4.6
300	10	MED	Endocrine disorders with CC	1.0950	1.0810	-1.3
301	10	MED	Endocrine disorders without CC	0.6182	0.5941	-3.9
302	11	SURG	Kidney transplant	3.9047	3.7570	-3.8
303	11	SURG	Kidney, ureter and major bladder procedures for neoplasm	2.6409	2.6139	-1.0
304	11	SURG	Kidney, ureter and major bladder procedures for nonneopl with CC	2.3716	2.3982	1.1
305	11	SURG	Kidney, ureter and major bladder procedures for nonneopl without CC	1.1776	1.1695	-0.7
306	11	SURG	Prostatectomy with CC	1.2258	1.2168	-0.7
307	11	SURG	Prostatectomy without CC	0.6708	0.6455	-3.8
308	11	SURG	Minor bladder procedures with CC	1.5252	1.5120	-0.9
309	11	SURG	Minor bladder procedures without CC	0.8860	0.8760	-1.1
310	11	SURG	Transurethral procedures with CC	1.0015	1.0248	2.3
311	11	SURG	Transurethral procedures without CC	0.5670	0.5866	3.5
312	11	SURG	Urethral procedures age >17 with CC	0.9124	0.9732	6.7
313	11	SURG	Urethral procedures age >17 without CC	0.5223	0.5783	10.7
314	11	SURG ¹	Urethral procedures age 0-17	0.4836	0.4916	1.7
315	11	SURG	Other kidney and urinary tract O.R. procedures	2.0574	2.0601	0.1
316	11	MED	Renal failure	1.3034	1.3089	0.4
317	11	MED	Admit for renal dialysis	0.4845	0.5489	13.3
318	11	MED	Kidney and urinary tract neoplasms with CC	1.1296	1.1594	2.6
319	11	MED	Kidney and urinary tract neoplasms without CC	0.5772	0.5808	0.6
320	11	MED	Kidney and urinary tract infections age 17W CC	0.9048	0.8782	-2.9
321	11	MED	Kidney and urinary tract infections age >17 without CC	0.6077	0.5838	-3.9
322	11	MED	Kidney and urinary tract infections age 0-17	0.5133	0.5342	4.1

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
323	11	MED	Urinary stones with CC, and/or ESW lithotripsy	0.7496	0.7555	0.8
324	11	MED	Urinary stones without CC	0.4159	0.4298	3.3
325	11	MED	Kidney and urinary tract signs and symptoms age >17 with CC	0.6377	0.6207	-2.7
326	11	MED	Kidney and urinary tract signs and symptoms age >17 without CC	0.4320	0.4188	-3.1
327	11	MED	Kidney and urinary tract signs and symptoms age 0-17	0.2341	0.3516	50.2
328	11	MED	Urethral stricture age >17 with CC	0.6886	0.6878	-0.1
329	11	MED	Urethral stricture age >17 without CC	0.4567	0.5080	11.2
330	11	MED ¹	Urethral stricture age 0-17	0.3115	0.3167	1.7
331	11	MED	Other kidney and urinary tract diagnoses age >17 with CC	0.9914	1.0009	1.0
332	11	MED	Other kidney and urinary tract diagnoses age >17 without CC	0.6070	0.5964	-1.7
333	11	MED	Other kidney and urinary tract diagnoses age 0-17	0.8562	0.8389	-2.0
334	12	SURG	Major male pelvic procedures with CC	1.6653	1.6359	-1.8
335	12	SURG	Major male pelvic procedures without CC	1.2610	1.2190	-3.3
336	12	SURG	Transurethral prostatectomy with CC	0.8848	0.8870	0.2
337	12	SURG	Transurethral prostatectomy without CC	0.6147	0.6129	-0.3
338	12	SURG	Testes procedures, for malignancy	1.0499	1.0950	4.3
339	12	SURG	Testes procedures, nonmalignancy age >17	1.0194	1.0038	-1.5
340	12	SURG ¹	Testes procedures, nonmalignancy age 0-17	0.2769	0.2815	1.7
341	12	SURG	Penis procedures	1.0745	1.1089	3.2
342	12	SURG	Circumcision age >17	0.7578	0.8511	12.3
343	12	SURG ¹	Circumcision age 0-17	0.1504	0.1529	1.7
344	12	SURG	Other male reproductive system O.R. procedures for malignancy	1.0083	1.0298	2.1
345	12	SURG	Other male reproductive system O.R. proc except for malignancy	0.8422	0.8552	1.5
346	12	MED	Malignancy, male reproductive system, with CC	0.9559	0.9573	0.1
347	12	MED	Malignancy, male reproductive system, without CC	0.5096	0.4603	-9.7
348	12	MED	Benign prostatic hypertrophy with CC	0.7107	0.6958	-2.1
349	12	MED	Benign prostatic hypertrophy without CC	0.3974	0.4154	4.5

350	12	MED	Inflammation of the male reproductive system	0.6611	0.6797	2.8
351	12	MED ¹	Sterilization, male	0.2309	0.2347	1.6
352	12	MED	Other male reproductive system diagnoses	0.5877	0.6263	6.6
353	13	SURG	Pelvic evisceration, radical hysterectomy and radical vulvectomy	1.9174	2.1179	10.5
354	13	SURG	Uterine, adnexa proc for nonovarian/adnexal malig with CC	1.4643	1.4963	2.2
355	13	SURG	Uterine, adnexa proc for nonovarian/adnexal malig without CC	0.9056	0.9180	1.4
356	13	SURG	Female reproductive system reconstructive procedures	0.7376	0.7701	4.4
357	13	SURG	Uterine and adnexa proc for ovarian or adnexal malignancy	2.3824	2.4309	2.0
358	13	SURG	Uterine and adnexa proc for nonmalignancy with CC	1.1713	1.2021	2.6
359	13	SURG	Uterine and adnexa proc for nonmalignancy without CC	0.8285	0.8452	2.0
360	13	SURG	Vagina, cervix and vulva procedures	0.8459	0.8708	2.9
361	13	SURG	Laparoscopy and incisional tubal interruption	1.1148	1.1872	6.5
362	13	SURG ¹	Endoscopic tubal interruption	0.2951	0.3000	1.7
363	13	SURG	D&C, conization and radio-implant for malignancy	0.6911	0.7485	8.3
364	13	SURG	D&C, conization except for malignancy	0.6739	0.6985	3.7
365	13	SURG	Other female reproductive system O.R. procedures	1.7237	1.7085	-0.9
366	13	MED	Malignancy, female reproductive system with CC	1.1941	1.1857	-0.7
367	13	MED	Malignancy, female reproductive system without CC	0.5216	0.5309	1.8
368	13	MED	Infections, female reproductive system	1.0230	0.9698	-5.2
369	13	MED	Menstrual and other female reproductive system disorders	0.5454	0.5367	-1.6
370	14	SURG	Cesarean section with CC	1.0401	1.0587	1.8
371	14	SURG	Cesarean section without CC	0.6838	0.7054	3.2
372	14	MED	Vaginal delivery with complicating diagnoses	0.5439	0.5590	2.8
373	14	MED	Vaginal delivery without complicating diagnoses	0.3602	0.3987	10.7
374	14	SURG	Vaginal delivery with sterilization and diagnoses and/or D&C	0.6775	0.7625	12.5
375	14	SURG ¹	Vaginal delivery with O.R. proc except steril and/or D&C	0.6698	0.6809	1.7
376	14	MED	Postpartum and post abortion diagnoses without O.R. procedure	0.5638	0.4822	-14.5
377	14	SURG	Postpartum and post abortion diagnosis with O.R. procedure	0.8188	1.0517	28.4
378	14	MED	Ectopic pregnancy	0.8054	0.8126	0.9
379	14	MED	Threatened abortion	0.3591	0.4028	12.2
380	14	MED	Abortion without D&C	0.4775	0.3501	-26.7
381	14	SURG	Abortion with D&C, aspiration curettage or hysterotomy	0.5151	0.4809	-6.6

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
382	14	MED	False labor	0.2013	0.2086	3.6
383	14	MED	Other antepartum diagnosis with medical complications	0.4655	0.4636	-0.4
384	14	MED	Other antepartum diagnosis without medical complications	0.3921	0.3539	-9.7
385	15	(1)	Neonates, died or transferred to another acute care facility	1.3443	1.3665	1.7
386	15	(1)	Extreme immaturity or respiratory distress syndrome, neonate	4.4329	4.5063	1.7
387	15	(1)	Prematurity with major problems	3.0276	3.0777	1.7
388	15	(1)	Prematurity without major problems	1.8268	1.8570	1.7
389	15	.....	Full term neonate with major problems	2.2451	1.4862	-33.8
390	15	(1)	Neonate with other significant problems	1.2845	1.3058	1.7
391	15	(1)	Normal newborn	0.1490	0.1515	1.7
392	16	SURG	Splenectomy age >17	3.2443	3.1695	-2.3
393	16	SURG ¹	Splenectomy age 0-17	1.3168	1.3386	1.7
394	16	SURG	Other O.R. procedures of the blood and blood forming organs	1.5994	1.6479	3.0
395	16	MED	Red blood cell disorders age >17	0.8362	0.8181	-2.2
396	16	MED	Red blood cell disorders age 0-17	0.6966	0.6284	-9.8
397	16	MED	Coagulation disorders	1.2612	1.2679	0.5
398	16	MED	Reticuloendothelial and immunity disorders with CC	1.2106	1.2242	1.1
399	16	MED	Reticuloendothelial and immunity disorders without CC	0.7030	0.6836	-2.8
400	17	SURG	Lymphoma and leukemia with major O.R. procedure	2.5572	2.6402	3.2
401	17	SURG	Lymphoma and nonacute leukemia with other O.R. proc with CC	2.4834	2.5653	3.3
402	17	SURG	Lymphoma and nonacute leukemia with other O.R. proc without CC	1.0255	1.0145	-1.1
403	17	MED	Lymphoma and nonacute leukemia with CC	1.6925	1.6964	0.2
404	17	MED	Lymphoma and nonacute leukemia without CC	0.8059	0.7917	-1.8
405	17	(1)	Acute leukemia without major O.R. procedure age 0-17	1.8669	1.8978	1.7
406	17	SURG	Myeloprolif disord or poorly diff neopl with maj O.R. proc with CC	2.6841	2.6147	-2.6
407	17	SURG	Myeloprolif disord or poorly diff neopl with maj O.R. proc without CC	1.1787	1.1516	-2.3
408	17	SURG	Myeloprolif disord or poorly diff neopl with other O.R. proc	1.7393	1.7294	-0.6

409	17	MED	Radiotherapy	0.9763	0.9534	-2.3
410	17	MED	Chemotherapy without acute leukemia as secondary diagnosis	0.7514	0.7968	6.0
411	17	MED	History of malignancy without endoscopy	0.3837	0.4214	9.8
412	17	MED	History of malignancy with endoscopy	0.4080	0.5175	26.8
413	17	MED	Other myeloprolif dis or poorly diff neopl diag with CC	1.3257	1.3777	3.9
414	17	MED	Other myeloprolif dis or poorly diff neopl diag without CC	0.7337	0.7041	-4.0
415	18	SURG	O.R. procedure for infectious and parasitic diseases	3.4430	3.5166	2.1
416	18	MED	Septicemia age >17	1.4838	1.4797	-0.3
417	18	MED	Septicemia age 0-17	0.8089	0.7688	-5.0
418	18	MED	Postoperative and post-traumatic infections	0.9697	0.9679	-0.2
419	18	MED	Fever of unknown origin age >17 with CC	0.8991	0.8831	-1.8
420	18	MED	Fever of unknown origin age >17 without CC	0.6264	0.6064	-3.2
421	18	MED	Viral illness age >17	0.7153	0.7069	-1.2
422	18	MED	Viral illness and fever of unknown origin age 0-17	0.5347	0.5347	0.0
423	18	MED	Other infectious and parasitic diseases diagnoses	1.5947	1.5690	-1.6
424	19	SURG	O.R. procedure with principal diagnoses of mental illness	2.3637	2.4581	4.0
425	19	MED	Acute adjust react and disturbances of psychosocial dysfunction	0.7051	0.6857	-2.8
426	19	MED	Depressive neuroses	0.5680	0.5648	-0.6
427	19	MED	Neuroses except depressive	0.5495	0.5818	5.9
428	19	MED	Disorders of personality and impulse control	0.7303	0.6975	-4.5
429	19	MED	Organic disturbances and mental retardation	0.9075	0.8728	-3.8
430	19	MED	Psychoses	0.8391	0.8073	-3.8
431	19	MED	Childhood mental disorders	0.6556	0.8371	27.7
432	19	MED	Other mental disorder diagnoses	0.7363	0.7647	3.9
433	20		Alcohol/drug abuse or dependence, left AMA	0.2986	0.3053	2.2
434	20		Alc/drug abuse or depend, detox or oth sympt treat with CC	0.7141	0.6865	-3.9
435	20		Alc/drug abuse or depend, detox or oth sympt treat without CC	0.4164	0.4015	-3.6
436	20		Alc/drug dependence with rehabilitation therapy	0.8183	0.8110	-0.9
437	20		Alc/drug dependence, combined rehab and detox therapy	0.7657	0.7343	-4.1
438	.....		No longer valid .....	.....	.....	.....
439	21	SURG	Skin grafts for injuries	1.6144	1.6391	1.5
440	21	SURG	Wound debridements for injuries	1.7725	1.8456	4.1

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
441	21	SURG	Hand procedures for injuries	0.9294	0.9298	0.0
442	21	SURG	Other O.R. procedures for injuries with CC	2.1653	2.1818	0.8
443	21	SURG	Other O.R. procedures for injuries without CC	0.8849	0.9116	3.0
444	21	MED	Traumatic injury age >17 with CC	0.7312	0.7007	-4.2
445	21	MED	Traumatic injury age >17 without CC	0.4845	0.4842	-0.1
446	21	MED ¹	Traumatic injury age 0-17	0.2894	0.2942	1.7
447	21	MED	Allergic reactions age >17	0.4918	0.4927	0.2
448	21	MED	Allergic reactions age 0-17	0.0777	0.0968	24.6
449	21	MED	Poisoning and toxic effects of drugs age >17 with CC	0.7902	0.7860	-0.5
450	21	MED	Poisoning and toxic effects of drugs age >17 without CC	0.4274	0.4406	3.1
451	21	MED ¹	Poisoning and toxic effects of drugs age 0-17	0.2570	0.2613	1.7
452	21	MED	Complications of treatment with CC	0.9473	0.9476	0.0
453	21	MED	Complications of treatment without CC	0.4822	0.4960	2.9
454	21	MED	Other injury, poisoning and toxic effect diag with CC	0.8575	0.9035	5.4
455	21	MED	Other injury, poisoning and toxic effect diag without CC	0.4467	0.4453	-0.3
456	22	.....	Burns, transferred to another acute care facility	1.8327	1.7396	-5.1
457	22	MED	Extensive burns without O.R. procedure	1.4657	1.5860	8.2
458	22	SURG	Nonextensive burns with skin graft	3.4991	3.5746	2.2
459	22	SURG	Nonextensive burns with wound debridement or other O.R. proc	1.6538	1.5588	-5.7
460	22	MED	Nonextensive burns without O.R. procedure	0.9547	0.9421	-1.3
461	23	SURG	O.R. proc with diagnoses of other contact with health services	0.9963	1.0123	1.6
462	23	MED	Rehabilitation	1.4298	1.4041	-1.8
463	23	MED	Signs and symptoms with CC	0.7101	0.6907	-2.7
464	23	MED	Signs and symptoms without CC	0.5028	0.4872	-3.1
465	23	MED	Aftercare with history of malignancy as secondary diagnosis	0.5571	0.5858	5.2
466	23	MED	Aftercare without history of malignancy as secondary diagnosis	0.5905	0.6336	7.3
467	23	MED	Other factors influencing health status	0.4588	0.4669	1.8

468	.....	.....	Extensive O.R. procedure unrelated to principal diagnosis	3.6028	3.6202	0.5
469	.....	(2)	Principal diagnosis invalid as discharge diagnosis .....	.....	.....	.....
470	.....	(2)	Ungroupable .....	.....	.....	.....
471	8	SURG	Bilateral or multiple major joint procs of lower extremity	3.5980	3.4771	-3.4
472	22	SURG	Extensive burns with O.R. procedure	10.9989	10.2429	-6.9
473	17	.....	Acute leukemia without major O.R. procedure age >17	3.5740	3.4853	-2.5
474	.....	.....	No longer valid .....	.....	.....	.....
475	4	MED	Respiratory system diagnosis with ventilator support	3.6765	3.7291	1.4
476	.....	SURG	Prostatic O.R. procedure unrelated to principal diagnosis	2.2479	2.2234	-1.1
477	.....	SURG	Nonextensive O.R. procedure unrelated to principal diagnosis	1.7266	1.7461	1.1
478	5	SURG	Other vascular procedures with CC	2.2883	2.2981	0.4
479	5	SURG	Other vascular procedures without CC	1.4080	1.4113	0.2
480	.....	SURG	Liver transplant	13.9424	11.4672	-17.8
481	.....	SURG	Bone marrow transplant	11.2299	11.2821	0.5
482	.....	SURG	Tracheostomy for face, mouth and neck diagnoses	3.6578	3.5999	-1.6
483	.....	SURG	Tracheostomy except for face, mouth and neck diagnoses	16.0413	16.0451	0.0
484	24	SURG	Craniotomy for multiple significant trauma	5.6821	5.7762	1.7
485	24	SURG	Limb reattachment, hip and femur proc for multiple significant TR	3.2058	3.1562	-1.5
486	24	SURG	Other O.R. procedures for multiple significant trauma	4.7915	4.8882	2.0
487	24	MED	Other multiple significant trauma	2.0305	2.0229	-0.4
488	25	SURG	HIV with extensive O.R. procedure	4.7905	4.5078	-5.9
489	25	MED	HIV with major related condition	1.8141	1.8009	-0.7
490	25	MED	HIV with or without other related condition	1.0116	0.9952	-1.6
491	8	SURG	Major joint and limb reattachment procedures of upper extremity	1.6308	1.6579	1.7
492	17	MED	Chemotherapy with acute leukemia as secondary diagnosis	4.0299	4.6393	15.1
493	7	SURG	Laparoscopic cholecystectomy without C.D.E. with CC	1.7100	1.7561	2.7
494	7	SURG	Laparoscopic cholecystectomy without C.D.E. without CC	0.9169	0.9400	2.5
495	.....	SURG	Lung transplant	9.2870	9.5171	2.5
496	8	SURG	Combined anterior/posterior spinal fusion .....	.....	5.5214	.....
497	8	SURG	Spinal fusion with CC .....	.....	2.7692	.....
498	8	SURG	Spinal fusion without CC .....	.....	1.6171	.....
499	8	SURG	Back and neck procs except spinal fusion with CC .....	.....	1.4827	.....

TABLE D-21.—DIAGNOSIS-RELATED GROUPS RELATIVE WEIGHTS, FISCAL YEARS 1997 AND 1998—Continued

DRG	MDC	Type	Title	1997	1998	Percent change
500	8	SURG	Back and neck procs except spinal fusion without CC	.....	0.9708	.....
501	8	SURG	Knee proc with pdx of infection with CC	.....	2.5660	.....
502	8	SURG	Knee proc with pdx of infection without CC	.....	1.6004	.....
503	8	SURG	Knee procedures without pdx of infection	.....	1.2380	.....

¹ Medicare data for low-volume DRGs have been supplemented by data for non-Medicare patients from 19 States.

² DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.

Note.—Abbreviations are as follows:

aicd = automatic implantable cardioverter defibrillator	D&C = dilation & curettage	gastroent = gastroenteritis	nutrit = nutritional
alc hepa = alcoholic hepatitis	debrid = debridement	G.I. = gastrointestinal	OR = operating room
AMA = against medical advice	detox = detoxification	HIV = human immunodeficiency virus	pdx = principal diagnosis
ami = anterior myocardial infarction	diag. = diagnosis	HR = hour	proc = procedures
amputat = amputation	diff = differentiated	humer = humerus	sprn = sprain
cath = catheterization	digest = digestive	int = internal	strn = strain
CC = complication or comorbidity	dis = diseases	lowleg = lower leg	subcut = subcutaneous
C.D.E. = common duct exploration	disch = discharge	malig = malignancy	surg = surgical
cholecyst = cholecystectomy	disl = dislocation	MDC = major diagnostic category	syst = system
circ = circulatory	disord = disorder	med = medical	T&A = tonsillectomy and/or adenoidectomy
cirr = cirrhosis	endoc = endocrine	metabol = metabolic	TIA = transient ischemic attack
comp = complication	ESW = extracorporeal shock wave	muscskelet = musculoskeletal	TR = trauma
conn = connective	extrem = extremity	myeloprolif = myeloproliferative	uparm = upper arm
c.v. = cardiovascular	fix = fixation	neopl = neoplasm	WND = wound
	FX = fracture	nonneopl = nonneoplasm	

Source: Health Care Financing Administration.

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